

Brighton and Sussex University Hospitals NHS Trust

Princess Royal Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Brighton and Sussex University Hospitals (BSUH) is an acute teaching hospital with two sites the Royal Sussex County Hospital in Brighton (centre for emergency and tertiary care) and the Princess Royal Hospital in Haywards Heath (centre for elective surgery). The Brighton campus includes the Royal Alexandra Children's Hospital and the Sussex Eye Hospital.

The trust provides services to the local populations in and around the City of Brighton and Hove, Mid Sussex and the western part of East Sussex and more specialised and tertiary services for patients across Sussex and the south east of England.

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

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

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

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

Our key findings were as follows:

Safe

- Incident reporting, process and culture was much improved with enhanced analysis. Feedback to staff via safety huddles and other communications had also been improved. However, in some areas learning and sharing had not been maximised and in critical care a significant backlog of incidents had occurred that impeded the opportunity to learn from incidents.
- Following an improvement initiative the trust had reduced the number of never events at the trust. The root cause analysis of serious incidents was also of a good standard.
- There was not an overarching strategy for the maintenance of a clean environment and the fabric of some areas of the hospital remained in a poor condition. The concerns relating to fire safety expressed in our last report had been addressed by a process of external review and assessment. However, action plans to complete the work identified lacked documentation of completion and had no corporate oversight mechanism.
- Although overall consultant cover has increased we remain concerned regarding the provision of paediatric nursing and paediatric anaesthetist cover to the emergency department. The trust is continuing to work with local commissioners regarding the perception and use of the paediatric emergency department by the local population.
- IT provision in the emergency department is now aligned with RSCH addressing the risk identified in our last report.
- Staffing levels and recruitment remain challenging for the trust. However, staff are now more likely to report staffing issues as incidents than previously.

Summary of findings

- As at our last inspection, medicines management, safeguarding and duty of candour were well managed and applied appropriately. Although the trust has improved its compliance with mandatory and safeguarding training many departments remain below a low threshold target of 75%.

Effective

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

Caring

- As reported at our last inspection, patients received compassionate care throughout the trust and we observed this in the interactions between staff and patients. Patients were very positive in their feedback regarding the care they received.
- Patients reported they were involved in decisions about their treatment and care and this was reflected in the care records we reviewed.

Responsive

- Similar to our last inspection, referral to treatment time was consistently below the national standard for most specialties. The trust had improved compliance with two week wait and 31 day standard for cancer but was not attaining the 62 day target. Delays were also being incurred in the processing of biopsies for pathology.
- The number of patients whose operation was cancelled and who were then not re-seen within 28 days exceeded the national average.
- Provisions for the care of patients living with dementia was well developed with appropriate forms of patient identification and well considered design of clinical environment and signage.
- Our review of complaints identified a tendency to respond in a defensive manner and a lack of negotiated extended timelines. However, external peer review of complaints over the last three years had not identified issues with the quality of responses.

Well led

- At our last inspection, staff widely reported a culture of bullying and harassment and a lack of equal opportunity. We discussed the findings in individual interviews and staff focus groups and the findings were largely acknowledged as accurate. However, the trust had not clearly communicated its acknowledgment of the issue to the workforce.

Summary of findings

- The trust has commissioned and commenced an external consultancy to develop a strategy that addresses the current persistence of bullying and harassment, inequality of opportunity afforded all staff, but notably those who have protected characteristics, and the acceptance of poor behaviour whilst also providing the board clear oversight of delivery.
- The trust has tried to address bullying and harassment via leadership training and an initiative "Working Together Effectively #stopbullying". This was promoted by a poster campaign using a well-crafted definition of bullying and a supporting intranet web site providing helpful guidance and tools. During our interviews and focus groups very few staff indicated recognition of the initiative.
- Some staff indicated during focus groups and interviews that there had been an improvement in the management of poor behaviour, notably in maternity where a behaviour code of conduct had been introduced. However, representative groups described a lack of corporate acknowledgement of discrimination and inequality issues and little change over the last twelve months.
- The lack of equitable access to promotion was again raised by members of the BME network citing recent changes in the management of soft FM services as an example of bias. This has resulted in a further review of the soft FM management of change process by the trust and a pause in implementation. Concerns on this issue have been raised by staff.
- The role of out-dated human resource policies and their inconsistent application in exacerbating inequality was highlighted in our last report. The human resource team have responded with a comprehensive review of policy and revised training of team and managers. Representative groups viewed that there had been a lack of engagement in the development and review of these policies.
- BME staff again indicated the lack of equitable access to training and leadership initiatives. The trust did not maintain data indicating the equality of access to leadership programmes.
- Staff in focus groups indicated that staff themselves had not been suitably trained to manage the diversity of patients they treat leading to an inability to manage difficult situations and support staff who have been abused.
- The latest staff survey results rank among the worst nationally. Overall the organisational culture and the management of equality remains a significant obstacle to the trust improvement plan.
- We observed improvements in local directorate governance arrangements but the complexity of the operational model continues to lead to a lack of clarity in terms of accountability, alignment of strategy and consistent dissemination of information and direction.
- Clinical leaders indicated a need for personal development, increased non-clinical time and greater management expertise in order to deliver the required organisational change. This group appeared as highly motivated with an appetite for the challenge ahead. The clinical transformation programme was seen as indicative of the potential this group has for delivery.

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

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

We saw several areas of outstanding practice including:

Summary of findings

- The new self-rostering approach to medical cover had a significant impact on Urgent Care service. Medical staff appreciated the autonomy and flexibility this promoted as well as the effective and safe cover for the department. Due to this initiative, the department was able to provide round the clock medical cover without the use of temporary staff.
- The introduction of the clinical fellow programme that had improved junior cover in the Emergency Department and also the education and development opportunities for juniors.
- Arrangements for the care of patients living with dementia were well developed on Hurstpierpoint Ward. There was a "bus stop" in the ward corridor and this was used as a focal point for patients to meet. Some patients wandered and this enabled them to rest and also provided a distinct reference if a patient could not remember where they were going. Each bay was also painted a distinct colour to support patients to find their way back to their beds. A computer was available for patients to use in order that they could skype family who could not visit every day. We also saw there was a quiet room available for patients and family to meet away from the ward area. This room contained life-sized stuffed animals that were used as therapy due to the health and safety issues around bringing in a pet as therapy dog. The ward also had a reminiscence room that was decorated and set up like a living room from the 1950's. Staff advised us this area was used for therapy sessions as patients felt more at ease in the surroundings. Inside the room there was also a made-up switchboard for patients with electronic and operator experience.

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

Importantly:

- In ED, the trust must ensure that medical gases are stored safely and securely.
- In ED, the trust must ensure the current paediatric service provision is reviewed and has a safe level of competent staff to meet children and young people's needs.
- In outpatients and diagnostic imaging, the trust must take action to ensure that patient records are kept securely.
- In surgery, the trust must ensure that safer sharps are used in all wards and department.
- National Specification of Cleanliness (NCS) checklists and audits must be in place including a deep cleaning schedule for theatres.
- In critical care, the hospital must take action to ensure that information is easily available for those patients and visitors that do not speak English as a first language.
- In critical care, the trust must ensure there is adequate temperature monitoring of medicines fridges.
- In critical care, the controlled drug register must comply with legislative requirements.
- In critical care, the trust must ensure that pharmacy support meets national guidance.
- In critical care, the trust must make arrangements to meet national guidance on dietetic provision.
- The trust must ensure that all staff within the medical directorate have attended mandatory training and that there are sufficient numbers of staff with the right competencies, knowledge and qualifications to meet the needs of patients.
- The trust must ensure all staff within the medicine directorate have an annual appraisal.
- The trust must ensure fire plans and risk assessments ensure patients, staff and visitors can evacuate safely.
- The trust must ensure all medical wards where medicines are stored have their ambient temperature monitored in order to ensure efficacy.

Summary of findings

In addition:

- In ED, the trust should consider how patients with impaired capacity have these risks identify and managed appropriately.
- In ED, the trust should consider how mandatory training rates could be improved to meet the trust own compliance rates.
- In ED, the trust should consider how it manages continuity with incident, compliant and risk management processes across both sites.
- In ED, the trust should provide sufficient housekeeping cover in the department twenty-four hours a day.
- In ED, the trust should improve staff engagement at the PRH site.
- In outpatients and diagnostic imaging, the trust should improve compliance with mandatory training completion.
- In outpatients and diagnostic imaging, the trust should consider how appraisal targets are met.
- In outpatients and diagnostic imaging, the trust should discuss incidents regularly with staff and share.
- In outpatients and diagnostic imaging, the trust should develop a strategy for the outpatients and diagnostic imaging department.
- In surgery, the trust should take steps to consider how the 18 week Referral to Treatment Time is achieved so patients are treated in a timely manner and their outcomes are improved.
- In surgery, the trust should continue to work on reducing the waiting list for a specific colon surgery.
- In surgery, the trust should make arrangements so all staff have attended safeguarding and all other mandatory training.
- In surgery, the trust should ensure the plan to improve staff engagement is fully implemented.
- In critical care, the trust should take steps consider altering the record keeping system so it is the same as that at the RSCH.
- In critical care, the trust should not store items in corridors or use wooden pallets.
- In critical care, the trust should look to change the main door to the unit to one that is motorised.
- The trust should take steps to fully meet the national guidelines around the rehabilitation of adults with a critical illness.
- The critical care department should improve their performance in relation to the local critical care network measure of quality and innovation.
- The critical care department should take steps to ensure that medical staff are given Mental Capacity Act and Deprivation of Liberty Safeguards training.
- The critical care department should widely publish information collected from the friends and family test.
- The trust should take steps to address the delays that patients have when being discharged from critical care.
- The senior leadership team should develop an interim strategy and vision for the critical care department.
- The critical care management team should work with the HR team to address the issue of staff working between the trust's two sites.

Summary of findings

- The medicine directorate should review the provision of the pain service in order to provide a seven day service including the provision of the management of chronic pain services.
- The medicine directorate should review the provision of pharmacy services across the seven day week and improve pharmacy support.
- The medicine directorate should prioritise patient flow through the hospital as this impacted on length of stay, timely discharge and capacity.
- In maternity, the trust should consider involving the directorate in Morbidity and Mortality meetings to ensure robust learning and review.
- Targets for mandatory training in maternity and gynaecology should be reviewed so trust targets can be met, in particular in regards to safeguarding.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement

Rating



Why have we given this rating?

At our previous inspection in April 2016, overall, we rated the ED as inadequate. At this inspection we have changed the rating to requires improvement. This was because:

- The department struggled to meet the surges in demand and manage access and flow at busy times.
- Clinical Incidents were reported and investigated and learning points identified to prevent recurrence. However, theme analysis and learning from incidents only happened at a local level. Good practice and learning from incidents was not shared across site. A backlog of incidents had accumulated and this had an impact on the department's ability to prevent recurrence, and learn from past incidents.
- Mandatory training and appraisal rates were low although improved since our last inspection. This meant that staff were not always able to access the training and personal development opportunities needed to undertake their roles. However, staff were better supported by the department in their development. New competency-based assessment tools had been developed to promote personal development and assurance that staff had the right level of training to meet people's individual care needs.
- Nurse retention and sluggish HR processes continued to be a concern within the department.
- The culture in terms of cross-site learning, morale, and staff engagement was identified as an area for continued improvement. We recognised some improvement to the culture since our last inspection but staff felt that further improvement was needed to improve morale at

Summary of findings

this site. The feedback about the culture in the department was negative in tone, as some staff did not feel that much had changed since our last inspection.

- Medical staffing did not reflect the National College of Emergency Medicine guidelines for twenty-four hour cover. However, the consultant cover provided was good and ensured patients had access to a senior clinical decision maker twenty four hours a day. There was robust middle-grade doctor cover in the department as a result of the new clinical fellows programme.
- Concern relating to the treatment of children and the provision of appropriate medical and nursing cover remained unchanged. There were dedicated facilities for children but there was a lack of trained children's nurses. There was only one dual trained adult and paediatric nurse and one adult nurse with a specialist interest in paediatrics. This did not comply with the Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012). There was also a lack of appropriate medical cover to support children

However, we also found:

- The feedback we received from patients and their relatives was consistently positive. Staff were observed being caring, compassionate and professional with patients. Even when the ED was very busy, staff still took time to listen to patients and to explain things to them. Friends and family data for the department was generally better than the England average.
- Patients had their individual needs met by the service. Staff demonstrated a sound knowledge of how to provide care for patients with complex needs, including those with dementia, learning difficulties and mental health conditions.
- Patients were protected from the risk of acquiring health related infections and staff were

Summary of findings

observed adhering to best practice guidance. Medicines were handled and stored appropriately in line with trust policy and national guidance.

- Records were securely stored, were accurate, contemporaneous and comprehensive and kept confidential and stored securely.
- The care provided reflected best practice and national guidelines. The department had introduced the use of prompt cards as a support tool for staff. Patient outcomes were predominately in line with the England averages.
- Clinical Incidents were reported and investigated and learning points identified to prevent recurrence. There were sufficient plans to ensure an appropriate response to a major incident, and business continuity plans which had been tested and deemed effective.
- We saw new processes to assess, monitor, and improve the quality and safety of the service. Governance, risk management and quality measurements systems were found to be much improved at this inspection.
- The senior leadership team were found to be effective and visible. There was an appropriate vision and strategy but staff did not feel consulted about, or involved in its design.
- There had been investment in IT systems which had improved by replacement with a more functional, usable and safe system.
- We found appropriate systems and processes to handle and learn from complaints. We found good clinical oversight of departmental complaints.

Medical care (including older people's care)

Requires improvement



We rated Medical care services as requires improvement in 2016. At this inspection, we have retained this rating because:

- There continued to be a lack of learning from incidents, although incident reporting was variable across the medical directorates. Silo working had improved within directorates;

Summary of findings

however, we found no evidence that there was cross directorate learning from incidents or complaints. Risks, issues and poor performance were not always dealt with appropriately or in a timely way. For example, each directorate had its own risk register, which did not feed into an overarching risk register. Therefore, senior managers had no effective method for understanding issues affected by all directorates.

- Compliance with mandatory training did not meet the trust's targets. The only area of medicine where mandatory training rates met the trust target was in safeguarding adults.
- Outcomes from national audits were mixed and were below expectations when compared with similar services. The service scored a higher than expected risk of readmission for two of the top three specialties for all elective admissions.
- There had been no improvements in arrangements for the specialist management of acute pain out of hours, or for chronic pain. The hospital did not have any formal arrangements for access to the acute pain team out of hours and there was no pain team for chronic pain management.
- There were insufficient numbers of cleaning staff at some times. Nurses were required to support housekeepers in maintaining the cleanliness of the wards due to lack of staff.
- Staff from all levels advised us there were still issues with human resources processes. Although there were policies and standard practices, not all staff followed them and managers reported a lack of consistent HR guidance.
- Referral to treatment times were worse than the England average. There were long waiting times, delays and cancellations and the actions to address these were not timely or effective. The number patient of bed moves was worse than the England average.
- Complaint response times were worse than the trust target set out in their policy.

Summary of findings

However, we also found:

- Patients were mainly supported and treated with dignity and respect at all times. Staff responded compassionately when patients needed help and supported them to meet their personal needs as and when required.
- There was shared decision-making about care and treatment. Assessments carried out to comply with the Mental Capacity Act (2005) and consent forms are completed appropriately.
- There was a range of appropriate facilities to properly support patients living with dementia on Pierpoint Ward.
- The service had made adjustments to the rehabilitation pathway to ensure it was fully compliant with national guidance.
- Medicines were always supplied, stored and disposed of securely with medicine cabinets and trolleys were kept locked and only used for storing medicines and IV fluids. However, there was no monitoring of ambient temperatures in any medicines storage areas except for refrigerated items.
- The endoscopy service had been awarded Joint Advisory Group on GI Endoscopy (JAG) accreditation.

Surgery

Requires improvement



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

- Improvements had been made to reduce the admitted referral to treatment time (RTT), but it still remained below the national standard for all specialities apart from cardiac surgery. Work had been done on identifying patients on the waiting list for a specific colon (bowel) surgery but there was still a backlog of patients waiting for surgery. The percentage of patients whose operations were cancelled and not treated within 28 days remained worse than the England average.
- Guidance relating to the infection prevention and control was not being followed. National

Summary of findings

Specification of Cleanliness (NSC) check lists and audits were not in place including a deep cleaning schedule for theatre. The theatre corridor was found to be dusty and cardboard boxes in theatres were stored on the floor risking the integrity of the sterile contents.

- The theatre department was not complying with The Health and Safety (Sharp instruments in Healthcare) regulations 2013.
- Staff mandatory training and appraisal compliance rates were worse than the trust target.

However, we also found:

- Feedback from patients and their families was positive about the way staff treated them. We observed that staff treated patients with compassion, kindness, dignity, and respect.
- Care and treatment was explained in ways patients and relatives could understand and patients were encouraged to make their own decisions. Progress had been made on reviewing and ensuring improved consent processes.
- There had been no Never Events at PRH since our inspection in April 2016. A number of programmes and training events had been used to re-enforce the checking of prosthesis prior to implantation and using national programmes to make surgery safer.
- Care and treatment by all staff including therapists, doctors and nurses was delivered in accordance with best practice and recognised national guidelines.
- All patients admitted with a fractured neck of femur were treated at the PRH and governance systems had been developed to monitor the quality of the service. There was evidence of cross working across the surgical directorates to deliver joined up care and ensure the timely management of patients through their care pathway.

Summary of findings

- At local level senior management teams were seen as visible, supportive and approachable. Staff spoke of a collaborative, supportive culture.
- Each of the four directorates had strategies and business plans in place which could demonstrate progress over the last year. Risk registers were established for all four directorates, staff were aware of risks in their own department and there was assurance that risks were kept under review.

Critical care

Requires improvement



When we inspected the Princess Royal Hospital in April 2016 we rated critical care as requires improvement. At this inspection, we have retained this rating. This was because:

- Medicines were not always managed safely. There were gaps in the recording of fridge temperatures used to store drugs and the checking of medication expiry dates had not been recorded in January and February 2017.
- The unit still did not fully meet the requirement of National Institute of Health and Care Excellence guidance relating to rehabilitation after critical illness in adults. The hospital failed to meet their own standards and key performance indicator in relation to the discharge of patients with a rehabilitation prescription. Performance against the South East Coast Critical Care Network Commissioning for Quality and Innovation (CQUIN) measures was mixed with the majority of targets missed.
- There was no data submitted to NHS England regarding the friends and family test results.
- Provision of information in languages other than English was extremely limited.
- There were ongoing problems relating to the application of human resources policies and access to robust HR support. The senior management team had not been able to fully deal with the issue of staff being reluctant to travel to the other units in the trust to work.

Summary of findings

- There was no formal vision and strategy in place at the time of the inspection with the senior leadership team waiting for the trust wide vision and strategy to be announced.
- IT systems did not support safe and effective care across the trust. The unit at Princess Royal had an IT system that was not compatible with those of other critical areas in the trust.

However, we also found:

- Incident reporting and investigation had improved. Incidents were investigated, discussed and any learning was disseminated through the critical care team. Clinical governance meetings were well attended and minutes were thorough. Actions were assigned to a named, accountable individual.
- Performance as described in the measures defined by the Intensive Care National Audit Research Centre (ICNARC) was either better or similar to the national average. There were improvements in cleanliness and infection control, particularly around hand hygiene.
- There was a good culture amongst all staff where teamwork was seen as the key to an effective service. Multi-disciplinary working was well established and we saw examples of members of the therapy teams being available and having input into patient care.
- Nursing staffing was consistently good with the majority of shifts filled with appropriately trained staff.
- Staff treated patients and visitors to the unit with compassion and a real understanding for their personal circumstances.
- The bed occupancy rate had been below or in line the England average for nine of the 12 months prior to the inspection period. No critical care patients had been admitted to recovery or other area due to lack of critical care bed in the period April 2016 and May 2017. However, the unit had difficulty in discharging patients in a timely manner.

Summary of findings

- There were examples of innovative practice. Each patient on the ICU had a 'patient diary'. This was a diary written to record what had happened to the patient and how they had been cared for.

Maternity and gynaecology

Good



In April 2016, we rated maternity and gynaecology services as requires improvement overall. At this inspection we have changed the rating to good. This is because:

- All clinical guidelines had been reviewed and were now in-date with good processes to ensure they remained current.
- There was some improvement across maternity and gynaecology services in mandatory training compliance, and overall services were meeting the trust mandatory training target of 75%. The trust employed a dedicated preceptorship midwife and a midwifery placement educator who met with midwives throughout their employment and helped with the training development of student and newly qualified midwives.
- Previously reported poor behaviour from staff including consultants this was widely reported as improved. With a new consultant body there was a much improved multidisciplinary approach to care.
- Processes for gaining valid consent had been made more robust. We saw consent was given the appropriate importance and that staff followed trust policy.
- Staff were committed to providing and promoting normal birth. Women were offered a choice of birthing options and the trust had high homebirth rates. Targets for elective caesarean sections showed improvement, but the trust target was still not being achieved.
- Women were supported in making informed choices about birth settings which were appropriate to their clinical needs. There was adequate support in place for dealing with

Summary of findings

patients with complex needs such as learning disabilities. However, there has been no further development of a midwife led birthing unit (MLU) since our last inspection.

- Feedback from women and their families was positive about staff kindness and compassion. Staff treated patients with dignity and respect and patients were involved in their care and treatment.
- Previously, patients were often being transferred and units were being closed due to lack of staff. This had improved as there were no closures reported at PRH from April 2016 to January 2017.
- There were improvements to the governance structure. Staff were positive about local leadership, However, we still found that services lacked clear leadership from the executive to the ward.

However, we also found:

- Although incident reporting had improved and we found feedback was routinely given via a number of methods we did see some incidents not categorised in line with trust policy and some incidents that did not have actions to mitigate risks recorded. The directorate did not take part in morbidity and mortality meetings.
- There was an improvement in staff numbers and 1-1 care in labour had improved, but the unit was still not achieving then national and hospital target of 100%. Staff felt they were under pressure despite this increase in staff numbers.
- Daily equipment checks on the Central Delivery Suite (CDS) were not recorded regularly.
- Babies on the CDS were not tagged and this posed a security risk.
- Complaints were not dealt with in a timely way and within the trust's published policy timescales.

End of life care

Good



We did not inspect end of life care as we rated this service good in 2016.

Summary of findings

Outpatients and diagnostic imaging

Requires improvement



When we inspected this service in 2016 we rated it as requires improvement overall. At this inspection we have retained this rating. This is because:

- World Health Organisation (WHO) checklist audit compliance was worse than the target set in interventional radiology and consent was not always obtained in this department in line with best practice.
- Room cleaning checklists had variable rates of completion across the outpatient department. Carpeted areas appeared dirty and soiled. Many rooms were cluttered and some waiting areas were cramped. However, rooms in the diagnostic imaging department were consistently cleaned and this was documented.
- Staff understood their responsibilities to report incidents and near misses; however, incidents were not regularly discussed at team meetings.
- Patient records were not always kept securely.
- Mandatory training and staff appraisal compliance rates were low.
- The trust was not meeting national targets for patients that should be seen within 18 weeks of their referral, or for patients that should receive their cancer treatment within 62 days of urgent referral.
- There was no formal strategy in place for the outpatient department and staff were unsure of the management structure for their department.

However, we also found:

- People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. We observed good radiation compliance in accordance with national policy and guidelines. The diagnostic imaging department had retained Imaging Services Accreditation Scheme (ISAS) accreditation.
- Medicines were managed safely and prescription forms were stored safely and securely.

Summary of findings

- Staff could access the information they need to assess, plan and deliver care to people in a timely way.
 - Patients' privacy and dignity was maintained in all areas. Friends and Family test (FFT) results were better than the England average for four out of six months we reviewed. Patient comment cards were consistently positive about the care received.
 - The trust had introduced two-way texting for patient appointments and had seen a significant improvement in number of calls abandoned by patients calling into the booking hub.
 - All complaints were investigated and closed within the trust-wide target for investigating complaints.
 - We saw that the culture in the service was good. Staff felt supported by both their immediate line managers and their directorate lead nurse. There was staff engagement at department level with team meetings and forums for staff to attend.
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Princess Royal Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Maternity and gynaecology; Medical care (including older people's care); Surgery; Critical care; Outpatients and diagnostic imaging;

Detailed findings

Contents

Detailed findings from this inspection	Page
Background to Princess Royal Hospital	21
Our inspection team	22
How we carried out this inspection	22
Facts and data about Princess Royal Hospital	23
Our ratings for this hospital	24
Findings by main service	26
Action we have told the provider to take	162

Background to Princess Royal Hospital

Brighton and Sussex University Hospitals (BSUH) is an acute teaching hospital with two sites, the Royal Sussex County Hospital in Brighton (centre for emergency and tertiary care) and the Princess Royal Hospital (PRH) in Haywards Heath (centre for elective surgery). PRH was built in the 1970's and is situated on the outskirts of Haywards Heath. The trust does not have Foundation trust (FT) status.

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

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

The trust provides district general hospital services to local populations in and around the Brighton and Hove, Mid Sussex and the western part of East Sussex and more specialised and tertiary services for patients across Sussex and the south east of England. The trust primarily serves a population of over 750,000 people.

The Princess Royal Hospital (PRH) provides a full range of elective and general acute services, an emergency department (ED) and a maternity unit, working in clinical

partnership and interdependently with the Royal Sussex County Hospital (RSCH) at Brighton. PRH accepts medical emergency patients. All surgical emergency patients, with the exception of urology cases, are transferred to RSCH.

The Emergency Department (ED) at the Princess Royal Hospital (PRH) provides urgent and emergency care services to the local populations of Haywards Heath, Mid Sussex and the western part of East Sussex. There is a paediatric walk-in centre, which treats minor injuries and illnesses. More complex paediatric patients are stabilised and transferred to the Royal Alexandra Children's Hospital in Brighton.

In 2016 the trust had:

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

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

Detailed findings

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

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

We inspected the trust in April 2016 and rated the Princess Royal Hospital as requires improvement, and the trust overall as inadequate. The trust was

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

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

We inspected the core services of emergency care, medical services, surgery, critical care, maternity and gynaecology and outpatients and diagnostics. We did not inspect end of life care as this was rated good in 2016. We have retained the ratings for this service from the 2016 inspection for the purposes of aggregating ratings.

Our inspection team

Our inspection team was led by:

Chair: Martin Cooper, Consultant Surgeon and retired Medical Director

Head of Hospital Inspections: Alan Thorne, Care Quality Commission

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

How we carried out this inspection

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included clinical commissioning groups (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch team.

We spoke with staff, patients and carers who wished to share their experiences with us.

We carried out the announced inspection visit on 25 - 27 April 2017.

We held focus groups and drop-in sessions with a range of staff in the hospital including; nurses, junior doctors, consultants, midwives, student nurses, staff side

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

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

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

Detailed findings

Facts and data about Princess Royal Hospital

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

Safety

- Between March 2016 and February 2017, the trust reported five incidents which were classified as Never Events. Three of these was at the Princess Royal Hospital. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There were 5,746 incidents reported to NRLS between 1 April 2016 and 30 September 2016. Seven resulted in death, and three were classified as causing severe harm, 64 as moderate harm and 4,635 were recorded as causing no harm. During this period NRLS incidents were reported at a rate of 8.9 per 100 admissions, similar to the England average of 8.8 per 100 admissions
- Data from the Patient Safety Thermometer showed that the trust reported 28 new pressure ulcers, 28 falls with harm and 76 new catheter urinary tract infections between February 2016 and February 2017. All three areas have shown a mixed performance throughout the reporting period.
- There was one case of MRSA reported between February 2016 and February 2017. Trusts have a target of preventing all MRSA infections, so the trust failed to meet this target within this period. Additionally, the trust reported 51 MSSA infections and 22 C.Difficile infections over the same period.
- The trust failed to meet the safeguarding training completion target of 100% for all staff across four modules. 75% of staff had completed training in safeguarding adults. The module with the highest completion rate was Safeguarding Children Level 1 with 79%. For nursing staff, 80% had completed safeguarding adults training, and the module with the highest completion rate was Safeguarding Children Level 2 with 86%.

- As of February 2017, the trust reported an average vacancy rate of 0.8%.for nurses with a turnover rate of 15.7%. The use of bank and agency nursing staff was 8%.
- The vacancy rate for medical staff in February 2017 was 6.4%, with a turnover rate of 41.8%.the bank and locum usage rate was 9.1%. In November 2016, the proportion of consultant staff reported to be working at the trust was higher than the England average and junior (foundation year 1-2) staff reported to be working at the trust were the same as the England average.

Effective

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

Caring

- The trust's Friends and Family Test performance (% recommended) was generally about the same as the England Average between February 2016 and January 2017. In the latest available period, January 2017 trust performance was the same as the England average of 95.2%.
- In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trusts for four of the 34 questions, in the middle 60% for 24 questions and in the bottom 20% for six questions.

Detailed findings

- In the CQC Inpatient Survey 2015, the trust performed about the same as other trusts in all of the 12 questions examined by the CQC.
- The trust performed about the same as the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to Cleanliness and Food. The performance was lower than the England average for both privacy/dignity and well-being and facilities.

Responsive

- Between Q2 2015/16 and Q1 2016/17 the trust's bed occupancy was generally in line with the England average. Bed occupancy then exceeded the average in Q2 2016/17 and Q3 2016/17.
- The main reasons for delayed transfer of care at the trust were waiting further NHS non-acute care (38.4%), followed by Patient or family choice (15%). This was recorded between February 2016 and January 2017.
- Between February 2016 and February 2017 there were 1,374 complaints about the trust. The trust took an average of 73 days to investigate and close complaints, despite trust policy stating complaints should be responded to within 40 days. The speciality with the highest number of complaints was A&E with 160 (11%).

Well led

- The trust's sickness levels between November 2015 and September 2016 were similar to the England average.
- In the NHS Staff Survey 2016, the trust performed about the same as other trusts in 27 questions. It performed better than other trusts in one question (Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months) and worse than other trusts in five questions relating to: work related stress, effective team working, satisfaction with resources and support, management interest and action on well-being and good communication between staff and senior management. The engagement score for this trust was 3.62, which is lower than the England average of 3.81.
- In the same survey, 32% of white staff, and 74% of Black and Minority Ethnic (BME) reported experiencing harassment, bullying or abuse in the past 12 months. This was worse than the median average for acute trusts. For white staff, 82% believed the trust provided equal opportunities for career progression or promotion but only 64% of BME staff agreed with this statement while 8% of white staff and 21% of BME staff had personally experienced discrimination at work, worse than average.

Our ratings for this hospital

Our ratings for this hospital are:







Detailed findings

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

Notes

We did not inspect end of life care at this inspection. The rating shown here is from our previous inspection in April 2016.

Urgent and emergency services

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

Information about the service

Brighton and Sussex University Hospital Trust (BSUH) is an acute teaching trust and has achieved trauma centre status. It has two sites the Royal Sussex County Hospital in Brighton (centre for emergency and tertiary care) and the Princess Royal Hospital in Haywards Heath (centre for elective surgery).

The Emergency Department (ED) at the Princess Royal Hospital (PRH) provides urgent and emergency care services to the local populations of Haywards Heath, Mid Sussex and the western part of East Sussex.

The Princess Royal Hospital (PRH) provides a full range of elective and general acute services, an emergency department (ED) and a maternity unit, working in clinical partnership and interdependently with the Royal Sussex County Hospital (RSCH) at Brighton. PRH accepts medical emergency patients. All surgical emergency patients, with the exception of urology cases, are transferred to RSCH.

Between January 2016 to January 2017, the ED at the PRH saw 30,030 attendances aged 17 years plus and 6,082 children aged 0-16.

There is a paediatric walk-in centre, which treats minor injuries and illnesses. More complex paediatric patients are stabilised and transferred to the Royal Alexandra Children's Hospital (RACH) in Brighton.

There is a six bedded Clinical Decision Unit (CDU) which provides care to patients for up to twenty four hours until a decision to admit is made.

In order to undertake this inspection, we gathered the views of patients, staff, external stakeholders. We reviewed care records, service feedback and trust performance data. We spoke with 21 patients, 3 relatives, and 18 staff, including medical and nursing staff of all grades. We viewed 10 patient care records.

Urgent and emergency services

Summary of findings

We rated this service as Requires Improvement.

At our previous inspection in April 2016, overall, we rated the ED as inadequate. This was because we identified the following concerns:

- There was inadequate emergency medicine consultant presence in the department which could affect the quality and safety of care patients receive.
- Levels of mandatory training and appraisals fell well below the trust target, there was poor compliance with safeguarding training to protect patients from harm; and the recording of mandatory training was inadequate.
- There was poor completion of patient assessments such as pressure area assessments.
- There was inadequate nurse staffing in the resuscitation department. There was only one part time children's nurse, which did not comply with the Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012).
- Medicines were not kept securely; and there was no medicines fridge in the department, which meant there could be a significant delay in patients receiving emergency medication.
- Staff were also unaware where the major incident equipment was stored.
- The electronic patient record system was not fit for purpose and could pose a safety risk. There was poor completion of local and national audits because of the inability of the electronic patient system to support these. There was a lack of evidence to support evidence based care and compliance with national guidance.
- Nursing leadership was poorly organised with no single individual providing strategic nursing direction

On this inspection, we have changed the rating to 'requires improvement'. This reflects the improvements to patient safety, risk and quality management, strengthened senior leadership and oversight, and an improved culture. This rating also takes into account the need for further improvement.

- Mandatory training and appraisal rates fell below the trust own targets. This meant that staff were not accessing the training and personal development opportunities needed to undertake their roles.
- Nurse retention and sluggish HR processes continued to be a concern within the department.
- The culture in terms of cross-site learning, morale and staff engagement was identified as an area for continued improvement.
- Our concern relating to the treatment of children and the provision of appropriate medical and nursing cover remain unchanged. There were dedicated facilities for children but there was a lack of trained children's nurses. There was only one dual trained adult and paediatric nurse and an adult trained nurse with a paediatric interest. This did not comply with the Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012). There was also a lack of appropriate medical cover.
- Patient outcomes measured through the national audit process indicated the need for improvement to ensure compliance with national standards and best practice guidelines to improve care.
- We recognise some improvement to the culture since our last inspection. However, staff felt that further improvement was needed to improve morale at this site.

However:

- The feedback we received from patients and their relatives was consistently positive. Staff were observed being caring, compassionate and professional with patients
- The care provided reflected best practice and national guidelines. The department had introduced the use of prompt cards as a support tool for staff. These cards contained information on best practice guidance, care pathways, and treatment protocols for staff
- Clinical Incidents were reported and investigated and used to prevent recurrence.
- Governance processes had been strengthened and the senior leadership team were found to be effective and visible.

Urgent and emergency services

- Staff were better supported by the department to undertake their roles. New competency based assessment tools had been developed to promote personal development and assurance that staff had the right level of training to meet peoples individual care needs.
- Patients were protected from the risk of acquiring health related infections and staff were observed adhering to best practice guidance.
- The problematic IT system had been replaced with a more functional, usable and safe system

Are urgent and emergency services safe?

Requires improvement



We rated safe as Requires improvement.

At our previous inspection in April 2016, we rated safety at the Princess Royal Hospital (PRH) as inadequate.

- In our view, the ED did not adequately protect patients from avoidable harm. There was inadequate emergency medicine consultant presence in the department, which could affect the quality and safety of care patients receive.
- There was poor completion of patient assessments such as pressure area assessments
- Levels of mandatory training and appraisals fell well below the trust target, there was poor compliance with safeguarding training to protect patients from harm; and the recording of mandatory training was inadequate.
- There was inadequate nurse staffing in the resuscitation department.
- Medicines were not kept securely; and there was no fridge in the department, which meant there could be a significant delay in patients receiving emergency medication.
- Staff were also unaware where the major incident equipment was stored.
- The electronic patient record system is not fit for purpose and could pose a safety risk. There was poor completion of local and national audits because of the inability of the electronic patient system to support these.
- There was a lack of evidence to support evidence based care and compliance with national guidance.
- Nursing leadership was poorly organised with no single individual providing strategic nursing direction.
- There were no robust processes in place to ensure emergency equipment was fit for use.
- There was only one part time children's nurse, which did not comply with the Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012).

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

Urgent and emergency services

- Patients were protected from the risk of inappropriate or unsafe care because there were systems to ensure that incidents were identified, reported, investigated, and learned from to prevent recurrence.
- The Duty of Candour was routinely applied when indicated.
- The department had systems to safeguard adult and children patients who may be identified as at risk of abuse.
- Records demonstrated effective management of patient's individual health risks because a wide range of risk assessment were undertaken.
- Medicines were handled and stored appropriately in line with trust policy and national guidance
- Systems and processes for the assessment and management of individual patient risk, as well as departmental safety, was much improved. For example, the introduction of single clerking and safety check lists, comfort rounds and the new escalation policy.
- Medical staffing did not reflect the National College of Emergency Medicine guidelines for twenty-four hour cover. However, the consultant cover provided was good and ensured patients had access to a senior clinical decision maker twenty four hours a day. There was robust middle grade doctor cover in the department as a result of the new medical fellows programme.
- There were sufficient plans to ensure an appropriate response to a major incident, and business continuity plans which had been tested and deemed effective.
- Records were securely stored, were accurate, contemporaneous and comprehensive and kept confidential and stored securely.

However,

- Whilst we recognised there was trend, theme analysis and learning from incidents, it only happened at a local level. Good practice and learning from incidents was not shared across site. For example, the processes for linking incidents to the risk register which was in operation at RSCH but not at PRH. A back log of incidents had accumulated and this had an impact on the department's ability to prevent recurrence, and learn from past incidents.

- Whilst we recognised there was an improvement to mandatory training and appraisal completion rates, these remained low.

Incidents

- The department was using an electronic system to report incidents. This data was analysed to identify trend and theme analysis and promoted learning, but it only happened at a local level. Trends identified included medication errors and lost property.
- There was a new incident information board in the staff corridor that provided staff with easy access to incident trends, themes and departmental learning. Nursing handovers, the team information boards, and emails were also used to communicate learning to staff.
- Staff told inspectors they actively reported incidents and received feedback about these.
- A backlog of reported incidents requiring review had been identified by the matron. This had an impact on the learning and trend analysis necessary to prevent recurrence and improve the service. However, the matron provided assurances that the department had a sufficient action plan and that the backlog was being addressed. The plan included additional training and support for the lead incident reviewer.
- The introduction of a dedicated quality and risk post was of benefit to the Royal Sussex County Hospital (RSCH) site; however, their scope did not include the oversight or management of incidents at the PRH ED. The incidents reported in department were not linked to the risk register (unlike at the RSCH). This demonstrated a lack of directorate continuity in terms of how risks arising from the oversight and management of incidents.
- We noted a lack of staff with Root Cause Analysis (RCA) training at this site. RCA training can be defined as a problem solving and quality improvement approach used to identify, understand, and resolve any root causes of problems or incidents.
- We found very little evidence of cross site learning from incidents. This meant that the organisation was missing an opportunity to improve departmental learning.
- Between March 2016 and February 2017, the trust did not report any incidents which were classified as Never

Urgent and emergency services

Events for Urgent and Emergency Care. Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

- In accordance with the Serious Incident Framework 2015, the trust reported 29 serious incidents (SIs) in Urgent and Emergency Care which met the reporting criteria set by NHS England between March 2016 and February 2017. This data was provided at trust level, and not site specific. Of these, the most common type of incident reported was Commissioning Incident meeting SI Criteria (18), (4) Adverse media coverage or public concern about the organisation or the wider NHS, (3) Diagnostic incident including delay meeting SI criteria (including failure to act on test results) (2) Treatment delay meeting SI criteria, (1) Environmental Incident meeting SI criteria (1) Slips/trips/falls.
- Mortality and Morbidity (M&M) meetings were held regularly. We reviewed minutes of these which demonstrated these meetings were of quality and fit for purpose. The aim of an M&M meeting is to improve patient care by developing a culture of awareness of quality and encouraging front line staff to identify harm, report problems, and share lessons to prevent recurrence.
- Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person." All the staff we talked with were aware of the duty of candour (DoC) regulations and we saw records showing it was being applied.

Cleanliness, infection control and hygiene

- Patients were protected from health related infections because appropriate precautions were taken to minimise the risk.
- Hand hygiene data was presented at trust level for the departments and showed compliance as between 90% and 97% between December and April 2017, this was an improvement on our previous inspection.

- There were adequate supplies of using personal protective equipment (PPE). PPE can be defined as equipment that protected the user against health or safety risks at work. We observed staffing using this appropriately.
- We observed staff, using hand sanitiser and washing their hands in between patient contacts and adhering to the bare below the elbows policy. This meant that patients were protected for the risks of infection.
- Side rooms were available in the event of a suspected infection. This meant that patients could be isolated to prevent the spread of infection.
- Equipment including commodes had been labelled with an 'I'm clean' sticker to indicate to staff they had been cleaned appropriately. The sluice area was tidy and the commodes we viewed appeared clean.
- There was an appropriate waste management policy which was being adhered to. We saw waste appropriately segregated.
- Sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw staff used approved sharps containers which were correctly assembled.
- Medical equipment and trolleys were visibly clean throughout the department, which indicated that staff followed good cleaning practice.
- There was a colour coded (Red, Blue, Green and Yellow) approach to cleaning in line with best practice guidance. Cleaning rotas was made available which indicated that cleaning was regularly undertaken. The areas we viewed appeared clean and tidy.
- The department achieved a score of 100% in its recent Patient Led Assessment of the Care Environment (PLACE) for cleanliness.
- However, we were made aware of insufficient housekeeping provision in the department after 5 pm and out of hours. There was only one housekeeper on duty for the entire hospital overnight. This individual was responsible for the deep cleaning of the theatre department, providing cover to A&E and all the other clinical areas. This meant there was an insufficient level of housekeeping cover in the department out of hours.

Environment and equipment

Urgent and emergency services

- Adult and paediatric resuscitation equipment was available and accessible. The trolleys were sealed with a red tag to indicate they were ready for use. Records we viewed demonstrated these were checked daily in line with trust policy.
- The department facilities were not sufficient to meet people's needs. For example the newly refurbished mental health assessment room had a ligature point and did not have a panic alarm, the treatment bays did not have piped oxygen or suction and there was no dedicated minor injury treatment area. Staff told us that they would use the suction on the emergency trolley for this area should it be needed. However, there was only one portable suction unit available, which may pose a safety concern at busy times.
- The resuscitation area was unsuitable to care for critically ill patients because it was too small to accommodate three patients and the equipment required to care for critically ill patients. We recognise that the department had recently secured funding to improve this area.
- The mental health assessment room had undergone a recent renovation; however, the room was not ligature free. We were told by the matron that patients who used this room were never left unsupervised in this area. Whilst we recognise there was a process to manage the risk, it was not as robust as removing the risk altogether, especially at busy times.
- Medical equipment was serviced and tested in accordance with manufacturer guidance. Records we viewed demonstrated routine electrical testing, calibration and maintenance of medical equipment was completed as per hospital policy.
- The department achieved a score of 87% in its recent PLACE assessment for the Condition, Appearance & Maintenance of the department.

Medicines

- Medicines were handled and stored securely in line with current regulations.
- Pharmacy services were available Monday, Wednesday and Friday 8.30am to 5.00pm, Tuesday 9.15am to 5.00pm, Thursday 9.30am to 5.00pm and Saturday 9.00am to 12 noon for emergency services only and closed on Sunday.

- Fridge temperatures checks were undertaken. This meant there were sufficient assurances that medicines were stored at the required temperature range to maintain their function and safety.
- We observed appropriate checks were undertaken before medicines were administered in line with best practice guidance from the Nursing and Midwifery Council (NMC). We saw medicine prescribing reflected the General Medical Council (GMC) prescribing standards. This meant that people were protected from the risk of medication errors.
- Managers had not reinstated a Patient Group Direction (PGD) for the administration of analgesia since our last inspection. This was about to be put back into practice after the inspection, however, the departmental response to address this was considered very slow.
- We looked at medicine administration records, which were part of the ED nursing notes, and saw staff completed these appropriately. Patients had their allergies and sensitivities identified and documented and charts demonstrate medication was administered at the prescribed times.
- Controlled drugs (CDs) were stored in separate locked cabinets and we saw nursing staff checked stock levels daily. The pharmacy department conducted quarterly audits to check compliance with the trust CD policy.
- There were effective processes in place for the ordering and returning medication to the pharmacy department.
- We carried out a random medication check that showed appropriate level of in date stock.
- However, we found a two large cylinders (of air and oxygen) in the ED storeroom that were not stored in line with national guidance which states the following: Cylinders must be stored on suitable trolleys, and restrained with chains. Cylinders must only be stored in designated storage areas, where access is controlled. All rooms that cylinders are stored in must be appropriately labelled, to ensure that the presence of potential flammable gases is known in the event of fire or other emergency.

Records

Urgent and emergency services

- Records were stored securely and kept confidential. The department used a combination of electronic records and paper files. We saw patient personal information and staff records managed safely and securely, in line with the Data Protection Act.
- Nursing documentation was being reviewed and standardised across both hospital sites at the time of the inspection.
- We reviewed a sample of patients records and found them to be accurate, complete and met the General Medical Council and Nursing and Midwifery Council standards.
- We noted the problematic electronic records system used at our previous inspection had been decommissioned. An alternative had been identified and staff told us that this was working well and had improved safety.
- Information governance was part of the trust's mandatory training. Data we reviewed demonstrated the following levels of compliance: 97% for medical staff, 92% nurses, 89% healthcare assistants. The data provided was presented at trust level.
- There was information posters displayed in the department that provided staff and the public of the contact numbers to call should they need to report a safeguarding concern.
- The trust wide data we reviewed showed 67% of healthcare assistants, 84% of nurses and 85% of medical staff had received MCA and DoLs training.
- No safeguarding referrals were made during the inspection timeframe.
- The trust promoted a prevent programme. Prevent is one of the four elements of CONTEST, the Government's counter-terrorism strategy. It aims to stop people becoming terrorists or supporting terrorism. Prevent training was aimed at recognising when vulnerable individuals are being exploited for terrorist related activities. Safeguarding Adults training in BSUH has included an introduction to Prevent since Jan 2014.

Mandatory training

Safeguarding

- The department had systems to safeguard adults and children who may be identified as at risk of abuse.
- Safeguarding policies and procedures were available and reflected best practice guidance.
- The trust employed a team of nurses to support staff with safeguarding issues upon request, who were available Monday to Friday between 9am and 5pm. Outside of these hours staff were informed to speak to with their line manager or clinical site managers. Staff were able to tell inspectors how they would escalate a concern to the safeguarding team.
- Nurses were able to describe the reporting process for recognising and raising safeguarding concerns. This included the identification and reporting of patients who may have been subjected to female genital mutilation (FGM). This meant that staff had the knowledge necessary to safeguard adult patients in vulnerable circumstances.
- The child protection register was accessible should staff need to consult it.
- Mandatory training rates for the department were not meeting the trusts own compliance rates. It was noted on our last inspection that training rates were low and this continued to be the case at this inspection. The training data provided to CQC was at trust level, which meant that we were unable to provide data at site level.
- Data showed low training rates in the department. The overall compliance rate reported for the healthcare assistant group was 69%. Detailed data demonstrated the following compliance rates: 64% for basic life support, 70% conflict resolution, 72% health and safety, 89% information governance, 67% manual handling, 82% management of sharps and splashes.
- The overall compliance rate for the nursing staff group was 76%. Detailed data demonstrated the following compliance rates: 61% for the administration of blood products, 65% basic life support, 76% conflict resolution, 82% health and safety, 88% infection prevention, 92% information governance, 65% manual handling, 90% management of sharps and splashes and 76% venous thrombosis prevention training.
- The overall compliance rates for medical staff was reported as 84%. Detailed data demonstrated the following compliance rates: 85% basic life support, 59% conflict resolution, 90% health and safety, 92% infection

Urgent and emergency services

prevention, 97% information governance, 72% manual handling, 72% of paediatric life support, 87% management of sharps and splashes and 72% venous thrombosis prevention training.

- Training was provided using a combination of e-learning and practical teaching sessions.

Assessing and responding to patient risk

- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met the standard for the entire 12-month period.
- Trust data showed performance against this standard showed a trend of improvement. In December 2016 the median time to treatment was 49 minutes compared to the England average of 60 minutes.
- The department used a coloured wristband system to alert staff to patients risk. For example, a red wristband meant the patient had an allergy and prompted staff to check notes before prescribing any medication or offering food. A green wristband meant the patient was a falls risk.
- The department used a NEWS scoring system to monitor deteriorating patients. NEWS can be defined as a guide used by medical services to quickly determine the degree of illness of a patient. The escalation pathway was readily available on the observation records for staff to easily refer to. There were processes to ensure that elevated NEWS scores were reported to a medical practitioner and patients had access to necessary medical reviews. Records we viewed provided evidence that patients were having their risks regularly assessed and concerns were appropriately escalated.
- The systems and processes relating to the management of deteriorating patient had also been reviewed and strengthened since our last inspection. Changes included new documentation that provided guidance and a comprehensive checklist laid out hour by hour. This documentation also took account of the various risk assessments that were needed to manage people's individual needs. Examples include: safeguarding management tool, Mouth Care tool, News scoring chart and fluid management.

- We saw a range of risk assessments being used in the department. For example, falls risk assessments, bed rail and Venous thromboembolism (VTE) assessment.
- The risk assessment documents we reviewed were found to be accurately completed.
- Patients who were considered as a mental health risk were referred to the mental health team for review and support. However, staff told us that were occasions in the past where this service had not provided the support needed in a timely manner.
- The department implemented a daily safety huddle to manage risks in the department. However, we did not see this in practice during the inspection.
- Between February 2016 and January 2017 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes. In January 2017, 72% of ambulance journeys had turnaround times over 30 minutes. The trend over time has shown a gradual increase from May 2016 onwards.
- A "black breach" occurs when a patient waits over an hour from ambulance arrival at the emergency department until they were handed over to the emergency department staff. Between July 2016 and January 2017 PRH did not record any "black breaches".

Nursing staffing

- The department offered a paediatric minor injury service. However, there was insufficient staffing (medical and nursing) to safely meet the needs of the children who attended the department. This meant little had changed since we identified this as a concern at our last inspection. The risk was recorded on the risk register, without resolution. All the staff we talked with felt the situation was unattainable, and told inspectors they felt 'exposed'. Most parents were not aware that the PRH site offered a reduced service therefore continued to take their children to the department for treatment. This meant that the trust had failed to manage the widely accepted safety risks to children and young people in an effective or responsive manner. This also meant the trust was failing to protect the staff from situations where they may have to work outside their remit and competency levels.
- The department used a staffing acuity tool to measure the staffing levels in the department.

Urgent and emergency services

- The matron told us that a formal staffing review in the trust was underway.
- Nursing leadership had been reviewed and strengthened by recruiting a new matron for the department.
- A new nurse consultant had been recruited since our last inspection. This post was to ensure the development of Emergency Nurse Practitioners.
- We were told that the nurse team were flexible and multi skilled and worked where a need was identified. We saw staff rotate between areas during the inspection to meet people's individual care needs.
- PRH reported a desired Whole Time Equivalent (WTE) of 44.55 and an actual WTE of 40.03. This showed a vacancy rate of 4.52 WTE however, staff had been appointed to some of the vacant positions as they were due to commence work at the hospital.
- Temporary staff were used to backfill outstanding staffing vacancies. Senior nursing staff told us that the temporary staff used in the department had worked there for a prolonged period and were familiar with trust policies, procedures and the team they worked with.
- We were told by senior staff that temporary staff went through a formal induction process and we saw examples of the induction documents.
- Handover processes had improved since our last inspection. Improvements included a structured approach to communicating the demands of the service, patient risks, team achievements and other important departmental messages.
- Three new consultants had been recruited and were due to join the team after the inspection. This meant that this site would be able to provide twenty four hour consultant cover as reflected in the Royal College of Emergency Medicine guidelines.
- The department did not use any locum cover as the limited outstanding cover required each month was covered in house.
- The improved cover was a result of new and very successful approach to self-rostering and a flexible approach to PA allocation.
- Junior staffing had also been improved after a successful business case to develop a new workforce of educational, management and research fellows with flexibility in working practice and rostering. The new initiatives have been recognised by the RCEM as a 'beacon of good practice'.
- Junior staff provided cover twenty-four hours a day in the department. The juniors we talked with told us they felt there was sufficient medical cover to meet people's needs.
- Two GP's supported the department between 2pm and 11pm and who treated patients with minor illness and injuries. However, this was not currently covered every day and the job vacancy was advertised.
- Cover for junior grade outstanding shifts was covered internally by the ED team. The rotas we viewed confirmed this.
- We were provided with sufficient assurances that a sufficient medical handover process was in place. However, we did not observe these during the inspection.

Medical staffing

- Our last inspection raised a concern about medical cover in the department. Medical staffing and consultant cover in the department was reviewed and improved. A consultant provided cover from 9am to 5pm daily. Outside of these hours there was two middle grade decision making doctors and an additional junior doctor.
- After 23:00hrs medical cover was provided by two middle grade doctors who had senior decision maker status.
- The trust approach to planning medical staffing relied on quantifying the volume of medical care to be provided on the basis of the size of population, mix of patients, and type of service and relating it to the activities undertaken by different members of the team. PRH was reported as a desired WTE of 12.1, but had an actual WTE of 9.4. This meant there was a vacancy rate of 2.7. The trust had recently employed three additional consultants which would reduce the vacancy rate.
- The trust had not addressed the concerns previously identified in our last report regarding the provision of a

Urgent and emergency services

paediatric service. As a result of this, the medical director decided to commence a campaign with the help of the local Clinical Commissioning Group CCG to make people aware of the reduced service provided at PRH. There was a service level agreement to transfer acutely unwell children to the Brighton site. If the on call anaesthetist was required to accompany the child on a transfer, they found themselves in a position where they did not have the required skills and competency to provide care to a child. This meant that the trust had failed to manage the widely accepted safety risks to children and young people in an effective or responsive manner. This also meant the trust was failing to protect the staff from situations where they may have to work outside their remit and competency levels.

Major incident awareness and training

- The department had an appropriate and in date major incident policy in the department.
- We asked staff what was expected of them should a major incident occurred and they were able to tell inspectors how they would support the department and their colleagues in the event of a major incident.
- There was appropriate security staff cover to support patients and staff twenty four hours a day.
- Records we viewed demonstrated fire training was provided to staff. Data was presented by staff group, at trust level. The compliance rates were reported as: 77% for healthcare assistants, 81% for nurses and 95% of medical staff.
- Appropriate Hazardous material (HAZMAT) arrangements were in place and staff were able to explain these.
- Information about major incidents was included in the new staff induction pack.
- We requested data to evidence major incident training in the ED. Data provided suggested 15 band 5 nurses, 12 band 6 nurses, 5 band 7 nurses, 7 band 3 healthcare assistants and 5 enhanced nurse practitioners had received training. However, the data submitted did not highlight the level of noncompliance in the department.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement



We rated effective as requires improvement because:

At our previous inspection in April 2016, we rated safety at the PRH requires Improvement because we identified the following concerns:

- Staff generally followed established patient pathways and national guidance for care and treatment. However, they did not always complete pain assessments and band five nurses were not authorised to administer oral pain relief under the trust's patient group directions (PGD). This meant patients sometimes experienced a delay in pain relief.
- Mandatory training attendance was low and we saw that some specific training needs were not met.
- There were arrangements for staff appraisal arrangements, but compliance was low and accountability for these lapses was unclear. The matron post was vacant and we were told this was the primary reason for a lack of training and appraisal records. We were not provided with evidence of appraisal rates of medical staff.

On this inspection we maintained a rating of requires improvement. This rating reflected the following findings:

- Patient outcomes measured through the national audit process indicated the need for improvement to ensure compliance with national standards and best practice guidelines to improve care.
- Patient Group Direction (PGD) for the administration of analgesia had not been re-instated since our last inspection. Whilst we acknowledge that these were about to be put back into practice for band 6 nurses after the inspection, the departmental response to address this was considered slow.
- There was no audit lead in the department and the audit culture was not fully embedded.

However:

- The policies and procedures used within the ED department reflected evidence based practice.

Urgent and emergency services

- Pain management had improved since our last inspection.
- Staff were supported to ensure they were competent to carry out their roles and meet people's individual needs.
- There were suitable arrangements in place to access support and specialist services seven days a week.
- Staff had sufficient access to the information to be able to undertake their roles.

Evidence-based care and treatment

- Policies and procedures used within the ED department reflected evidence based practice from Royal College of Emergency Medicine (RCEM), National Institute for Health and Care Excellence and the Department of Health (DOH).
- Care was provided in line with 'Clinical Standards for Emergency Departments' guidelines.
- Patient assessments were undertaken with the use of a standardised checklist adapted from Royal College of Emergency Medicine (RCEM) guidelines.
- The medical records we reviewed demonstrated care was being delivered in line with national and best practice guidance.
- We were shown the department's new prompt cards that were introduced for staff to ensure best practice guidelines and treatment protocols were readily available for staff to follow. Staff told us the prompt cards were a useful resource. All of this information was made available on the newly designed landing page on ED intranet.
- The department followed the Sepsis 6 Pathway. Sepsis can be defined as a potentially a potentially life-threatening condition, triggered by an infection or injury. We saw documented evidence that compliance with the sepsis pathway was audited. Staff showed us this was easily accessed on the trust intranet. Staff were in the process of auditing the new sepsis proforma against compliance markers. However, the audit was not completed at the time of the inspection.
- The virtual fracture clinic provided a safe and effective way of improving patients' experience while reducing demand on vital hospital services.

Pain relief

- The department used a recognised pain assessment tool to measure patients' pain levels.
- The records we viewed demonstrated that pain scores were recorded and acted upon. Inspectors observed patients' pain was managed in a very prompt manner and we saw staff using the pain tool to measure and record pain levels.
- Patients told us they received appropriate pain relief in a timely manner.
- In the CQC A&E Survey, the trust scored 5.32 out of 10 for the question "How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.
- The trust scored 7.58 for the question "Do you think the hospital staff did everything they could to help control your pain?" This was about the same as other trusts.
- However, at our last inspection in April 2016, staff told us that band five nurses were not allowed to administer analgesia via a Patient Group Direction (PGD) due to a previous error. This meant a more senior nurse had to be called to approve pain relief, which may lead to delayed administration. We found that this was still the case at this inspection. We were told the PGDs had been rewritten and were awaiting final approval before they were reintroduced to the department. Whilst we acknowledge that these were about to be put back into practice for band 6 nurses after the inspection, the departmental response to address this was considered slow.

Nutrition and hydration

- Patients were protected from the risk of poor nutrition because staff ensured they had appropriate access to food and fluids.
- There was an appropriate assessment tool in place to help staff identify patients' risks of malnutrition.
- A drinks trolley was available for patients to make hot drinks. However, the trolley was not in line of sight of the waiting area and was stored at the opposite end of the department to the waiting area.
- There was a water fountain in the waiting area that was out of order. This meant that patients and their relatives were unable to access water easily.

Urgent and emergency services

- Patients we talked with told inspectors that their nutrition and hydration needs were met whilst in the department. Support workers provided additional help to patients when needed.
- We observed intravenous fluids were prescribed, administered and recorded appropriately.
- The CQC A&E Survey demonstrated the trust scored 7.16 for the question “Were you able to get suitable food or drinks when you were in the A&E Department?” This was about the same as than other trusts. This meant that people had access to appropriate nutrition and hydration need met whilst using the department.

Patient outcomes

- In the 2015/16 RCEM audit for vital signs in children, the site was in the lower 25% of departments compared to other hospitals for four of the six measures, in the upper 25% for one and in the middle 50% for the remaining measure. The site did not meet either of the two fundamental standards.
- In the 2014/15 RCEM audit for initial management of the fitting child, the site was in the lower 25% of A&E departments compared to other hospitals for two of the five measures, and was in the middle 50% for the remaining three measures. The site did not meet the fundamental standard of checking and documenting blood glucose for children actively fitting on arrival. The measures for which the site performed in the lowest 25%, related to the fundamental standard on checking blood glucose levels, and proportion of discharged patients whose parents/carers were provided with written safety information.
- The 2015/16 RCEM audit for procedural sedation in adults, the site was in the upper 25% of departments compared to other hospitals for four of the seven measures, and in the lower 25% for the remaining three. This meant the PRH site met one of the five fundamental standards. However, it should be noted that the department had a very low sample size for the audit.
- In the 2014/15 RCEM audit for mental health in the ED, the PRH site was in the upper 25% of departments compared to other hospitals for four of the eight comparable measures, was in the lower 25% for two measures and in the middle 50% for the remaining two measures. Of the two fundamental standards included in the audit, the site did not meet either the standard of having a documented risk assessment undertaken, or having a dedicated assessment room for mental health patients. The measures for which the site performed in the upper 25%, related to having a history of the patient’s mental health issues recorded, a patient being assessed by a mental health practitioner (MHP) from organisation’s specified acute psychiatric service, being assessed by a MHP within 1 hour and having details of follow-up arrangements documented. The measures for which the site performed in the lower 25% were having a mental state examination taken and recorded and having a provisional diagnosis documented. Since this audit was undertaken, the department was able to provide dedicated mental health room.
- In the 2013/14 RCEM audit for paracetamol overdose, the PRH site was in the upper 25% of A&E departments compared to other hospitals for two of the four measures and was in the lower 25% for the remaining two measures.
- In the 2013/14 RCEM audit for severe sepsis and septic shock, the site was in the lower 25% of A&E departments compared to other hospitals for four of the 12 measures. Performance was in the middle 50% for six measures and in the upper 25% of departments for the remaining two. The measures for which the site performed in the lowest 25%, was having the first intravenous crystalloid fluid bolus given in the ED within one hour, and having antibiotics administered in the ED and within one hour.
- Between December 2015 and November 2016, the trust’s unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5% and generally worse than the England average. In latest period, trust performance was 8% compared to an England average of 7.5%. The trust met the England average of 7.5% in June 2016, although the trust remained above the England average the trend appears to be reducing over time. This data was provided at trust level and incorporates both ED sites.
- Between December 2015 and November 2016 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was similar to the England average.

Urgent and emergency services

Throughout the time period the performance in this metric showed no real trend of improvement or decline and remained between 3-4% as did the England average. Between August and November 2016 the trust performance was slightly better than the England average. This data was provided at trust level and incorporates both ED sites.

- The trust had a fractured neck of femur pathway in place based on current best practice and national guidance taken from the Fractured neck of femur-rapid improvement programme 2009. Data demonstrated that this pathway was meeting national performance targets.
- In the 2014/15 RCEM audit for assessing cognitive impairment in older people, the trust was in the upper quartile compared to other hospitals for one of the six measures, and was between the upper and lower quartiles for four of the six measures.

Competent staff

- Whilst the appraisal rates remained low, we acknowledge that there had been an improvement in compliance.
- The department had introduced new ED band 6 competency based development programme. For example this took into account key department documents, critical incident reflection, co-ordinating competency, nurse in charge leadership role, trust policies and procedures, and a Continued Professional Development (CPD) log.
- A new induction programme had been introduced for staff. We were told resulted in a standardised approach to inductions across both sites. The booklet provided information relating to working in the department, the nursing structure, rostering, education, documenting, Manchester triage, trauma at BSUH, stroke calls, major incident handling, mental health, human resources (HR) support and an induction checklist.
- Nurses' Nursing and Midwifery Council (NMC) registrations were checked appropriately by senior staff to ensure they were current. Appropriate referrals were made the NMC when a breach of their code of conduct was identified. We received evidence of one referral to the NMC, however, it did not relate to this site.

- There were appropriate HR processes in place to ensure that staff had the relevant experience and qualifications and were of good character before being offered a post. This meant that appropriate background checks, including Disclosure and Barring Service (DBS) checks, and employment checks were undertaken prior to a new member of staff commencing work.

Multidisciplinary working

- There was evidence of good working relationships with multidisciplinary professionals at the PRH site. We observed staff interact with each other in a thoughtful, kind and professional way. These interactions demonstrated a strong and positive team approach to the care they deliver.
- We observed a positive and supportive working relationship with the local ambulance service.
- A mental health liaison team was available 24 hours a day seven days a week. However, staff told us that accessing the service could be difficult. We received assurances from the matron that this concern was escalated to senior leadership who were reviewing the service provision.
- There was a Hospital Rapid Discharge Team (HRDT) based in the department. This meant that this team were able to provide support to patients and staff and promote safe and timely discharges.
- A practice educator had been recruited but had not commenced work at the time of the inspection. This new post was created to oversee and provide education, training and assessment of the nursing and support worker team based in the Accident and Emergency department.

Seven-day services

- The department provided a twenty four hour, service seven days a week.
- There was support provided from other services to ensure that patients had access to the specialist care they needed. This included clinical input from the medical and surgical specialities.
- The diagnostic imaging department provided a seven day, on call service. This was in line with; NHS services, seven days a week, priority clinical standard 5, 2016.

Urgent and emergency services

This requires hospital inpatients to have seven-day access to diagnostic services such as x-ray, ultrasound, CT and MRI and radiology consultants to be available, seven days a week.

- Mental health phone support services were available twenty-four hours a day. However, staff told that occasionally obtaining a mental health review for patients proved difficult.
- The outreach service was available twenty four hours, seven days a week to support the department care for acutely ill patients.

Access to information

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The staff we talked with were aware of their roles in terms of obtaining consent.
- There was an appropriate consent policy in place that provided sufficient guidance for staff.
- Staff were able to demonstrate their knowledge about applying the Mental Capacity Act (MCA) 2005 and the deprivation of liberty safeguards (DoLS).
- The trust wide data we reviewed showed 67% of healthcare assistants, 84% of nurses and 85% of medical staff had received MCA and DoLS training. These rates did not meet trust targets

Are urgent and emergency services caring?

Good



We rated caring as good.

At our previous inspection in April 2016, we rated the caring domain as good. On this inspection, we have retained a rating of good.

This rating was an ongoing recognition of the caring approach and kindness shown to patients. Our observations of the interactions between staff and patients during the inspection demonstrated a visible, approachable, and considerate workforce. It also takes into consideration what patients and their relatives and their loved ones told us about their experiences of the care they received.

- Patients who used the service were treated with dignity, respect and had their confidentiality upheld.
- There were times when the ED was very busy, but staff still took time to listen to patients and to explain things to them. Patients also told us they felt involved in making decision about their care and treatment.
- The interactions we observed between staff and patients were kind, respectful and professional.
- Patients told us they felt cared for and felt safe in the department and overwhelmingly provided positive feedback about the service they received at the ED in PRH.
- There was sufficient support provided by the staff and wider trust personnel to meet people's emotional needs.
- Friend and family data for the department was generally better than the England average and The results of the CQC A&E survey 2014 showed the trust scored about the same as other trusts in all of the 24 questions relevant to caring.

Compassionate care

- We observed compassionate care delivered by nurses and doctors, particularly to children. Staff engaged in an open and positive way with patients and their relatives.
- Patients told us they had their personal beliefs respected and their personal details kept confidential.

Urgent and emergency services

- Staff were observed being attentive and sensitive to patient's needs. All the interactions we saw were professional and kind.
- Staff treated patients and those close to them with compassion and we saw staff responding to patients in a timely and appropriate manner.
- The department had embraced the 'hello my names is' campaign. All staff wore name badges and introduced themselves by name. This encouraged and reminds healthcare staff about the importance of introductions in healthcare.
- The trust's Urgent and Emergency Care Friends and Family Test performance (% recommended) was generally better than the England average between February 2016 and January 2017. In the latest period, January 2017 trust performance was 89% compared to an England average of 87%. The percentage that would recommend the emergency department varied between 87% and 91% over the 12 month period. The overall trend has been mixed. Recommendation rates reached a high point of 91% in June 2016 and met the England average in August and October 2016. It is important to note that the data presented above was accumulated data and reflected both ED departments.
- However, the department achieved a score of 50% in the recent Patient Led Assessment of the Care Environment (PLACE) scores for privacy. The national average PLACE score for privacy was 89%. This meant the department was not meeting the national expected range.
- Patients told us "It's an excellent hospital and staff are very helpful".

Understanding and involvement of patients and those close to them

- There was a named nurse system in place for each clinical area. The 'named nurse' can be defined as a designated individual who is responsible for a patient's nursing care during their hospital stay.
- Patients were able to tell inspectors the names of the nurses who were providing their care. They also told us they understood their care plan and where they were in their care pathway. This demonstrated effective communication between staff and patients.

- Patients told us they felt informed about the processes in ED. They said that once treatment had started, staff dealt promptly with their needs and most felt very confident about the explanations and care they received.
- Patients and relatives told us that doctors and nurses in ED explained what they were doing and consulted them about their treatment options.
- The patients' we talked with told us they were provided with enough information and access to clinicians to ensure they were able to make informed choices.
- There was a nurse in charge for each shift, who wore an arm band to indicate their role. This meant patients could easily identify who had nursing responsibility for the department during their stay.
- Staff wore different coloured uniforms which made identifying different disciplines easier for staff. There were posters in the department that indicated what the different colours meant.

Emotional support

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

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

Urgent and emergency services

Requires improvement



We rated responsive as requires improvement.

At our previous inspection in April 2016, we rated safety at their ED at Princess Royal Hospital as requires improvement. This was because:

- Issues around the department's inability to meet surges in demand, escalation protocols, leadership and record keeping all caused delays to assessment and treatment.
- Many of the issues were longstanding and had been brought to the trust's attention previously. While there had been some improvements, the trust needed to demonstrate sustained progress.

On this inspection, we have retained a rating of requires improvement. This is because:

- There was a lack of planning to meet the needs of a growing local population and the proposed and sizable housing developments in the area.
- We were concerned about the paediatric service provision at this site. Local residents did not have the clarity needed to understand that the service was unable to meet the needs of children who required acute or emergency care and treatment.
- The department struggled to meet the surges in demand and manage access and flow at busy times.

However:

- We found appropriate systems and processes to handle and learn from complaints. We found good clinical oversight of departmental complaints.
- Patients had their individual needs met by the service. Staff demonstrated a sound knowledge of how to provide care for patients with complex needs, including those with dementia, learning difficulties and mental health conditions.

Service planning and delivery to meet the needs of local people

- Whilst we were made aware of a renovation programme to improve the departments' facilities, we were concerned that there was a lack of planning to meet the

needs of a growing local population and the proposed and sizable housing developments in the area. Staff also echoed this concerns and we found little evidence of forward planning to meet the future needs of people.

- We were concerned about the paediatric service provision at this site. Local residents did not have the clarity needed to understand what the service was able to provide to children in an emergency. Parents continued to take their children to the department for treatment because they were not aware that the department was unable to support all their needs. The medical director, with the assistance of the CCG was in the process of running a public awareness campaign. This was to raise the awareness of local parents about the current level of service provision in the aim of helping them to make an informed decision about where they took their children in the event of an emergency.
- During busy times the department struggled to meet the surges in demand and manage access and flow due to the bed capacity in ward areas. These concerns were identified at the last inspection, and there was insufficient progress made to address them.

Meeting people's individual needs

- There was a large display screen in the waiting area that had been out of order for at least 18 months. We were told that it was in working order but was missing a cable. We were told that this screen was going to be used to display waiting times, health promotion advice and other department information. This appeared to be a missed opportunity for the trust to utilise a readily available visual aid as a communication tool.
- Staff were able to demonstrate a sound knowledge of how to provide care for patients with dementia. They told us the trust used the dementia butterfly scheme. The Butterfly Scheme aims to improve patient safety and wellbeing by teaching staff to offer a positive and appropriate response to people with memory impairment and allows patients with dementia, confusion or forgetfulness to request that response via a discreet butterfly symbol on their notes.
- There was a small and separate paediatric waiting area which was child friendly.

Urgent and emergency services

- Records we viewed contained assessment of the patients' individual needs. For example, these included falls risks assessments, emotional assessments, nutrition, hydration risks and preferences. The majority were found to be contemporaneous and complete.
- Patients with a learning disability had their individual needs identified and were told that staff encouraged carers to stay in the department to act as an advocate. However, this process was not observed during the inspection.
- Staff told us they were able to provide translation services for those whose first language was not English. They also told us that staff who worked in the hospital also provided translation services to patients in emergencies. Information leaflets were only provided in English.
- ED referred older people with complex needs to the elderly care team for review before discharge. This was observed in practice during the inspection.
- There was mental health support services to assist staff meet the needs of those with a mental health diagnosis. However, staff told us that it was becoming more difficult to get the help and support needed to meet people's needs in a timely manner. We received assurances from the matron that this concern was escalated to senior leadership who were reviewing the service provision.
- Patients who were suspected as suffering or been exposed to domestic abuse were provided with the necessary support and information.
- During our inspection, we observed call bells being answered immediately and staff were attentive to patient needs.
- A range of food was available to patients so their individual dietary and religious needs or preferences could be met.
- The department achieved a score of 57% for dementia friendliness and 53% for disability friendliness in the recent PLACE assessment. The national average scores for dementia was 75% and 89% for disability. This meant the department performed below the national averages in both areas.
- Our last inspection we identified concerns with patient access and flow in the department. The data provided was presented as accumulated figures for both trust ED's and was not site specific.
- Between January 2016 and January 2017 the ED at PRH reported 37,045 attendances.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The trust breached the standard between February 2016 and January 2017, however it had improved since our last inspection.
- Between February 2016 and January 2017 performance against this metric showed a trend of decline, although the trend mirrors the England average throughout the time period. However, in March and April 2017 the department achieved a rate of 94%. The lowest rate of compliance was in January 2017 (77%).
- Between February 2016 and January 2017 the trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was worse than the England average. Between February 2016 and January 2017 performance against this metric showed a trend of decline, there was a slight improvement between May and July 2016 where performance ranged between 16-18% against an England average of 10-12%. In the following months the trust showed a more rapid decline against the England average with performance in January 2017 reaching 40% against the average of 22%.
- Between December 2015 and November 2016 the trust's monthly median total time in A&E for all patients was consistently higher (worse) than the England average. Performance against this metric showed a trend of decline; although the trust performance slightly mirrored the England average the overall time spent in A&E was approximately 10 minutes longer at the trust between December 2015 and July 2016. From August 2016 the trust's performance against this metric continued to decline and in November 2016 the total time in A&E at the trust was 171 minutes worse than the England average of 151 minutes.

Access and flow

Urgent and emergency services

- The percentage of A&E attendances at this trust that resulted in an admission was higher than the England average from 2014/15 to 2015/16. Compared to 2014/15, the percentage of attendances resulting in an admission at this trust showed a slight increase in 2015/16.
- Data April 16 to March 17 demonstrated the time to initial assessment for 95% of patients to be within 60 minutes with the exception of February 17 and March 17 in which it increased to 78 and 65 minutes respectively.

Learning from complaints and concerns

- There were effective systems and processes to manage and learn from complaints.
- The newly appointed matron took the lead on managing and responding to complaints.
- Trends and themes analysis helped promote learning and drive service improvement. For example patients raised concerns about poor communication and long waiting times. The staff response was more proactive communication between the clinical team and patients.
- A notice board which was easily accessible in the staff corridor displayed information about the complaints the service received. Staff reviewed feedback from complaints on the information board, at daily handovers, by email, and in person via verbal feedback.
- Complaints records we reviewed demonstrated the formal responses contained an apology when appropriate, were detailed and fair. We saw evidence the department was complying with the duty of Candour regulations when handling complaints.
- Meeting minutes demonstrated complaints were discussed at the regular clinical governance meetings.
- The trust website provided relevant information on how to raise a complaint with the trust. Staff were also able to provide printed information leaflets to patients that provided all the relevant information on how to raise a concern and the process to have it investigated.
- There was a Patient Advice Liaison Services (PALS) in operation that provided patients with support and appropriate signposting when they wished to raise a concern.

Are urgent and emergency services well-led?

Requires improvement



At our previous inspection in April 2016, we rated well led at the Princess Royal Hospital as inadequate. This was because:

- Senior medical leadership was visible in the department but it was not clear how they provided overall support to the department.
- The delivery of high quality care was not assured by the leadership, governance or culture in place.
- Strategic nursing leadership was absent although we saw signs of potential improvement with the recent appointment of a divisional nurse manager. Nurses said they felt unsupported in their role as “senior management spent the majority of their time at RSCH”.
- Staff told us they rarely saw tangible help from senior members of staff when they escalated concerns such as capacity issues.
- Staff told us that there was managerial support up to the level of matron but there was a lack of support beyond that level.
- Staff told us there was a disconnection between staff and the executive board and they were out of touch with the demands and problems of working in the ED.
- There was limited audits undertaken which prohibited improvements to patient care and best practice.
- There was no evidence that feedback from staff and patients was acted on.
- There was a local governance structure in place in conjunction with RSCH but it was not clear how this fed into the overarching governance structure. There was regular clinical governance meetings but there was a lack of action points which meant the effectiveness of these meetings to improve safety and patient care is unclear. Risks, issues and poor performance were not always dealt with appropriately or in a timely way.

Urgent and emergency services

At this inspection, we have changed the rating to requires improvement. This reflects the improvements made to improve the culture, leadership, and vision and strategy of the service.

- Whilst we recognise the improvements made in this key question, we are mindful that the improvements made need time to become embedded practice. This was also true of the staff who were new to the leadership team.
- The feedback we reviewed about the culture in the department was negative in tone, as some staff did not feel that much had changed since our last inspection.
- The trust had developed behaviour and values code that promoted communication, kindness and understanding, fairness and transparency, working together, excellence.
- We were told that staff were involved in their development. However, the trust values were not widely known or recognised and staff told us they did not feel involved in their development.
- Engagement with the staff at the PRH site showed signs of improvement. However, the historic damage of confidence and trust in the senior management still resonated within the team.

However:

- We saw new processes to assess, monitor and improve the quality and safety of the service. Governance, risk management and quality measurements systems were found to be much improved at this inspection.
- We found evidence of improved staff engagement strategies and staff told us they felt more involved in the change process. They also told us the culture had undergone positive changes, which meant an open, inclusive, and no blame culture was developing.
- There was an appropriate vision and strategy in place but staff did not feel consulted about, or involved in, its design.

Leadership of service

- Each directorate management team consisted of a directorate manager, a clinical director and a directorate lead nurse, who worked across all specialties within the directorate.

- The leadership of the service had changed since our last inspection. The department matron had only been in post for four months and therefore the effectiveness of their role and the recent changes, required time to become embedded practice.
- We received mixed feedback from staff about the support and leadership in the department. Comments included “We are working really hard and feel supported” to “We are disempowered by the senior management and the communication is poor” and “management need to be more visible on the shop floor”.
- It was clear to inspectors from the conversations and interactions we had indicated staff in this department felt worse off than their RSCH colleagues. Perceptions of this included a disparity in senior leadership input, poor communication and a disjointed approach to service delivery across sites.
- Staff on this site told inspectors that they would like stable leadership at a local and board level. The churn of leadership at both levels had not provided the stability the team needed to ensure a strong vision, strategy leadership continuity and positive culture and moral.
- Staff told us that communication with the RSCH site required improvement. They told us that they frequently had ambulances diverted to the PRH without staff communicating this arrangement or checking on the capacity, acuity or staffing levels in the department.
- The matron operated an open door policy for staff. This meant that staff had regular access to senior leadership should they wish to raise a concern or ask for additional support.
- Compliance rates for mandatory and additional training continued to low at this inspection. This demonstrated a lack of senior drive to ensure staff received the necessary training.
- We received feedback regarding the support received from the HR directorate. Staff told us support was inconsistent and ineffective. Staff also felt that HR processes were having a negative impact on the department’s ability to recruit. An example of this related to the timeliness of carrying out the relevant checks.

Urgent and emergency services

Vision and strategy for this service

- The vision and strategy was at a development stage. Staff neither understood the proposed vision, nor felt involved in its conception. This meant that staff felt unable, and were unlikely to support a vision and strategy they were not familiar with, or were committed to.
- Staff reported that finances had been secured to improve the department, which included extending the resuscitation areas. This was collaborated by the medical director of the department provided evidence of the funding agreement.

Governance, risk management and quality measurement

- The processes to assess, monitor, and improve the quality and safety of the service had been improved. Governance arrangements had been reviewed and strengthened. Meetings were attended by staff from both sites and there was a plan to rotate the location of the meeting to make it equitable for staff and to dilute the concept of silo working. However, it is important to note these processes needed further time to mature and become embedded in practice.
- The various governance processes consisted of appropriate RAG rated RISK register. The RAG system is a widely used method of rating for issues or status reports, based on Red, Amber (yellow), and Green colours used in a traffic light rating system.
- Incidents were regularly discussed at the quality and safety board meeting. However, we noted that incidents were not linked to the risk registered as at the RSCH site. This meant that good practice was not shared effectively.
- There was evidence of an enhanced complaints review processes, contemporaneous M&M meetings and an improved incident reporting culture. Data collected and collated from these systems and process were reviewed at a departmental level through the quality and safety improvement board. There was also an additional meeting the trust governance lead to review the department risks regularly.

- The matron assured us that the risks in the department were known and being addressed appropriately by the senior leadership team. However, the lack of stable leadership had an impact on the speed at which these risks were being addressed and resolved.
- We asked the leadership team if they had the same level of confidence in the governance and risk management meant structures outside of the department and were unable to get that assurance. This may suggest that the senior leadership team would benefit from improved feedback processes to ensure that governance processes at board level were effective and efficient.
- Performance dashboards had been developed for unscheduled care and shared both internally in the department and with the executive and operational teams.
- It was currently mandatory that band 7 level nurses attended the department governance meeting. At the time of the inspection, staff from other designations and roles did not attend these meetings. We were told that the leadership team wanted to make these meetings accessible to all staff at all levels, and intended to extend an 'open invite' and advocate an MDT approach to future meetings.
- They also told us that the department planned to develop a governance lead role for band 6 nurses.
- Our concerns regarding the paediatric service remained unchanged since our last inspection. This demonstrated a lack of trust leadership to manage the risk in the service appropriate and timely way.
- Data management and reporting in the department required further improvement to provide robust assurance and oversight of both ED sites.

Culture within the service

- Our last inspection identified serious concerns with the culture in the department.
- Staff morale at the last inspection was found to be extremely low. Whilst we recognised that some attempts had been made to address this, the culture and moral on the PRH site remained low.
- Staff told us they were did not feel involved in departmental changes and they told us they felt the "department is disjointed".

Urgent and emergency services

- Several staff told us about concerns relating to email communications in the department. Staff felt the tone and approach of communication did not promote professionalism, a health culture or the organisational values.
- The trust had developed an organisational values and beliefs system. However, staff did not feel involved in their development. The trust values were not widely known or recognised.
- We asked staff if they were aware of the speak up guardian role. The majority of staff we spoke with were not aware of the trust speak up guardian role and did not know about the role or function. A speak up guardian can be defined as a person who provides support for staff to embrace culture change and to help staff to feel safe to speak up about their concerns.
- We were told about a team away day that was used to strengthen relationships and resilience in the team. The feedback we received about this approach was positive.
- Previously the leadership of the department was described as inconsistent and fluid. Staff told us that they felt more assured about the culture changing now that the department had management consistency.
- The management team had arranged for an independent service to visit the department to provide staff with opportunities to access help and support.
- Comments we received from staff included “from an ED perspective the one thing that has made the changes possible is the staff have respect for each other and the support and drive to help patients. They have worked hard to hold the department together”.
- Other comments we received included “people are supportive but we are pulled in different directions” and uncertainty about the plan and vision means that things get delayed

Equalities and Diversity

- The trust had a current equality, diversity and human rights policy and an annual report.
- The trust had a current Lesbian, Gay, Bisexual and transgender (LGBT) forum equality and diversity action plan. This included actions such as involving the LGBT

forum in the development of HR policies. We saw the trust were committed to support the Trans-pride and the LGBTQ+ pride events. Staff were supported with their preparation for the local Pride event.

- The trust had a current equality, diversity and human rights policy and an annual report. Staff were provided with equality, diversity and human rights training. Data we reviewed showed 77% of healthcare assistants, 86% of nurses and 82% of medical staff had received this training.

Public engagement

- The lead consultant was concerned that the department was unable to offer limited paediatric cover. There was an action plan being developed with external stakeholder to raise public awareness that the ED offered a reduced paediatric service.
- The department had various ways to connect with and capture the voice of the public. This included using social media, friends and family surveys, NHS choices website.
- There were patient participation groups including the Stakeholder Forum, League of Friends, Healthwatch, complaints and the ‘How Are We Doing?’ initiative. However, this engagement had not been fully incorporated into the development of the department.

Staff engagement

- Staff continued to feel disenfranchised at this site. There was evidence of improved engagement with the team. This included improved written communications, engagement and improved consultation processes with the team. However, the new matron had only been in post four months. The feedback we received their about their leadership style and approach was positive. However, new engagement initiatives would need significant time to become embedded. The same was true in terms of establishing the trust and confidence of staff to prove the attempts to improve engagement was meaningful.
- There was evidence that staff views were sought more than previously. Staff told us they felt more involved and empowered to raise a concern about the service. We saw minutes from staff meetings, which showed regular engagement.

Urgent and emergency services

- There were signs of some improvements made by the leadership team to improve communication and morale in the team. An example of this was carrying out a rostering survey before making changes to the way the off duty was compiled and the team-building day. This received positive feedback from staff.
- Staff also used a closed social media platforms as a method of engagement.
- Whilst the majority of the feedback we received about engagement at a department level was positive, it was more critical about engagement with the senior leadership team and colleagues at the ED at RSCH. It was clear that these areas required further consideration, development and input to reassure staff of a cohesive management approach.
- Staff continued to make us aware of the struggle they faced to work across site at the trust because of the difficulties using public bus service that provided one bus an hour. They provided examples of working a 12 hour shift, missing the bus and having to wait for another. This extended their day up to 15 hours day, if travel both ways was taken into consideration. We were told that this was having an impact on work life balance, staff retention and people's ability to do their jobs because they were frequently late for the start of shifts because of traffic.
- There was a 35% response rate to staff survey from the PRH site. The results highlighted some areas of improvement since our last inspection, but also, many areas that require further development.







Innovation:

- The new self-rostering approach to medical cover had a significant impact on the department. Medical staff appreciated the autonomy and flexibility this promoted as well as the effective and safe cover for the department. As a result of this initiative, the department was able to provide sound around the clock medical cover without the use of temporary staff.
- The introduction of the clinical fellow programme that improved junior cover in the department and also the education and development opportunities for juniors.
- We found a successful incentive where a healthcare assistant completed a regular nutrition and comfort round at the Royal Sussex County Hospital ED. However, this positive and effective change to practice had not been shared or implemented at the PRH site. This meant that the trust was missing an opportunity to standardise good practice processes across the ED sites.

Improvement.

- The department had introduced various new roles including the practice nurse educator and the consultant nurse post.
- The MD driving a public awareness campaign to inform the public about the reduced paediatric services provided at PRH.

Medical care (including older people's care)

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

Information about the service

The Princess Royal Hospital is part of Brighton and Sussex University Hospitals NHS Foundation Trust located in Haywards Heath in West Sussex. The hospital provides a full range of general and specialist medical services including specialist dementia and endoscopy services. The medical services within the trust are divided into six different directorates: acute; abdominal surgery and medicine, which included endoscopy; cancer services; cardiovascular; neurosciences and stroke services and the specialty medicine directorate which includes care of the elderly.

The Princess Royal Hospital has 181 medical inpatient and eight day care beds located within 12 wards. Trust wide, there were 46,448 medical admissions between November 2015 and October 2016. Of these emergency admissions accounted for 20,225 (43%), 2,302 (5%) were elective, and the remaining 23,921 (52%) were day case. Admissions for the top three medical specialties were General Medicine 7,783, Gastroenterology 7,064 and Geriatric Medicine 6,647. We were not provided with site specific information.

During our inspection, we reviewed information from a wide range of sources to get a balanced and proportionate view of the service. We reviewed data supplied by the trust, visited wards in all six of the directorate areas as well as the pharmacy and discharge lounge in order that we understood the flow of patients through the hospital. CQC held focus groups as well as a stall where staff and patients could talk to inspectors and share their experiences of working and receiving care at

the hospital. We spoke with 36 members of staff including; divisional directors, the chief nurse, matrons, ward managers, nurses, health care assistants, ward clerks, therapists, porters and domestic staff. We also spoke with 19 patients and relatives and checked 21 sets of patient records.

Medical care (including older people's care)

Summary of findings

At our previous inspection we found the following issues:

- Understaffing was a challenge throughout the service.
- The trust had a complex vision and strategy, which staff did not feel engaged with.
- Whilst there were governance systems in place the directorates operated in silos. There was little cross directorate working, few standard practices and ineffective leadership in bringing the directorates together.
- There was also a problem in managing staff from different ethnic backgrounds, which was compounded by ineffective Human Resource (HR) policies and lack of leadership support.
- The management of incident reporting was variable across the directorates with limited feedback or learning identified. We found there was under reporting across the medical services for non-clinical incidents.

At this inspection, we focused on the above areas of concern as well as the regulatory action from the previous inspection report in order to ensure the directorates were showing improvements in the areas of most concern.

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

- There continued to be a lack of learning from incidents, although incident reporting was variable across directorates.
- Silo working had improved within directorates; however, we found no evidence that there was cross directorate learning from incidents or complaints. Each directorate had its own risk register, which did not feed into an overarching risk register. Therefore, senior management had no effective method for understanding issues affected by all directorates.
- Staff from all levels advised us there were still issues with HR processes, stating support depended on the

HR representative. Although there were policies and standard practices, not all HR representatives followed them. Managers reported a lack of consistent HR guidance.

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

Medical care (including older people's care)

Are medical care services safe?

Requires improvement



When we inspected the Princess Royal Hospital in April 2016, we rated safe as requires improvement. This was because:

- Managers' response to incidents, safeguarding concerns and complaints was variable across the medical directorates and relied on individual managers to be proactive and disseminate information rather than following a standardised process.
- Although medicines were usually supplied, stored and disposed of appropriately they were not always held securely.
- There was a lack of storage facilities and space throughout the hospital. This meant corridors, including the main corridor, were cluttered with equipment.

However:

- The medical and nursing records provided an accurate personalised record of each patient's care and treatment. Risk assessments and care plans were completed appropriately, with appropriate action taken when a change in the patient's condition was detected.
- Each ward received a monthly safety and quality summary, which included patient feedback and safety thermometer information. The information gathered was used to inform priorities and develop strategies for reducing harm.
- Staff were aware of safeguarding principles and able to follow the correct procedures.

At this inspection we have retained this rating because:

- There was no monitoring of ambient temperatures in any medicines storage areas except for refrigerated items.
- The only area of medicine where mandatory training rates met the trust target was in safeguarding adults.

- Nurses were required to support housekeepers in maintaining the cleanliness of the wards due to lack of staff.

However:

- Since our inspection in April 2016, the trust had appointed a sepsis clinical lead and clinical nurse specialist which enabled the introduction of a sepsis care pathway, sepsis audit programme and improvements in availability of information for staff.
- Storage had improved in the hospital since our last inspection and corridors were no longer cluttered with equipment.

Incidents

- Staff knew where to find standard operating procedures for incident reporting and showed us how to access these. Staff also described their responsibilities in relation to incident reporting.
- Staff had been trained to use the online incident reporting system. We saw examples where staff reported incidents on-line using the trust electronic reporting system.
- At our inspection in April 2016, we identified that incident reporting was mixed regarding how managers responded to incidents and that standardised processes were not followed. Staff we spoke with said they felt this was still the case and that clinical incidents were followed up but non clinical incidents such as those relating to staffing numbers were not.
- Staff showed us examples of incidents reported in the last month. There were five falls, one medication error and a minor injury sustained by a staff member.
- We found feedback from incidents was discussed at staff handovers and staff meetings. We saw paper copies of feedback were filed in a 'lessons learned' folder in clinical areas to enable staff who had not attended the handover or meeting to remain updated.
- Between March 2016 and February 2017, the trust reported one incident that was classified as a Never Event for medicine at the Royal Sussex Hospital site. Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. It involved a patient with reduced sensation in her feet, soaking

Medical care (including older people's care)

her feet in hot water and sustaining burns. The patient had to be transferred to the Burns Unit and was referred for specialist care. Staff told us that a root cause analysis had been undertaken and that learning from the incident was shared across the trust via the trust patient safety podcasts and newsletters. This ensured that staff on both sites shared learning to reduce the likelihood of a similar incident occurring at Princess Royal.

- In accordance with the Serious Incident Framework 2015, the trust reported two Serious Incidents (SIs) in medicine at Princess Royal Hospital, which met the reporting criteria set by NHS England between March 2016 and February 2017. Of these, the most common type of incident reported was slips/trips/falls (60%).
- On Hurstpierpoint Ward we noted the ward manager investigated an increased number of slips, trips and falls. Data showed the majority occurred in the morning when housekeeping were mopping the floor. Therefore, housekeeping times had been amended in order that mopping occurred between 1pm and 3pm when patients had bed rest. Since this change, the number of slips, trips and falls had dramatically reduced. This demonstrated how the ward used safety information to reduce risks.
- Staff knew their responsibilities regarding duty of candour and when to apply it. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. On Ardingly Ward staff had applied duty of candour to a patient that had come to the ward through the emergency department. The patient was very confused and crying and during treatment staff had missed a secondary injury of a fracture to the knee. We saw that staff had received training in looking after confused patients after this incident.

Safety thermometer

- The NHS Patient Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. This

enabled measurement of the proportion of patients that are kept 'harm free' from pressure ulcers, falls, and urine infections (in patients with a catheter) and venous thromboembolism (VTE).

- Data collection took place one day each month and was reported on a quarterly basis by the medical service across the trust. Although the trust was monitoring safety thermometer information, the data was not publically displayed in patient areas.
- The patient safety thermometer data showed that the medical service across both sites at the trust reported 13 new pressure ulcers, 15 falls with harm and 48 new catheter urinary tract infections between February 2016 and February 2017. No pressure ulcers were reported in March, and from May to July 2016. The highest numbers of pressure ulcers were reported in April 2016 (3) October 2016 (2) and February 2017 (2). For the remaining six months, one pressure ulcer per month was reported. For the remaining seven months, one fall per month was reported.
- Trust wide figures for medical service reported no falls with harm in February 2016, May 2016 and January 2017. From September to November 2016, the number of falls increased with two falls in September and three falls each in October and November 2016.
- A high number of catheter related urinary tract infections (UTIs) (48) was reported trust wide by medical service from February 2016 to February 2017, we were not provided site specific data. On average, four infections were reported per month. High numbers were reported in February 2016 (4), April (6) May (5), June 2016 (8) and February 2017 (10). From August to October 2016 three infections were reported per month. In December 2016 no infections were reported, although numbers increased from zero in December 2016 to ten in February 2017.
- As the trust did not provide data that was specific to a site, ward or area of medicine, we were unable to determine whether there were themes regarding whether a particular staff group required further training, for example to help reduce UTI numbers.

Cleanliness, infection control and hygiene

Medical care (including older people's care)

- From 1 April 2016 to 31 March 2017 there were 17 reported cases of Clostridium Difficile (C.Diff) at PRH. Of those, 11 were reported in the medical service.
- At our inspection in April 2016, we identified requirements for cleaning, schedules and checklists set out in the 'Health and Social Care Act 2008: Code of practice for health and adult social care on the prevention and control of infections' and associated guidance were not adhered to. However, on this inspection we saw that daily ward safety checklists including cleaning instructions and checklists had been standardised.
- The ward environments looked clean and patients praised cleanliness at the hospital. We received comments from patients and visitors stating they were impressed with the hygiene standards of the ward environment. However, staff on several wards commented that there was not enough housekeeping staff and nurses had to support the cleaning of wards in order to maintain standards. Housekeepers advised us if an area of cleaning had not been completed, they handed this over to the nurse in charge to ensure another member of staff completed the task.
- The trust did not have a strategic and operational cleaning plan as required by the 'National Specification of Cleanliness (NSC) in the NHS, 2007'. The strategic document outlines the Board's commitment to cleaning and supplying sufficient funding. The operational document shows how the complete cleaning operation actually works in practice.
- NICE QS61 states that health care workers must decontaminate their hands immediately before and after every episode of direct contact or care. We saw that staff consistently used hand sanitisers, were bare below the elbow and washed their hands in accordance with guidelines.
- We noted the wards had sufficient supplies of personal protective equipment (PPE), for example, aprons and gloves. We observed staff using and disposing of PPE appropriately.
- We also saw visitors, including other staff and patient's relatives and friends consistently used hand sanitisers and wore personal protective equipment.
- We observed staff segregated clinical and domestic waste and placed it in different coloured waste sacks in line with national guidance. There were arrangements for the management of high risk used linen and staff complied with these.
- We saw staff complied with 'Health and Safety (Sharp Instruments in Healthcare) Regulations 2013'. In all ward areas we visited, sharps containers were dated, signed and securely closed.
- In the Endoscopy Suite, we observed all staff followed 'Health Technical Memorandum HTOM 01-06: Decontamination of flexible endoscopes' and Health and Safety Executive (HSE) Standards.
- Staff tested endoscopes for leaks and were flushed through in accordance with guidelines immediately after each procedure. Staff ensured instruments were packed and transported in a closed trolley from the procedure room to the washer disinfectant (EWD) in the decontamination area within the operating theatre department.
- Staff stored all returned decontaminated endoscopes in a drying cabinet in the endoscopy suite.

Environment and equipment

- Staff told us they were satisfied they had enough equipment which was in good working order, to care for patients. All equipment we reviewed was regularly serviced in accordance with manufacturers guidance and all electrical equipment was tested.
- Resuscitation trolleys were readily available and accessible throughout the medical service. Staff knew the location of all emergency equipment and we saw a checklist which indicated emergency equipment was checked at least a daily and all required equipment was present and in date. Trolleys were secured and had tamper proof tags attached to show they had not been compromised.
- Staff told us there was usually same day delivery of equipment when requested. We did not see any of the clutter in corridors that was identified at our inspection in April 2016. Corridors were clear and equipment was stored appropriately.
- During our inspection, we walked past Ardingly Ward several times. Each time we walked past, we saw the

Medical care (including older people's care)

door to the ward was open. The ward manager advised us this was an issue as although the door locked when closed; the door hinges prevented the door from closing automatically. We saw this was on the ward risk register. However, there were no plans from estates to improve the situation, which posed a security threat to staff and patients.

Medicines

- There were systems that ensured the supply, administration and disposal of medicines was in accordance with 'NICE NG5 Medicines optimisation: the safe and effective use of medicines'.
- At our inspection in April 2016, we identified that not all medicines were stored appropriately. During this inspection, on all wards we visited we saw medicines were stored securely in locked cupboards away from areas accessible to patients and visitors.
- Fridge temperatures were monitored and recorded daily to ensure medicines requiring fridge storage were kept in optimal conditions. However, ambient room temperature in areas where medicines were stored was not monitored in any of the clinical areas we visited. This presented a risk that medicines may be stored in conditions that adversely affected their efficacy or safety. We brought this to the attention of managers who advised us this would be looked into. Since the inspection, the trust has provided information showing the introduction of remote monitoring of ambient temperatures across the trust from June 2017.
- Controlled drugs (CDs) are medicines that require additional security. In all of the patient areas we visited we saw CDs were stored in locked cupboards bolted to the wall in accordance with guidelines. CD records showed all CDs were checked by two appropriately qualified members of staff. We reviewed stock levels and found these tallied with the CD registers and were correct.
- Staff documented medicines in patient records in accordance with local and national guidance and we saw all medicines were given as prescribed. Allergies were recorded in all the medicines administration records we reviewed and we saw staff check patient allergies every time medication was given.

- Pharmacy staff provided a stock top up service which ward staff praised as it ensured medicines never ran out on the wards. Site managers could access restricted pharmacy and emergency medicines storage cupboards when emergency supplies were required.
- The pharmacists' clinical input to reviewing medicines administration records (MARs) was inconsistent. Four out of nine MARs we reviewed on Plumpton Ward, did not have a drug history documented on them, and four had no evidence of any clinical input from the pharmacy team at all.
- Prescriptions for PRN medicines (medicines to be supplied and administered when necessary) did not always have an indication to help staff who administered medicines to understand why they should be used.
- Staff on Plumpton Ward felt that they needed a dedicated pharmacy service and this was not provided. They told us without regular visits from a pharmacist they were concerned about the risks of managing medicines in people with complex needs. The staff tried to alleviate this problem by sending charts and handovers to the pharmacy for screening and advice. However, this sometimes meant that charts were not available when they were needed on the ward. No other wards on site reported this issue.
- Staff reported they had not received any feedback on the incident reports they had completed on medicines errors. Therefore, there was limited assurance of learning from medicine errors in order to prevent similar incident occurring in the future.

Records

- Individual care records were managed in a way that kept people safe. The hospital had a clear policy, which described how records should be completed and stored. There was clear guidance on how information should be recorded and which areas of the records had to be filled in, for example: hospital numbers and discharge details.
- We reviewed 21 sets of patient notes, which included records of the patient's journey through the hospital. All patient notes we reviewed were fully completed, legible, signed and dated. Staff signed and wrote their

Medical care (including older people's care)

name in the notes, therefore it was clear who contributed to the record. Records included person centred care plans that detailed preferences of patients and their families, and included clear instructions for staff to follow. Review dates were clearly identified and we saw plans were regularly reviewed in line with this.

- At our inspection in April 2016, we required the trust must ensure safe and secure storage of records. We saw records were generally stored securely and safely. However, on Pyecombe Ward we found a handover report sheet containing a summary of all the patients on the ward had been filed in a patient's nursing notes and was not labelled confidential. The nursing notes were stored at the end of the patient's bed and fully accessible by the patient and their visitors and could result in a breach of confidentiality.

Safeguarding

- There were no reported safeguarding concerns at the time of our inspection, in the six months prior to our inspection, and between January 2016 and December 2016.
- The chief nurse was the designated executive lead for safeguarding. There was a trust wide team of nurses established to support staff with safeguarding issues upon request, who were available 24 hours a day, seven days a week.
- We saw that safeguarding policies for children and young people and adults were up to date, staff knew how to access the policies and were able to describe the actions they would take if they had any safeguarding concerns. Noticeboards in patient areas displayed information about safeguarding, for example, different types of abuse and details of who and how to report any concerns. These boards were accessible for staff and the public.
- From April 2016 to February 2017, medical staff and nursing and midwifery staff had a Safeguarding Adults training completion rate of 100% meeting the trust target and in line with the overall trust average.
- The intercollegiate document 'Safeguarding children and young people: roles and competences for health care staff March 2014' states that "All staff who come into contact with children and young people have a

responsibility to safeguard and promote their welfare and should know what to do if they have concerns about safeguarding issues, including child protection. This responsibility also applies to staff working primarily with who have dependent children that may be at risk because of their parents/carers health or behaviour".

- Trust wide figures for medicine showed the 100% target was not met for Safeguarding Children Level 2 training. For medical staff the completion rate was 77% and was lower than the trust overall average of 82%. For nursing and midwifery staff there was a completion rate of 71% for Safeguarding Children Level 2, which was lower than the trust target and overall trust completion rate of 86%. Trust wide figures for medicine also showed the mandatory training target of 100% was not met for Safeguarding Children Level 3 (88%). We were not provided with site specific information.

Mandatory training

- Our inspection in April 2016 identified staff compliance with mandatory training fell below the trust target for both nurses and doctors across every department in the hospital. One of our requirements from that inspection was that all staff completed mandatory training.
- The trust provided mandatory training records from April 2016 to February 2017, however none of the data was site specific and showed that compliance with mandatory training for medical and nursing and midwifery staff within the medical service continued to fall below the trust target.
- Trust wide medical service data showed the lowest completion rate for mandatory training was reported in Adult Basic Life Support training. Completion rates ranged from 44% in speciality medicine to 70% abdominal surgery and medicine. There was a 56% completion rate in the cardiovascular department, and 53% in the cancer directorate. The trust did not provide us with site specific information or divide the data by grade.
- Staff at this site told us that it was difficult to access the Adult Basic Life Support course as there were only limited places each month and it was difficult to get released to attend training.

Medical care (including older people's care)

- Our previous report stated staff must complete Conflict Resolution training. However, trust wide data for medical staff showed 59% completion rate in the cardiovascular service, with the highest completion rate 79% in the neurosciences and stroke service. The information provided by the trust was not broken down by site.
 - Fire Safety training had generally improved since our last inspection, however it was still below the trust target. The highest reported completion rate was 88% in the neurosciences and stroke unit. The lowest reported completion rate was 78% in specialty medicine. The information provided by the trust was not broken down by site or grade of staff.
 - Trust wide staff rates for completion of Information Governance training ranged from 85% in the abdominal surgery and medical department to 93% in the neurological and stroke department. This information was not broken down by site or staff grade.
 - The above completion rates showed that CQC requirements from our last inspection had not been met.
 - The majority of mandatory training was on-line. Managers reported some staff were "Not used to computers, and kept forgetting their passwords" which delayed their completion of training. This had been raised as a training issue with the training and development matron and we were told was the subject of on-going work.
 - On Hurstpierpoint Ward, mandatory training was booked during appraisals. Therefore, staff only had the opportunity to review training needs and requirements once a year rather than at regular intervals when needs arose.
- signs (respiratory rate, oxygen saturation, temperature, blood pressure, heart rate and responsiveness). We observed staff regularly checked NEWS scores to identify and monitor patients who were deteriorating. In all records we reviewed, we saw NEWS was regularly monitored and staff escalated concerns appropriately when scores increased beyond thresholds.
- We observed staff during a safety huddle and saw staff use the safety, background, assessment and recommendations (SBAR) tool to promptly act on risks other issues discussed included staffing levels, safety incidents and infection prevention and control issues. We saw safety huddles occurring all of the areas of the hospital we visited and were told these were held twice daily.
 - At our inspection in April 2016, we identified a need to implement a sepsis audit programme across the trust. Since then a sepsis clinical lead and a clinical nurse specialist for sepsis had been appointed to enable audit and education activities across the trust. We saw that sepsis audits had been carried out in some areas. However, this was early work in progress and therefore we are unable to fully assess its impact at this stage.
 - Staff showed us the sepsis pathway, which enabled them to diagnose sepsis at an early stage and a clear treatment process to follow when a patient was deteriorating. This incorporated the sepsis six which are six nationally recognised steps staff should take with patients who are at risk.

Nursing staffing

- The trust did not utilise a patient acuity tool to determine levels of staffing. The leadership team told us approaches to planning staffing relied on quantifying the extent of nursing care to be provided based on the size of population, mix of patients, and type of service and relating it to the activities undertaken by different members of the team.
- Staff we spoke with told us that the staffing levels remained a concern, and that it was "A struggle on some occasions".
- In February 2017, medical services reported a nursing vacancy rate of 8%, however, the data was not site specific. There were vacancies in all parts of the

Assessing and responding to patient risk

- Trust wide data for medical services showed consultants assessed patients who were urgent or unplanned medical admissions within 12 hours of admission or within 14 hours of the time of arrival at hospital.
- National Early Warning Scores (NEWS) is a guide used by medical services to quickly determine the degree of illness of a patient. It is based on the six cardinal vital

Medical care (including older people's care)

service with the exception of the neurosciences and stroke department. As of February 2017, the trust reported a turnover rate of 17% in medicine compared to an overall trust turnover rate of 15.7% for nursing staff.

- Between April 2015 and March 2016, the trust reported a sickness rate of 4% in medicine across sites, slightly higher than the overall trust sickness rate of 3.6% for nursing staff.
- Between February 2016 and January 2017, Brighton and Sussex University Hospitals NHS Trust reported a bank and agency usage rate of 9% in medicine across both sites, slightly higher than the trust overall rate of 7%.
- During our visit, we saw that actual staffing levels were below the planned staffing levels on Ardingly Ward due to staff sickness. There were five registered nurses and five health care assistants scheduled for the shift we observed. We saw there were two registered nurses and four health care assistants on duty. In addition, a registered nurse was redeployed from critical care. A band 7 nurse was allocated a case load of eight patients, in addition to their ward co-ordinator role. This meant they were not supernumerary or supervisory.
- Staff rotas for medical services used a red, amber green rating system. We saw rotas that showed the average fill rate for registered day nurses on Clayton Ward (part of neurology) was 76.3% in July 2016, and was therefore rated as red during this period. Plumpton Ward was rated as amber for the same month, however Ardingly Ward and Hurstpierpoint Ward were both rated as green. We saw rotas from April to July 2016 and during this period noted there was no month where all medical wards at Princess Royal Hospital had been rated as green.

Medical staffing

- Senior medical staff we spoke with told us there were two consultant vacancies within the neurosciences and stroke service at PRH. Recruitment was underway, however the closing date for applications was pending at the time of our inspection. In the meantime, consultants were having to take on extra on call duties (one in four at weekends and one in six on week days) and were supported by specialist registrars.

- As of February 2017, the trust reported a vacancy rate of 6% in medicine across both sites. This was worse than other the national average.
- From April 2015 to March 2016, the trust reported a sickness rate of 1% in medicine across both sites, which was better than the national average.
- From February 2016 to January 2017, the trust reported a bank and locum usage rate of 10% in medicine, which was worse than the national average.
- From November 2016, the proportion of consultant staff reported to be working at the trust were lower than the England average and the proportion of junior (foundation year one to two) staff was about the same.
- Therefore, the trust was not providing sufficient cover for medical staffing on the wards.
- 'NHS England Seven Day Services Clinical Standards February 2017' states "All patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours, seven days a week." However, staff we spoke with told us the consultant led ward round normally took place twice a week in most areas, and on other days the ward round would be led by a specialist registrar with 24 hour telephone access to the consultant for advice. Therefore, the hospital was not meeting this standard.

Major incident awareness and training

- Staff understood the arrangements in place for managing major incidents and enabling business continuity. We saw records relating to a recent trust-wide business continuity incident in respect of patient flow and demand and available capacity. At the time of the incident, a meeting was held in the operational control rooms at both RSCH and PRH with a video link so all staff could access the meeting and share learning across sites.
- Major incident training did not form part of the mandatory training programme.

Are medical care services effective?

Medical care (including older people's care)

Requires improvement



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

- Accessing valid appraisals was variable depending on the ward or directorate. Not all staff had received an annual performance review or had opportunities to discuss and identify learning and development needs through this review.
- 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.

However:

- There were suitable arrangements to ensure that further training and development was available for staff to enable them to improve their skills and develop their competencies.
- Throughout the medical services we found effective multidisciplinary working. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.

At this inspection we have retained this rating because:

- Outcomes from national audits were mixed and were below expectations when compared with similar services. The service scored a higher than expected risk of readmission for two of the top three specialties for all elective admissions.
- The hospital did not have any formal arrangements for access to the acute pain team out of hours and there was no pain team for chronic pain management. CQC identified this at our April 2016 inspection.
- Appraisal rates were below the trust target for all medical specialties.

However:

- The endoscopy service had been awarded Joint Advisory Group on GI Endoscopy (JAG) accreditation and participated in external network events.

- Staff participated in a range of local and national audits. Outcomes were shared internally and externally and were understood by staff.

Evidence-based care and treatment

- Trust wide policies and procedures were up to date and based on recognised guidelines and national standards, for example; National Institute for Health and Health Care Excellence (NICE), Royal College guidelines, UK Resuscitation Council, and British Dietetic Association.
- At our inspection in April 2016, a “must do” from the report was that care must be planned in accordance with NICE CG83 rehabilitation pathway critical care. At this inspection, we saw that pathways at the hospital were in line with NICE guidance; therefore, the hospital had met the criteria set out in our previous report.
- However, there was no evidence based care pathway for bariatric patients, nor was there a commissioned bariatric service or formal arrangement for specialist advice and support when a bariatric patient attended hospital.
- There was evidence of involvement in local and national audit programmes, for example the National Diabetes Inpatient Audit and Sentinel Stroke National Audit Programme.
- The service used a sepsis screening tool and sepsis care pathway based on the ‘sepsis six’, which is a national screening tool for sepsis. Staff showed us this was easily accessed on the trust intranet.

Pain relief

- We saw staff asked patients about their pain on a regular basis as part of clinical observations using a formal patient reported pain scoring system. Patients were asked to score their pain on a scale of one to 10.
- On care of the elderly wards, staff used nationally recognised tools to support patients who may not be able to verbally communicate their level of pain. Staff scored patients against a number of different criteria including facial expressions and level of agitation.
- Patient records showed that staff regularly checked patient pain levels and that when analgesia was given, staff returned after a period of time to check it had been effective.

Medical care (including older people's care)

- All patients we spoke with said they were happy with the pain relief offered to them by staff and that staff were quick to respond when patients advised they were in pain.

Nutrition and hydration

- Dietitians were available across the medical service from 9am to 5pm Monday to Friday, however there was an out of hours telephone service for advice. However, there was no hospital or trust wide dietetic service commissioned or provided for bariatric patients and staff advised us they did not receive any specific bariatric nutritional training.
- Dietitians contributed to patient care plans and recorded instructions for other members of the multi-disciplinary team. Staff advised us that dietitians and speech and language therapists (SALT) supported them to look after patients nutritional needs. For example, SALT did training sessions on thickened fluids and how hot, cold and fatty drinks affected how many scoops of thickener were required.
- Staff used a Malnutrition Universal Screening Tool (MUST) to assess whether patients were at risk of malnutrition or whether they needed to be put on a special diet. We saw completed MUST's that also included details of patient input and output, in all patient records checked. Staff knew their responsibilities regarding escalating a concern if a patient had a low input or output for the day. We saw staff on Hurstpierpoint Ward tallied up input and output as the shift progressed in order that concerns were identified as they occurred, rather than wait until the end of the shift to ensure patients had consumed enough food and fluid.
- In Hurstpierpoint Ward, we saw that staff had reviewed meals in order to support the type of patients on the ward. As an elderly care ward, staff monitoring of patients showed that patients were more active during the morning and became less so as the day progressed. Therefore, meal sizes were swapped round in order that patients received a large cooked meal in the morning and a smaller evening meal. We saw patient records that showed this had improved patient input and MUST scores.
- Data provided by the trust showed from October 2015 to September 2016, medical patients at Princess Royal Hospital had a slightly higher than expected risk of readmission for one of the top three specialties for all elective admissions. Geriatric medicine had a higher than expected risk and neurology and respiratory medicine a similar to expected risk of elective re-admissions. For all non-elective admissions, the risk of readmission was mostly similar to expected, although respiratory medicine had a slightly lower risk of re-admission.
- The trust took part in the quarterly Sentinel Stroke National Audit Programme (SSNAP). However, the trust did not submit information for this site, only the Royal Sussex County Hospital.
- Princess Royal Hospital took part in the 2016 National Diabetes Inpatient Audit. They scored better than the England average in ten metrics and worse than the England average in eight metrics. There was 100% overall satisfaction rate compared to an England average of 83.7%, for the question 'All or most staff knows about diabetes' the hospital scores were better than the England average by 26%. For the two questions about staff awareness of diabetes and staff knowledge in answering questions, the hospital scored a 100 %, better than the England average of 84% and 81% respectively. PRH scored lower than the England average for all three questions related to foot risk assessment. For the question if patients were seen by the MDFT within 24 hours, hospital scores were 23% lower than the England average.
- The trust participated in the 2016 Lung Cancer Audit. The number of patients seen by a Cancer Nurse Specialist was 87%, which was better than the audit minimum standard of 80%. The proportion of fit patients with advanced Non-Small Cell Lung Cancer (NSCLC) receiving chemotherapy was 56.3%, which was in line with the national level. The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 73.9%, which was also in line with the national level. The audit showed that in the last year the trust had improved overall.
- Princess Royal Hospital results in the 2015 Heart Failure Audit were worse than the England and Wales average for all four of the standards relating to in-hospital care. The site performed significantly worse

Patient outcomes

Medical care (including older people's care)

than the England and Wales average for cardiology inpatient care, 8% compared to 49%. Princess Royal Hospital results were worse than the England and Wales average for three of the seven standards relating to discharge.

Competent staff

- The nurse practice educator post within the trust had been vacant for one year. We asked staff whether this impacted training and were told by a manager that not all their staff had completed training in administering cytotoxic medication because there was no one to support getting staff onto training courses. However, a new practice educator had been recruited and was due to take up the appointment in May 2017.
- Staff at PRH commented that the majority of sessions were held at RSCH and travelling time to and from the training events had to be taken into consideration, meaning PRH staff needed longer periods away from clinical practice than their colleagues at RSCH, and were more likely to be asked to cancel attendance.
- There were trust wide induction processes for both permanent and temporary (agency and locum) staff. Staff who were new to the hospital told us they felt the induction process supported them in their new role.
- Junior doctors told us it was difficult to attend core medical training teaching sessions as they were held at the Royal Sussex County Hospital in Brighton, not on site at Princess Royal. The same doctors were unable to provide examples of ward based learning. When junior doctors were on call they were not always given the opportunity to attend outpatient clinic or undertake clerking. Clerking is taking a comprehensive history and full examination of the patient. One doctor told us they had not clerked a patient in the previous three weeks and felt there were limited training opportunities. The reason they were unable to observe clinics was that medical students were in attendance.
- One of our requirements from the inspection in April 2016, was that all staff have an annual appraisal, as the trust was below target. At this inspection, trust wide figures for medicine services across both sites showed from April 2016 to January 2017 an improvement from 64% to 75%. The highest completion rate within the medical service was 88%

within the abdominal surgery and medicine division, 88% in the neurology and stroke service, 84% in specialist medicine, 79% in cancer services and 79% in cardiovascular. We were not provided with site specific information. These figures showed the trust was still not reaching its target of 100% staff appraisal.

Multidisciplinary working

- We observed MDT ward rounds and a safety huddles, however on Balcombe Ward and Ardingly Ward there were no meeting rooms for private and confidential staff discussion. Therefore these occurred in the open where patient confidentiality may be breached.
- We saw a handover meeting at the hospital, noted that a full MDT was present and that all members of the team had a chance to contribute, and were listened to, regardless of grade or area of expertise.
- Patients had access to a wide range of therapy practices including; physiotherapists, occupational therapists, dieticians and speech and language therapists, that provided practical support and encouragement for patients with both acute and long-term conditions.

Seven-day services

- During our inspection in April 2016, we found consultants and support services offered an on-call system over the weekend and out of hours, and that there was no seven day service provided by pharmacy. On this inspection we found that consultants still operated an on call system during weekends and out of hours and that the pharmacy service was still not provided seven days a week.
- The Discharge Lounge closed at 6pm on weekdays and was not open at weekends. This meant Mondays were extremely busy. In addition, due to the delays described above, staff reported that patients were often still in the Discharge Lounge after 6pm waiting for transport. Therefore, the unit relied on the goodwill of staff to stay on duty until all patients had left.
- The trust had approved for the cardiology team to complete waiting lists on a Saturday to reduce waiting lists and improve flow through the hospital. However, at the time of inspection this had not yet started.

Access to information

Medical care (including older people's care)

- Policies and procedures, mandatory training and safety alerts were all stored on the trusts intranet. Staff showed us how they accessed the system and we saw staff using policies in practice.
- On discharge from the service, staff sent discharge summaries to patient's GPs. All patient notes we looked at contained detailed discharge summaries and we saw staff give a copy of the discharge summary to the patient, send one to the GP, and keep another copy on file.
- We observed and staff confirmed that computers were available throughout ward areas. Staff were able to use the computers to access patient information including test results, diagnostics and records systems. Staff demonstrated accessing the system and advised us there were no issues regarding not enough computers.
- Staff used an archiving and communication system to download and view images of patients x-rays and tests. We saw staff use the system in practice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Since our last inspection, the trust had reviewed its consent policy and appointed consent champions. There were plans in place to complete an audit of the consent policy by the end of July 2017.
- Staff we spoke with were able to describe the reasons why they needed to obtain consent before performing care. Staff knew their responsibilities regarding best interest decisions for patients who lacked capacity. We saw patient records on Hurstpierpoint Ward that confirmed best interest practices were followed and recorded in accordance with guidelines.
- We saw qualified staff completed mental capacity assessments for patients lacking the capacity to consent. Staff knew they could access information regarding mental capacity protocols and Deprivation of Liberty Safeguards (DoLS) from specialist link nurses as well as the trust intranet.
- Staff understood the role of independent mental capacity advocates (IMCAs) and knew to seek support from the matrons and safeguarding team if a patient required one.

Are medical care services caring?

Good



When we inspected the Princess Royal Hospital in April 2016, we rated caring as good because:

- 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. The Patients' Voice and Family and Friends feedback indicated that this was not unusual and the majority of patients had a positive experience.
- Staff treated patients with dignity and respect. We observed patients being treated in a professional and considerate manner by staff. We observed staff treating patients with kindness, professionalism and courtesy.
- Patients were usually satisfied with the quality and standard of care they received from doctors and nurses and reported they were involved in decisions about their treatment and care. There was access to counselling, chaplaincy and specialist nursing services, where patients required additional emotional and psychological support.

On this inspection we have maintained a rating of good because:

- Patients and staff worked together to plan care and there was shared decision-making about care and treatment.
- Patients were mainly supported and treated with dignity and respect at all times.
- Staff responded compassionately when patients needed help and supported them to meet their basic personal needs as and when required.

However:

- On Balcombe Ward, staff did not always respect patient privacy as daily MDT meetings were held in open areas where other patients and visitors could hear.

Compassionate care

Medical care (including older people's care)

- The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used. The Friends and Family Test response rate for medicine at Princess Royal Hospital was 28%, which was better than the England average of 25% between February 2016 and January 2017. Clayton Ward had the highest average recommendation rate of 98%, although the lowest response rate of only 7%. Pyecombe Ward had an average recommendation rate of 96% and a higher than the average site response rate of 37%. Plumpton Ward had a higher than the average site response rate of 34% and an average recommendation rate of 95%. Balcombe Ward had the lowest average recommendation rate of 74%, we did not see any plans detailing how the ward was to improve this figure, although the ward had a higher than average site response rate of 34%.
- On the lead up to our inspection, CQC left comment card boxes on wards around the hospital. On the day of inspection, we received 10 comment cards related to medicine. Comments included "I have only ever received an excellent service, staff have always been caring and considerate" and "The service I have and am receiving is absolutely first class, ever so helpful staff, really made to feel at ease."
- In all areas we visited, staff closed curtains during examinations and spoke quietly enough so the patients in adjacent beds could not hear conversations. However, on Balcombe Ward, we witnessed an MDT meeting that staff held every day at 11am. Staff conducted the meeting by the nurses' station, which was loud enough that patients and visitors throughout the area could overhear conversations. Therefore, the team were not always respecting patient privacy and dignity.
- We spoke to five patients on Ardingly Ward, all of whom specifically commented on how kind the night staff were. Comments included "The night staff are lovely, just wonderful" and "They keep everything so calm and quiet during the night, its lovely."

- On Lindfield Ward, we saw during a quiet period a nurse played guitar to patients in one of the bays. The patients appeared relaxed and all said they really enjoyed the impromptu sessions and that the nurse did them regularly.

Understanding and involvement of patients and those close to them

- Patients had a named nurse and/or consultants name written next to their beds in all areas visited. All patients and relatives we spoke with knew the name of the nurse looking after them for that shift. The trust had recently introduced bright red armbands to show who was the nurse in charge and visitors on Ardingly Ward said this made it easier to know who to talk to if they had a question.
- We saw staff speak to patients using everyday language on all wards we visited. Where appropriate staff asked patients to repeat what had been discussed in order to ensure patients understood what was going to happen next. Staff also gave patients the opportunity to ask any questions.
- Patients we spoke with on Lindfield Ward knew the next steps in their treatment and could describe any upcoming procedures and when these were going to occur.
- Patients also advised us they felt involved in discharge planning. Patients on Lindfield Ward told us they were involved in setting therapy targets and goals and that the MDT team reviewed targets based on the patient's requirements. Patients and families also advised us they were included in discussions regarding discharge planning. All patients we spoke with knew how long they expected to be in hospital.

Emotional support

- There was a 24 hour chaplaincy service available at the hospital. The chaplain provided access to literature from six different religions as well as more general spiritual books. There was a separate Muslim prayer room next to the chapel as well as a prayer request sheet where patients and families could write a prayer that clergy read out during services.
- Staff in the specialist directorate received training from members of different faiths, such as Rabbis and Priests to support their understanding of patients' spiritual

Medical care (including older people's care)

needs. Staff also had access to religious information leaflets and had contact details of members of various churches. Staff advised us they appreciated this as it helped them to support patients from different backgrounds and found it especially important when a patient was nearing end of life in order that staff could arrange any requirements in advance.

- In the first instance, patients received support from staff on the wards. Staff knew how and when to refer patients to specialist nurses for emotional support when required.
- All wards we inspected had a side room that staff could use if difficult conversations were required. We noted all the rooms were suitable with regards to location, for example not being in an open, busy area and rooms did not have a dual purpose whereby the room may be required when families needed an extended time in the room alone.
- All care of the elderly and dementia wards had a dignity champion, usually a band 4 that supported staff in understanding how best to promote dignity within the ward as well as support patients. Staff could refer to the dignity champion if they needed support and advice and the champions held regular training sessions.

dementia provided a broad range of activities to stimulate the patients. Staff from the dementia ward also provided an outreach service to other wards that were caring for people living with dementia.

On this inspection we have maintained a rating of requires improvement because:

- Issues identified at the previous inspection had not been sufficiently addressed, for example: Referral to treatment times were worse than the England average.
- There were long waiting times, delays and cancellations and the actions to address this were not timely or effective. For example, the Discharge Lounge was not used consistently by staff, which led to delays.
- The number patient bed moves was worse than the England average.
- Complaint response times were worse than the trust target.

However:

- The inspection team was impressed with the facilities to support patients living with dementia on Hurstpierpoint Ward. For example, the reminiscence room and the use of a bus stop as a focal point.

Are medical care services responsive?

Requires improvement



When we inspected the Princess Royal Hospital in April 2016, we rated responsive as requires improvement because:

- The data available for average cancer wait times was not site specific and instead reflected the overall performance of the trust. Just over 91% of patients saw a specialist within 14 days. This was worse than the England average of just over 94% and below the 96% national standard.

However:

- There were good examples of how the hospital cared and treated patients living with dementia and their families. The main ward that treated people living with

Service planning and delivery to meet the needs of local people

- Between November 2015 and October 2016, the average length of stay for medical elective patients at Brighton and Sussex University Hospitals NHS Trust was 2.8 days, which was better than the England average of 4.1 days. For medical non-elective patients, the average length of stay was 7.0 days, which was similar to England average of 6.7 days. Non-elective patients for geriatric medicine was better than the England average, with 8.4 days compared to 9.7, as well as respiratory medicine, with 5.9 compared to 7.0 days. Between November 2015 and October 2016 the average length of stay for medical elective patients at Princess Royal Hospital was 2.9 days, which was better than the England average of 4.1 days. For medical non-elective patients, the average length of stay was 6.2 days, which is similar to England average of 6.7 days. Non Elective patients within geriatric medicine had a much shorter length of stay than the England

Medical care (including older people's care)

average, 6.2 compared to 9.7 days. The average length of stay for non-Medical care including older people's care elective diabetic medicine was 5.3 days less than the England average of 7.1 days.

- We found issues regarding ward layout in providing appropriate mixed sex accommodation. For example, Ardingly Ward was made up of four bay areas. At the time of inspection, bays one, two and four were occupied by female patients and bay three was used by male patients. Although each bay had its own toilet facility, the shower facilities were at either end of the ward. Therefore, male patients had to walk past a female inhabited area in order to use shower facilities and females in bay four, had to walk past a male occupied area to use their shower facilities. 'The Department of Health Health Building Note 00-09: Infection control in the built environment 3.11' states "The need to deliver the highest standards of privacy and dignity applies equally to all areas of a healthcare facility. Achieving these high standards will usually mean ensuring that men and women do not have to sleep in the same room or share toilet and washing facilities. Patients should not have to pass through areas used by the opposite sex to reach their own facilities." Therefore the ward was in breach of this regulation.
- Signage around the hospital was poor and did not assist patients to find their way. During our inspection, we saw several patients and relatives become lost due to poor signage around the hospital. The inspection team asked for directions to specific wards and staff did not always know where these were. One patient said to us they "Always get lost on the way to the Hurstwood Clinic, the place is a maze." At the time of our inspection, the Discharge Lounge had been moved to a different area of the hospital. However, signage had not been updated; therefore, patients were signposted to the wrong area. The inspection team knew the discharge lounge had moved, however it was located at the end of a long corridor in outpatients. When we asked staff for directions only staff working in outpatients knew where the discharge lounge was located.

Access and flow

- Between February 2016 and January 2017, the trust's referral to treatment time (RTT) for admitted pathways

for medicine, showed 78% of this group of patients were treated within 18 weeks, which was 16% worse than the England average of 93%. Trust performance was below the England average from February to October 2016. We were not provided with site specific data.

- Across both sites, the specialties better than the England average for admitted RTT (percentage within 18 weeks) were; thoracic medicine (respiratory) was 99% against an England average of 95%, rheumatology (arthritis and other disorders of joints and ligaments) was 100% against an England average of 95% and general medicine was 100% against an average of 96%. However, trust wide figures showed the specialties that were worse than the England average for admitted RTT (percentage within 18 weeks) were; gastroenterology was 90% against an England average of 94% and dermatology was 74% against an England average of 87%. We were not provided with site specific data.
- Between January 2016 and December 2016, at Princess Royal Hospital, 46% of individuals did not move wards during their admission, 22% moved once and 31% moved twice or more. Between January 2016 and December 2016, at Princess Royal Hospital, 77% of individuals did not move wards during their admission, 17% moved once and 6% moved twice or more. Between January 2016 and December 2016, at Princess Royal Sussex Orthopaedic Treatment Centre, 73% of individuals did not move wards during their admission, and 27% moved twice or more.
- The trust provided data regarding the number of times medical patients moved from one ward to another between 10pm and 6am. Between 1 October 2016 and 31 March 2017, there were 3,541 bed moves and of this number 812, or 23% occurred between 10pm and 6am. These figures were worse than the England average. However, we were not provided with site specific data, therefore we could not analyse if there were themes regarding a specific site, ward or area of medicine.
- We found a lack of consistency in the way wards discharged patients from the ward to the Discharge Lounge; this inconsistency was causing confusion and patient delays. For example, ward staff at the hospital advised us their bed manager put them under

Medical care (including older people's care)

pressure to send patients down to the Discharge Lounge as soon as possible. The reason for this was pharmacy had to screen take home medicines before a patient was moved to the Discharge Lounge. However, pharmacy could not keep up with demand and therefore the process was very slow. Therefore, wards sent patients to the Discharge Lounge to wait rather than on the wards. However, this meant pharmacy did not always know the location of the patient, which caused further delay. Policy in the Discharge Lounge stated that staff could not arrange patient transport services until the patient had their take home medicine. All of which caused further delay for patients and poor flow within the hospital.

- One of the “should do” from our previous report was the trust should “Prioritise patient flow as this impacted on length of stay, timely discharge and capacity”. The above data showed the trust had not met this requirement since our last inspection.

Meeting people's individual needs

- Food options whilst in hospital met the needs of different groups, for example, patients had access to kosher dishes. There was always vegetarian and vegan options and food was made available in a variety of textures to support patients with swallowing difficulties. Patient opinion regarding food varied greatly with some patients saying it was “Lovely” whilst others commented that it was “Dreadful”. However, most patients we spoke with said it was satisfactory and that they accepted “It’s not fine dining, but it is free and perfectly acceptable.”
- On Lindfield Ward, we saw acquired brain injury rehabilitation patients using a therapy kitchen as part of their occupational therapy treatment. Patients we spoke with said they enjoyed it and made them feel “Like normal again”. We observed staff using the backward chaining technique, which is used for teaching or re-teaching skills by breaking them down into steps, which are always performed in the same order. Every time the task is performed, the therapist does less and less until the patient can complete the task on his or her own.
- Staff had access to a translation service that was available 24 hours a day, seven days a week although staff who could speak another language said they helped out when appropriate. Staff knew that it was inappropriate to use family and friends to translate.
- Dementia friendly signs were used on all dementia wards we visited. These use pictures as well as large writing to signpost facilities, for example, dining room or toilet and helped to prevent patients from wandering into inappropriate areas.
- The inspection team was impressed with the use of a bus stop with bench in Hurstpierpoint Ward. It was in the ward corridor and was used as a focal point for patients to meet. Some patients wandered and this enabled them to rest and provided a distinct reference if a patient could not remember where they were going. Each bay was also painted a different colour to support patients to find their way back to their beds. A computer was available for patients to use in order that they could skype family who could not visit every day. We also saw there was a quiet room available for patients and family to meet away from the ward area. This room contained life sized stuffed animals that staff used as part of therapy, due to the health and safety issues around bringing in a pet as therapy dog. The ward also had a reminiscence room that was decorated and set up like a living room from the 1950’s. Staff advised us this area was used for therapy sessions as patients felt more at ease in the surroundings. Inside the room there was also a switchboard for patients with electronic and operator experience.
- Staff provided patients living with dementia with a twiddle mitten or blanket if they required a cannula. The reasoning was that patients could feel something on their arm and the mitten distracted them as it had buttons and ribbons the patients could play with rather than their cannula. Since the introduction of the mittens, the rate of re-cannulation had decreased.
- We saw staff used Makaton to help support communication with patients with dementia and learning disabilities. Makaton is a language programme using signs and symbols to help people to communicate. It is designed to support spoken language and the signs and symbols are used with speech, in spoken word order.

Medical care (including older people's care)

- Staff were able to support bariatric patients as they could access equipment when required. We saw that there was not the environmental issues that we had found at Royal Sussex Hospital and cubicles were large enough to accommodate bariatric equipment. This meant bariatric patients were cared for in an appropriate ward and were not outliers in an area of the hospital that could accommodate them.
- Staff could access a mental health and a learning disability link nurse when they required support and advice. On Ardingly and Hurstpierpoint Ward, staff were involved in special interest groups, including mental health and learning disabilities. This meant they were up to date with best practice and could support patients on those wards.
- On Hurstpierpoint Ward, we saw a side room that had recently been decorated in calm, non-clinical colours and had its own ensuite. Staff advised us the room was used for patients who were end of life as it had two sets of doors leading into the room. Therefore, families and patients in the room could not hear the bustle of the ward.

Learning from complaints and concerns

- We saw complaint leaflets were available on all ward areas and that they advertised the Patient Advice and Liaison Service (PALS).
- Between January 2017 and February 2017, there were 374 trust wide complaints about medical care. The medicine team responded to 82% of complaints within 38 working days; this is not in line with their complaints policy, which states that 90% of complaints should be responded to within 40 days. There were 66 complaints about medicine that were not responded to and closed yet. Of these 37 were received from February 2016 to December 2016, indicating that response and closure of these complaints will take longer than 40 days. Medicine received 29 complaints in January and February 2017 that were not responded to and closed. The most complained about subject was waiting times and treatment delays, followed by medical care and treatment and communication with patients or

relatives. We were not provided with site specific information, therefore we were unable to assess whether there were themes regarding a specific site, ward or area of medicine.

- In the specialist directorate, we were advised that practices in dealing with patients with pressure ulcers had improved as the result of a complaint. After a review of a complaint, the team found staff assumed that patients on flow air mattresses did not need repositioning. However, staff training had been implemented and patients on flow air mattresses were turned every two hours.

Are medical care services well-led?

Requires improvement



When we inspected the Princess Royal Hospital in April 2016, we rated well-led as requires improvement because:

- The frequent changes of management at senior level had led to stasis where nothing had happened for a long time.
- Although there were governance systems in place they were complex and operating in silos. There was little cross directorate working, few standard practices and ineffective leadership bringing the many directorates together.
- The trust had not dealt effectively with poor staff behaviour.

However

- There were systems in place to gather information and produce data sets and dashboards.

On this inspection we have maintained a rating of requires improvement because:

- The arrangements for governance and performance management did not always operate effectively. For example, moving Ardingly Ward from the neurology directorate to the specialist directorate.

Medical care (including older people's care)

- Risks, issues and poor performance were not always dealt with appropriately or in a timely way. For example, there was no overarching risk register across directorates.
- HR systems did not support staff or management effectively.

However:

- We found the trust had implemented a plan to improve staff survey results.

Leadership of service

- Each directorate management team consisted of a directorate manager, a clinical director and a directorate lead nurse, who worked across all specialties within the directorate. This team managed the different leads within each specialty, however the cardiovascular directorate only had three specialties and neurosciences had seven. Therefore, there was no balanced support across directorates.
- There was no neurophysiology lead, therefore there was no one to directly represent this team at the monthly clinical governance meetings. Therefore, there was limited assurance that issues within the department would be fed up into the executive safety and quality meetings.
- Ward managers advised us that due to staff shortages on the wards, they could not always use allocated management time for its intended purpose. For example on the day of inspection, the band 7 in Ardingly Ward had been taken off management duty as the ward was short staffed. We were advised this was a regular occurrence across wards.
- Staff on Balcombe Ward advised us the new executive board was not visible and they did not know who they were. However, staff on Cuckfield Ward stated they were looking forward to the new board starting in full and that they finally felt some stability from the senior management team.
- Each medical nursing team was supported by a matron. At PRH there had been three matrons in one year, staff felt this meant there had been limited stability and support.

Vision and strategy for this service

- CQC conducted interviews with directorate leads. We found that adherence to the strategy varied between directorates. For example, in cardiology we were advised the strategy had been lost and “Not articulated well” due to the changes within the board and therefore needs and requirements changed as well.
- When we asked directorate leads about the trust values all said that adherence to a trust idea of values was difficult, again due to the changing board. However, we were advised the current board with the support of another nearby trust, was looking to implement a trust wide set of values.
- Some wards had their own set of values that they worked towards and that staff knew. These were not linked to the trust values, however all staff we spoke with in these wards linked their values to appraisals. Wards that did not have values, such as Ardingly Ward, staff used the 6C's nursing values of care, compassion, courage, communication, commitment and competence to guide them.

Governance, risk management and quality measurement

- The cardiovascular directorate had three specialties; cardiac, renal and vascular. Each specialty had a monthly clinical governance meeting as well as a bi-monthly clinical governance and morbidity and mortality meeting. These fed into the quarterly meetings with the management team. We saw minutes of these meetings where they reviewed serious clinical incidents and updated action plans, updated the risk register and reviewed any incidents that required duty of candour. These quarterly meeting were fed back to the executive safety and quality meetings which were held quarterly. We were advised the monthly specialty clinical governance meetings were shared within all three specialties within the directorate. However, we found no evidence to suggest that good practice was being shared across directorates.
- The neurosciences directorate had seven specialties; neurosurgery, neurology, spinal surgery, neuroradiology, neurophysiology, stroke and rehab. Each specialty had monthly clinical governance meetings that had input from two clinical governance

Medical care (including older people's care)

leads. Neurosurgery, spinal surgery, stroke and rehab had monthly morbidity and mortality meetings and neurology had morbidity and mortality meetings every quarter. There was also a governance lead meeting held quarterly, we saw from minutes that they discussed any infection control updates, new NICE guidance and any safeguarding incidents. Again, these were fed back to the executive safety and quality meetings, which were held quarterly. We found no evidence to suggest that good practice and learning from incidents was shared outside the directorate.

- Staff advised us that Ardingly Ward had recently changed from being a stroke unit to being an elderly care ward. However, the trust advised us it was still managed by the neurology directorate rather than the specialist directorate. Because of this confusion, we found risks within the ward had been over looked. For example, we were advised by the ward manager that by August 2017, three members of staff would be going on maternity leave and a number of overseas nurses also had plans to leave the ward. The ward manager had added the issue to the risk register, however we saw no plans in place to mitigate the risks. This issue would have been highlighted if the trust had cross directorate risk registers. However, at the time of inspection each directorate still had its own risk register, despite CQC highlighting the issue at our previous inspection.
- During an interview with the ward manager of Hurstpierpoint Ward, they advised us they were the only specialist directorate ward on-site. However, Ardingly Ward was also part of the on-site directorate. Therefore, there was lack of communication regarding the transfer of Ardingly Ward from neurology to the specialist directorate.
- When we spoke with the neurology directorate leads we asked if silo working, which was described in our previous report, was still an issue. We were advised that collaborative working had improved within the neurology team. However, there were still concerns, for example, each of the six directorates within medicine did not meet regularly to discuss governance issues and look at any trends across medicine.
- At our previous inspection, we rated children and young people's services as outstanding. Whilst the

directorate leads congratulated the team for their achievement, we could not find any examples of where directorate leads had shared learning from the children and young people's team.

- There was no overarching risk register for medical services at the hospital that could identify shared risks across the directorates. Therefore, we found there was still evidence of medical directorates working in silos within the trust and a lack of shared learning.
- The ward manager in Ardingly Ward had removed keeping patient record trolleys locked from the ward risk register. This was because staff found it difficult to access records when required due to locating the nurse in charge with the key. However, we checked all record trolleys on the ward and found them to be open, which was not compliant with data protection legislation. CQC raised this issue at our previous inspection stating the hospital "Must ensure safe and secure storage of medical records." Therefore, the ward was not meeting this standard. We asked the ward manager how the decision was made to remove the item from the risk register and found there was no overarching process from the directorate leads and that the decision was made locally. If the trust had an umbrella risk register that included issues identified from the previous CQC inspection, processes may have been in place to ensure proper review before the item was taken off the risk register.
- CQC requested site specific data from the trust in order to understand the issues related to each site. However, the majority of data received was trust wide and therefore did not identify issues and risks regarding specific wards and areas of medicine on each site. Therefore, there was limited assurance that senior leadership understood site specific issues and concerns.

Culture within the service

- During our interviews with the directorate leads for each specialty, each one said the issues identified in our previous inspection around the culture of bullying and tolerance of poor behaviour, were not an issue within their directorate and that they were "Shocked by the bad behaviour found in the previous report."
- At the time of inspection, the number of trust wide on-going staff grievances that related to bullying and

Medical care (including older people's care)

harassment was eight, however there were another 6 grievances related to bullying and harassment within the previous 12 months that had since been closed. The average response time for the issue to be investigated and resolved was 17.5 weeks. These figures are worse than the England average for a trust this size. Therefore, bullying was still a cultural issue within the trust; however, we found there was limited acceptance by directorate leads that it was an issue within their teams.

- The endoscopy and associated staff trust wide survey 2016 showed a third of staff did not believe management and co-workers treated them with respect. Comments included “Never a positive word!” and “Totally unapproachable”. We saw comments that showed management expected staff to work on good will, which was a regular occurrence and was unsustainable. Comments included “Every session overruns” and “Every list overruns by 30 minutes to 1 hour”. When asked ‘Do you feel pressured into staying beyond the end of your shift?’ staff wrote “[We have] no choice, either we stay or patients are cancelled” and “[There is] no-one to cover me”. However, the trust had responded to this by creating an action plan to address the poor staff survey results. For example, by expanding the current 2017 engagement plan.
- At our previous inspection, we noted there were issues within human resources (HR) at the trust in that policies, procedures were not always adhered to, and the level of support from HR teams varied from directorate to directorate. All ward managers we spoke with, regardless of directorate described continuing issues within HR. The main issues continued to be those that were historical. For example, we were advised there was an “If the face fits” culture and that HR processes were not effective in disabling managers from recruiting staff they wanted, rather than the member of staff who was most qualified. One ward manager advised us that issues within HR were, “Brushed under the carpet.” Dealing with long-term sickness was another area identified as an issue within HR processes. We were advised the tone of HR letters were, “Inappropriate, they sound too harsh, we are not trying to tell staff off for being ill”.

Public engagement

- The trust's website provided safety and quality performance reports and information related to safety within the hospital. For example, the trust published staffing numbers on medical wards rated as red, amber or green depending on whether there were enough staff on shift.
- The public was able to engage with the trust through various patient participation groups including; the Stakeholder Forum, League of Friends, Healthwatch, Friends and Family Test, inpatient surveys, complaints and the ‘How Are We Doing?’ initiative.

Staff engagement

- The trust's staff survey for 2016 showed the trust was in the bottom 20% for all NHS trusts in the country. Staff carried around prompt cards which promoted 'The best of BSUH' however, nowhere in the prompt cards was there any information regarding the culture of the trust.
- We asked staff how they felt about the staff survey results and what the trust had tried to do to improve morale and ratings. We were told “It gets you down as there are some lovely people and lovely teams here, but that doesn't get recognised from the top.” And “It makes you sad to feel people don't want to come into work in a morning.” With regards to what the trust had done so far, we were told that the focus had been on the positives rather than the challenges shown in the survey and that staff believed this was due to the impending CQC inspection.
- Since our previous inspection, the hospital had introduced equality and diversity study days to improve staff culture. Staff we spoke with said they had been encouraged to attend, although it was thought more specific training was needed at a managerial level.
- Black, minority and ethnic (BME) staff on Ardingly Ward advised us they had been encouraged to attend BME workshops and that this was an improvement since our last inspection.







Innovation, improvement and sustainability

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

Medical care (including older people's care)

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

Surgery

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

Information about the service

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

It provides surgical services across two sites, the Royal Sussex County Hospital (RSCH) at Brighton and the Princess Royal Hospital (PRH) at Haywards Heath this report will focus on PRH. The service is made up of four directorates: head & neck, abdominal surgery and medicine, musculoskeletal and perioperative directorates.

The head & neck directorate manage audiology, ear, nose and throat (ENT), oral and maxillofacial, clinical media centre, ophthalmology (eyes) and out patients department (OPD).

The abdominal surgery and medicine directorate provide urology, gastro-intestinal (GI) and medicine services.

The musculoskeletal directorate provide orthopaedics, pain management and rheumatology services and the perioperative directorate provide operating theatres, anaesthetics and general surgery.

The PRH has five main theatres, one day surgery theatre and four theatres in the Sussex Orthopaedic Treatment Centre (SOTC). The PRH undertakes emergency, elective inpatient and day case surgery. There are 114 inpatient surgical beds across four wards (Ansty 31 beds, Albourn 15 beds, Newick 31 beds and Twineham 37 beds), a Day Case Ward with 22 beds and the SOTC.

There is a Pre Assessment Clinic based at the PRH which assesses approximately 13,000 patients per year for all elective and day surgery patients for both sites apart from vascular services which are carried out on the RSCH site.

We visited all surgical services as part of this inspection, and spoke with 37 staff including staff on the wards and in theatres, nurses, health care assistants, doctors, consultants, therapists, ward managers, porters and other health care professionals. We spoke with 13 patients and examined 10 patient records, including medical and nursing notes and medication charts.

Surgery

Summary of findings

When we inspected the Princess Royal Hospital in April 2016 we rated surgery as requiring improvement. This was because:

- The service had experienced two Never Events over a seven month period in 2015 both involved implanting the wrong prosthesis. A prosthesis is an artificial body part such as a joint.
- The service was not meeting its Referral to Treatment (RTT) targets of being seen by the service within 18 weeks, the only specialty to meet this target was cardiac surgery.
- Patient referrals on the waiting list for specific colon (bowel) surgery could not be found in the outpatient system. The service did not fully understand why these referrals had been lost and had started work to identify them and review treatment.
- Not all staff had received annual appraisals and less than 50% of staff had not completed statutory and mandatory training provided by the trust.
- The service had experienced a reconfiguration of its services and had started to get its governance systems in place but this was in its early stages and needed further embedding.
- There was a high number of nursing vacancies; agency and bank staff were used and sometimes staff worked additional hours to cover shifts.

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

- Whilst improvements had been made to reduce the admitted RTT it still remained below the England average for all specialities apart from cardiac surgery.
- Work had been done on identifying patients on the waiting list for a specific colon (bowel) surgery but there was still a backlog of patients waiting for surgery.
- National Specification of Cleanliness (NSC) checklists and audits were not in place including a deep

cleaning schedule for theatre. The theatre corridor was found to be dusty and cardboard boxes in theatres were stored on the floor risking the integrity of the sterile contents.

- Staff safeguarding training compliance rates were worse than the trust target.
- Not all staff had completed mandatory training in line with the trust target.

However:

- There had been no Never Events at PRH since our inspection in April 2016. A number of programmes and training events had been used to re-enforce the checking of prosthesis prior to implantation and using national programmes to make surgery safer.
- All patients admitted with a fractured neck of femur were treated at the PRH and new governance systems had been developed to monitor the quality of the service but at our previous inspection these were not yet fully embedded. At this inspection there was evidence of cross working across the surgical directorates.
- Progress had been made on reviewing and ensuring improved consent processes.
- At local level senior management teams were seen as visible, supportive and approachable.

Surgery

Are surgery services safe?

Requires improvement



When we inspected the Princess Royal Hospital in April 2016 we rated safe as good. This was because:

- Staff knew how to report incidents and felt confident that when incidents were reported they were listened to and acted upon.
- Nursing staff numbers, skill mix review and workforce indicators such as sickness and staff turnover were assessed using the electronic rostering tool. The Safer Nursing Care Tool, the planned and actual staffing numbers were displayed on the wards visited.
- There were regular safe, secure storage of medicine's audits which included areas such as fridges, medicines trolleys, drug cupboards, controlled drug cabinet and storage of intravenous drugs. Staff used Schwartz ward rounds which provided a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare.

However:

- The service had experienced two Never Events over a seven month period in 2015 which involved implanting the wrong prosthesis.

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

- Mandatory training figures had improved but in some areas remained low and compliance with safeguarding training had also failed to reach the trust target.
- Theatre corridor was found to be dusty and cardboard boxes in theatres were stored on the floor risking the integrity of the sterile contents.
- The hospital did not have cleaning schedules and audits in place in line with the National Specification of Cleanliness, including a deep cleaning schedule for theatres.

- The theatre department was not complying with 'The Health and Safety (Sharp instruments in Healthcare) Regulations' 2013 which states that healthcare providers must use safer sharps.
- All surgical wards had less whole time equivalent nursing staff than the trust determined was required to provide safe care resulting in significant use of bank and agency staff.

However:

- There had been no Never Events at PRH since our inspection in April 2016. Staff continued to report incidents and could describe the duty of candour. Examples were given where changes had occurred due to an incident.
- Since the last inspection, resuscitation trolleys were tamper proof, secured and checked.

Incidents

- We told the trust it must make improvements in ensuring lessons learnt from Never Events and incidents were shared across all groups. At this inspection, the trust had made some progress such as new programmes for updating staff on how to report incidents.
- There had been no Never Events at the PRH since our last inspection in 2016. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There had been a number of changes made as a result of learning from the Never Event investigations, which occurred. The department had undertaken a review of National Safety Standards for Invasive Procedures (NatSSIPs). NatSSIPs bring together national and local learning from the analysis of Never Events, Serious Incidents and near misses and go through a set of recommendations that will help provide safer care for patients undergoing invasive procedures.
- The trust also used a number of projects to ensure Never Events would not occur such as training sessions on prosthetic verification to ensure there was a local

Surgery

process for checking prosthesis before opening and implanting into a patient. Also there were presentations on the process for checking the correct patients and correct operating side.

- However there had been a recent near miss in theatre with an incorrect implant being opened. An investigation had taken place and staff were reminded to follow the trust's protocol and processes when using implants.
- Between November 2016 and February 2017, there were a total of 192 incidents for surgery at the PRH one resulting in moderate harm, 46 low harm and 145 causing no harm.
- Of the 215 incidents reported the highest number of incidents were experienced in the SOTC (59) followed by Twineham Ward (53) and operating theatres (46).
- The highest category of incident was due to falls (37) and medication errors (31).
- Mortality and Morbidity Meetings took place within all four directorates which included discussions about the efficacy of individual patients care and treatment.
- For example, the trauma and orthopaedics directorate discussed their mortality and morbidity issues at the start of the monthly clinical governance meetings. The perioperative directorate used its perioperative quality, safety and patient experience meetings to discuss their cases. There was evidence of individual case discussion and learnings being put in place.
- We found patient safety podcasts and newsletters were being published monthly and staff were aware of these. These podcasts told the stories about incidents and how they could be avoided in the future.
- Staff were able to describe the basis and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation requires the provider to notify the relevant person that an incident causing moderate or serious harm has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or

other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. At trust level, evidence was seen that duty of candour was exercised in letters sent by the chief executive following incidents.

Safety thermometer

- The Safety Thermometer is used to record the prevalence of patient harm and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms.
- This information was collected monthly. Some of this information was displayed on the wards such as the number of falls and pressure ulcers.
- Data from the Patient Safety Thermometer showed that the trust reported 13 new pressure ulcers, nine falls with harm and 13 new catheter urinary tract infections between February 2016 and February 2017.
- The falls rate varied for the first six months of the year reaching its highest in July 2016. The number of falls then fell to zero until one incident occurred in January 2017. The rate for catheter urinary tract infections (C.UTI's) was varied throughout the reporting period; performance was at zero between June and August 2016. However, the trend showed the number of infections rising more specifically in November and December 2016.
- Each ward we visited at PRH displayed the results for their area and staff were familiar with the data and could give examples of when these were discussed and actions taken. Minutes of ward managers meetings showed that safety information was discussed and actions put in place.
- Venous Thromboembolism (VTE) assessments were recorded on the drug charts and appropriate prescribing of anticoagulation (medication to prevent blood clots) was on prescription charts. This ensured best practice in assessment and prevention of VTEs.

Cleanliness, infection control and hygiene

Surgery

- Infection control policies were written in line with national guidelines and staff we spoke with were aware of these policies and knew how to access them on the trust's intranet.
- The PRH participated in the National Mandatory Orthopaedic Surgical Site Infection Surveillance for 2016 to 2017. The orthopaedic surveillance category selected was total knee replacement and the period of surveillance was October to December 2016. The completion date for this surveillance was March 2017. At the time of the inspection the results of this surveillance had not been published.
- PRH reported one case of hospital acquired Meticillin Resistant Staphylococcus Aureus (MRSA) between February 2016 and February 2017. Trusts have a target of preventing all MRSA infections, so the trust failed to meet this target within this period.
- Additionally, the trust reported 20 MSSA infections as trust acquired with no reduction target. The trust reported 47 Clostridium Difficile (C. Diff) infections over the same period. The year to date trajectory for C. Diff was just above the trust target of 46. The trust did not provide the data by site.
- The trust infection prevention team monitored all patients who were suspected to have or who gave a history of C. Diff. We saw evidence that this took place.
- The trust undertook an audit in January 2017, which examined the management of C.Diff, which showed an overall compliance of 94%. The completed audit contained discussion and recommendations for improvement and was part of regular surveillance.
- On the ward areas, we saw signs on side room doors indicating when a patient had an infection, there was equipment to support barrier nursing. This meant staff could take precautions to prevent the risk of infection spreading. Training records showed that cleaning staff had training on how to manage a patient being barrier nursed, and we saw them wearing appropriate personal protective equipment, such as gloves and aprons and these were available in sufficient quantities.
- We saw evidence of monthly meetings of the Infection Prevention Operational Meeting, chaired by the Deputy Director of Infection Control (DIPC) and attended by the microbiologist amongst others. The isolated case of MRSA was discussed and one action resulting from this was the enforcement of Visual Infusion Phlebitis (VIP) scoring across the trust to pick up any sources of infection. We saw there were standing agenda items of hand hygiene and surveillance monitoring.
- Hand hygiene gels were available throughout the wards and theatres. There was access to hand wash sinks in bays and side rooms on the wards. We observed all staff using gel when entering and exiting wards and theatre in accordance with the World Health Organisation (WHO) 'Five Moments for Hand Hygiene'
- In theatres, we observed all staff wore the appropriate theatre attire, such as theatre scrubs, hats and masks, all staff were bare below the elbow in line with national guidelines. We saw good scrub practice and there was good use of hand gel.
- There was good differentiation of clean and dirty area of theatres and we saw staff leaving and entering theatres change out of scrubs or cover them in accordance with trust policy.
- Two out of three instrument washers needed replacement and there was support from Royal Sussex County Hospital with decontamination until new washers were purchased.
- Minutes of the Safe Water Committee Meeting March 2017 were seen and it was seen that regular water testing was carried out across the trust.
- Between October 2016 and March 2017, the trust carried out monthly hand hygiene audits, which showed an overall 85% score for the surgical wards and theatres at the PRH. For example, Alborne Ward scored between 94% and 100%, Ansty Ward 86% to 95%, Newick Ward 93% to 100%, Twineham Ward 60% to 100%. Day Surgery scored 100%, Main theatres 93% to 95% and the SOTC 92% to 97%. Plans were in place to address non-compliance such as teaching sessions.
- We saw equipment in the main theatres was clean and 'I am clean stickers' were in place. This meant staff were assured the equipment was clean and ready for use.
- We saw cleaning schedules and mop posters on Ansty ward were compliant with the National Specifications of Cleanliness (NSC) and the cleaning score for March 2017 was 98%.

Surgery

- The theatre corridor was dirty and balls of fluff could be seen down the corridor. This meant it had not been cleaned effectively.
 - In a review of facilities we asked if there was a strategic and operational cleaning plan as required by the National Specification of Cleanliness (NSC), the trust did not have these documents. The strategic document outlines the Boards commitment to cleaning and supplying sufficient funding. The operational document shows how the complete cleaning operation actually works in practice.
 - We asked for the cleaning checklists as required by the NSC we were told these had been worked on and trialled but had been difficult to get the staff fully engaged with the process and the managers were in the process of re writing more appropriate cleaning checklists. Without the checklists it would be difficult for staff to know which areas had been cleaned, and for managers/supervisors to know if the areas had been cleaned. This could lead to areas being missed. The checklists can also be used when auditing to determine if the level of cleaning and timings of cleaning are appropriate.
 - We asked for the deep cleaning schedule for theatres and were told that this task had not been completed since the third party left as the cleaning provider in September 2015.
 - We observed that the National Institute for Health and Care Excellence (NICE) guideline 'CG74, Surgical Site Infection: Staff in the Theatre Environment Prevention and Treatment of Surgical Site Infections' (2008) was followed. This included skin preparation and management of the post-operative wound.
 - The trust performed about the same as the England average in the Patient Led Assessments of the Care Environment (PLACE) 2016 for assessment in relation to cleanliness. PLACE is a new system for assessing the quality of the hospital environment, which replaces Patient Environment Action Team (PEAT) from April 2013.
- Environment and equipment**
- At our previous inspection we told the trust it must make improvements to ensure resuscitation/emergency equipment were stored in tamper evident containers. At this inspection, the trust had made progress. We found new tamper proof trolleys had been procured and were in use. Training on the checking process and paperwork was undertaken by the resuscitation team with ward managers.
 - We saw the resuscitation trolleys were complete, checked, signed and dated. On the wards, we saw staff used a daily and weekly check record. This included the daily checks needed to be carried out, specimen signatures, daily external checks and full weekly contents checks. This meant there was an effective system in place which ensured emergency equipment was available for use.
 - We saw on Albourne and Ansty Wards there were two bays that did not have their own permanent provision of oxygen and suction. Staff told us this had been raised as a risk and was on the risk register. Portable oxygen and suction equipment was being used to reduce the risk of no static equipment.
 - Storage of equipment in operating theatres continued to be a problem with cardboard boxes containing sterile drapes and gowns being stored on the floor. There was a potential for these to become damp and as such compromising the sterility of the drapes and gowns.
 - We saw in theatres there was a process of regular checks to ensure all equipment was in date.
 - Items subject to Control of Substances Hazardous to Health (COSHH) were stored in a metal cupboard in the operating theatres and were compliant with Health & Safety guidance. However, we saw on Ansty Ward, chlorine tablets (COSHH) were stored in an unlocked cupboard which meant these were not secure.
 - Whilst there was good management of sharps within the department, senior managers in theatres decided not to adopt safer sharps initiative and as such were not compliant with the 'EU directive 2010/32/EU Prevention from sharps injuries in the hospital and healthcare setting' (2010).
 - We saw that electrical safety checking labels were attached to electrical items showing that it had been tested and were safe to use.
 - The PLACE audit carried out in 2016 showed the trust performance for facilities was lower than the England average.

Surgery

Medicines

- The trust had a medicine policy, which was in date and referenced national guidance for example the Nursing and Midwifery Care 'Standards for Medicines Management' (2010).
- Medicines were appropriately managed and stored safely within the service. There were systems in place through the hospital enabling self-administration of medicines however we did not see this during our inspection.
- Medicines were stored in secure rooms that had suitable storage and preparation facilities for all types of medicines, such as controlled drugs and antibiotics. We saw records of the daily checks of ambient temperatures in the medicines storage room had been completed.
- Entries in the controlled drug register were made regarding the administration to the patient and were signed appropriately. New stocks were checked and signed for, and any destruction of medicines was recorded.
- The trust carried out a medicines security audit in September 2016 with the PRH scoring 93%. For example, Albourne Ward scored 98% and the SOTC theatres scored an overall of 95%. We saw the trust collated actions to address identified issues and this was reported through to the Medication Safety Group.
- Up until 2015, the trust undertook yearly audits (as per previous national guidelines) and then moved to monthly point prevalence audits for 2016/2017 in accordance with new NICE guidelines.
- The trust now used the Medicines Safety Thermometer form to collect the data, which was then uploaded onto a national database and analysed and reported when required. This had been happening since approximately May 2016.
- Medication errors resulting in pharmacy interventions were recorded for each ward and department by month. In January 2017 there were 129 medication incidents with one of moderate severity, the rest being minor. There were no reported moderate incidents for PRH in the last year.

- Pharmacists were available Monday to Friday during opening hours and Saturday morning. However the emergency pharmacist was available outside of pharmacy opening hours.

Records

- We looked at eight sets of patient's records. These were comprehensive and well documented and included diagnosis and management plans, consent forms, evidence of multi-disciplinary input and evidence of discussion with the patient and families.
- We checked two sets of records at the SOTC, which showed other information was documented at pre-assessment such as MRSA screening, consent, any allergies, medications, social history and next of kin.
- In general medical and nursing records were stored securely either in trolleys behind the nurse's station or at the end of each bay. However, we did see some patients notes stored in an unlocked room at the SOTC. We informed staff of this at the time of the inspection.
- Records included details of the patient's admission, risk assessments, treatment plans and records of therapies provided. Preoperative records were seen, including completed preoperative assessment forms. Records were legible, accurate and up to date.
- The service used patient pathway documents which followed the patient journey through a specific surgical episode such as fractured neck of femur, knee and hip replacement. We saw evidence of completed World health Organisation (WHO) safer surgery checklists.

Safeguarding

- We saw that the trust had a safeguarding adults policy which included reference to Prevent, part of the government counter terrorism strategy. There was a separate trust policy stating what action to be taken in the case of suspected Female Genital Mutilation.
- The trust executive lead for safeguarding was the chief nurse. Adult safeguarding was managed by the deputy chief nurse along with 1.6 whole time equivalent (WTE) band seven safeguarding nurses and a band seven Mental Health Lead Educator.

Surgery

- A consultant nurse led child safeguarding services at the hospital and was supported by two band seven nurses and a named midwife. These responsibilities were shared across the trust.
- The trust failed to meet the safeguarding training completion target of 100% for all staff across all four modules. Adult safeguarding training completion was reported to be 75%. The module with the highest completion rate was Safeguarding Children Level 2 with 79%. The data for training was not provided for specific directorates.
- There were flow charts in each ward/department detailing the actions to be taken and who to contact in the event of adult safeguarding issues arising. Staff demonstrated an understanding of their safeguarding responsibilities and an understanding of safeguarding procedures.

Mandatory training

- At our previous inspection we told the trust it must make improvements in the completion of mandatory training. At this inspection, the trust had made some progress. We found overall 75% of staff had undertaken mandatory training.
- Mandatory training was differentiated by staff group but resuscitation training, conflict management, equality and diversity, fire and health and safety training, infection prevention and information governance were seen to be amongst the subjects mandated across all nursing and medical staff groups. Compliance was monitored by human resources and wards had access to compliance information so that staff could be reminded to attend.
- Since the last inspection the eLearning training programme contained on the trust wide electronic system had been extended.
- There was a trust wide induction policy and procedure that included details of a corporate induction day programme for permanent and temporary staff. In theatres, we saw evidence of a mandatory training day that all staff attend.

Assessing and responding to patient risk

- Patients having elective surgery attended a preoperative assessment clinic (Hickstead Unit) where all required

tests were undertaken. For example, MRSA screening and any blood tests. This was a nurse led service and there was a criteria in place which identified which patients needed review by an anaesthetist.

- Risk assessments were undertaken in areas such as VTE, falls, malnutrition and pressure ulcers. These were documented in the patient's records and included actions to mitigate the risks identified, we saw these had been completed and we could see appropriate action was taken to mitigate those risks.
- Nursing and medical handovers were well structured within the surgical wards visited. Nursing handovers occurred twice a day at the change of shift. We observed a handover which was carried out in the ward office for all staff and patient privacy, dignity and confidentiality were maintained. Staff were then allocated to bays and a more detailed handover took place at the patient's bedside, when staff introduced themselves to patients and involved the patients in discussion.
- We observed that swab and instrument counts followed Association of Perioperative Practice (AFPP) guidelines. There were standardised swab boards in each theatre, this meant there was a consistent approach to recording the swabs and instruments used during procedures.
- The staff met for a team briefing at the start of each operating list. Each patient was discussed to minimise any potential risk to the patient. Pre-existing medical conditions and any allergies were discussed to ensure the team was informed. Equipment needs were discussed; the briefing demonstrated enabled any potential issues to be highlighted. Staff told us that they felt empowered to speak up during this process.
- We observed theatre staff carrying out the World Health Organisation (WHO) 'Five Steps to Safer Surgery' checklist for procedures. The WHO checklist is a national core set of safety checks for use in any operating theatre environment. Staff told us that they felt empowered to speak up during this process.
- We saw observational audits had been carried out that showed 100% compliance with the World Health Organisation (WHO) 'Five Steps to Safer Surgery'.

Surgery

- The National Early Warning Scores (NEWS) tool was used across the service to monitor patients and to identify patients at risk of unexpected deterioration in accordance with the National Institute for Health and Care Excellence (NICE) guidance CG50.
- National Early Warning Scores (NEWS) were regularly audited for completeness. Data collected between February 2016 and January 2017 showed a general improvement in the standard of documentation relating to NEWS.
- NEWS is a simple scoring system of physiological measurements (for example blood pressure and pulse) for patient monitoring. This enabled staff to identify deteriorating patients and escalate concerns to a senior nurse or doctor.
- Staff on the wards told us that in the case of a deteriorating patient there was never any difficulty in accessing medical support. The service used a communication tool called Situation Background Assessment Recommendations (SBAR) for both medical staff and nursing staff to use when escalating concerns about a patient's condition to their seniors.
- The outreach service working from the intensive care unit was available twenty four hours; seven days a week to support staff on the surgical wards, therefore there was access to clinical advice and support if a patient's condition was deteriorating.
- The trust showed us agenda and minutes of the deteriorating Patient Steering Group, which met monthly and monitored the development of the Sepsis Inpatient Screening Tool released in March 2017. We saw that a sepsis clinical lead and a clinical nurse specialist for sepsis had been appointed to enable audit and education activities for the staff. Staff were able to demonstrate the sepsis pathway which incorporated the sepsis six guidelines a set of care interventions to improve treatment of patients with sepsis.
- The service used a Visual Phlebitis Scoring Tool for monitoring infusion sites and is recommended by the Royal College of Nursing (RCN). We saw Visual Infusion Phlebitis (VIP) scores had been undertaken and correct action taken in the patient records we reviewed. This meant the need for intravenous (administered into a vein or veins) devices, signs of infection and comfort of the devices were reviewed on a regular basis.

- We saw in patients' records that patients had a weekly falls risk assessment this was in line with NICE Guidelines 'CG161 Falls in Older People: Assessing Risk and Prevention'. Risk assessments were also undertaken in areas such as VTE, malnutrition and pressure ulcers. These were documented in the patient records and included actions to mitigate the risks. We saw evidence of this from the patient records we reviewed.
- On all ward areas there were nursing handovers that took place at least twice a day and we observed that these included a review of all patients including any safety information.

Nursing staffing

- The trust used an acuity and dependency tool (the Shelford model) in March 2017 to review staffing levels. Nursing staff numbers, skill mix review and workforce indicators such as sickness and staff turnover were assessed using the electronic rostering tool, the Safer Nursing Care Tool. The planned and actual staffing numbers were displayed on the wards visited.
- As of February 2017, the trust reported a vacancy rate of 11% a turnover rate of 11% and a sickness rate of 4% in surgical care.
- All wards at the PRH were under establishment for example Albourne Ward should have had an establishment of 16.52 WTE and was 13.53 WTE, Ansty Ward 22.81 WTE and was 21.21 WTE, Twineham Ward 39.21 WTE and was 30.39 WTE and Newick Ward 28.69 WTE and was 21.8 WTE.
- Between February 2016 and January 2017, the trust reported a bank and agency usage rate of 5% in surgical care. For example, abdominal surgery was 6%, cardiovascular surgery 6% and ENT 4%.
- We looked at nursing staff fill rates for the wards across the hospital for the last three months and on average during the day registered nurses requirement was 91% to 95% achieved and at night on average 95% of the required hours were filled. The fill rates for care staff were similar.
- Recruitment for contracted registered staff was being undertaken, there were radio adverts, posters displayed on buses and a recruitment open day was planned for May 2017.

Surgery

- For the SOTC, Operating theatres and Recovery there were four theatres suites (three laminar flow). Each theatre had a team of five registered nurses, operating department practitioners and a health care assistant as well as a circulating nurse and one recovery nurse.

Surgical staffing

- The number of surgical medical staff in post at Princess Royal Hospital as of December 2016 was 64.6 WTE, which was lower than the establishment of 74 WTE. As of November 2016, the proportion of consultant staff working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower than the average.
- As of February 2017, the trust reported a vacancy rate of 9% in surgical care and a turnover rate of 9% in surgical care.
- Between April 2015 and March 2016, the trust reported a sickness rate of 9% in surgical care.
- Three new colo-rectal surgeons and two advanced endoscopy nurses had been recruited to BSUH and would provide enhanced out of hours cover at the PRH and enable more complex surgery to be performed at the PRH site. A new tier of consultant and staff and associate specialist doctors were in post at the PRH.
- There was a non-resident consultant anaesthetist on call out of hours with a one in 12 rota to cover the Obstetric Unit, and any immediate returns to theatre that could be transferred to RSCH, and any emergency urology on the BSUH sites. The consultant cover was 10 hours weekdays, and then four hours minimum per day at the weekend.
- The anaesthetic rota at the PRH was one in eight full shifts to cover any patient airway issues and the Critical Care Unit. This included trainees and anaesthetic fellows.
- There was also a one in eight full shift (out of hours) anaesthetists to cover the obstetric unit and included trainees and trust doctors (CT2, ST3 and above).
- At the SOTC, there was one consultant with on call cover along with a specialist registrar on call from the RSCH site. There was an on site middle grade doctor between 8am and 9pm and another to cover the night from 8pm to 8am.

- Consultants at PRH covered surgical outpatients, operating theatres, surgical outpatients and the surgical wards. For Twineham and Albourne Wards and any patients that were outliers there were two middle grade doctors and another middle grade doctor covered Newick Ward.

Major incident awareness and training

- There was a trust wide Major Incident Plan (2015) which set out a framework for ensuring that the trust had appropriate emergency arrangements, which were in line with the Civil Contingencies Act 2004.
- Staff we spoke with were aware of the policy although they could not recollect a major incident occurring. Senior staff told us they were planning a major incident scenario in preparation for the upcoming Brighton marathon.
- The trust showed evidence of training for senior staff on the escalation policy and major incident planning command and control. Completed training and when next due was evident.

Are surgery services effective?

Good



When we inspected the Princess Royal Hospital in April 2016, we rated effective as good. This was because:

- The treatment by all staff including therapists, doctors and nurses was delivered in accordance with best practice and recognised national guidelines and patients received treatment and care according to guidelines.
- Policies and procedures were in line with national guidance and were easily accessible on the intranet.
- Patients' pain was addressed and national nutritional tools were used to monitor those patients who may be at risk of malnutrition.
- The nutritional needs of patients were assessed at the beginning of their care in pre-assessment through to their discharge from the trust. Patients were supported to eat and drink according to their needs. There was access to dieticians and medical and cultural diets were catered for.

Surgery

- The service had a consultant led, seven day service, with some elective lists on Saturdays and Sundays.
- There were a range of clinical nurse specialists and advanced nurse specialists who supported teams and patients in specific areas, bringing their own expertise and knowledge to develop innovative and individualistic ways of improving services.
- Staff and teams were committed to working collaboratively and found ways to deliver more joined-up care to patients. There was a range of examples of working collaboratively and the service used efficient ways to deliver more joined-up care to people who used services. There was a holistic approach to planning people's discharge and transfer to other services.

However:

- Consent practices and records were monitored and reviewed to improve how patients were involved in making decisions about their care and treatment but audit activity showed poor compliance with recording consent procedures.
- The service had a good pain service which supported medical and nursing staff in maintaining effective pain relief for patients but the service did not work out of hours or at weekends and had a restricted chronic pain service.
- Staff had an awareness of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) but the uptake of training was poor.

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

- The treatment by all staff including therapists, doctors and nurses continued to be delivered in accordance with best practice and recognised national guidelines and patients received treatment and care according to guidelines.
- The service could demonstrate collaborative and multi-disciplinary working across directorates to deliver joined up care and ensure the timely management of patients through their pathway of care.
- The trust had reviewed and expanded its pain service.

- Progress had been made on reviewing and ensuring improved consent processes.
- Progress had been made on the uptake of Mental Capacity Act (MCA) and Deprivation and Liberty Safeguard (DoLS) training.

However:

- Staff reported appraisals were being carried out but compliance rates remain worse than the trust target.

Evidence-based care and treatment

- The service demonstrated the use of evidence based practice in caring for patients. Policies were developed in line with current legislation and nationally recognised evidence based guidance such as the National Institute for Health and Care Excellence (NICE) guidelines.
- We reviewed 10 sets of patient records, which all showed evidence of regular observations, for example, blood pressure and pulse, to monitor the patient's health post-surgery. This was in line with NICE guideline 'CG50: Acutely ill patients in hospital, recognising and responding to acute illness in adults in hospital'.
- A new 'straight to test' pathway for colorectal referrals had been introduced which would improve quicker access to medical tests. Medical cover was to be provided by a middle grade doctor. This was in line with NICE guidance for the 'Management of Suspected Cancers'.
- We saw on the orthopaedic wards that patients undergoing hip and knee replacement were part of the enhanced recovery programme. The enhanced recovery programme was based on guidance from the NHS Institute for Innovation and Improvement, aimed to improve patient outcomes and speed of a patients recovery after surgery. Staff we spoke with were able to explain this programme including joint schools and when asked told us the average length of stay was 3 to 5 days.
- The service participated in the National Hip Fracture Database (NHFD), which is part of the National Falls and Fragility Fracture Audit Programme and took part in national audits, such as the elective surgery Patient Related Outcome Measures (PROMS) programme, and the National Joint Registry.

Surgery

- PROMS are a series of questions or a questionnaire that seeks the views of patients on their health, or the impact that any received healthcare has had on their health. During the period April 2015 to March 2016 there was no evidence to indicate any risks related to surgery when assessed as part of PROMS for hip and knee surgery as well as groin and varicose vein surgery.
- Within theatres, we observed that staff adhered to the NICE guidelines, CG74 and staff followed the recommended practice. This guideline offered best practice advice to prevent and treat surgical infection. For example, we observed the patient's skin at the surgical site was prepared immediately before incision using an antiseptic preparation.
- We observed that operating theatres followed the Association for Peri-operative Practice (AfPP) guidance, for example swab and instrument counts.

Pain relief

- At our previous inspection we told the trust it should make improvements in reviewing the provision of its pain service in order to provide a seven day service including the provision of the management of chronic pain services.
- At this inspection, the trust had made some progress. We found the trust had a review meeting in February 2017, which resulted in a locum consultant anaesthetist being commissioned one session per week to review patients with chronic pain. A nurse consultant in acute pain management had been appointed to cover both sites and a consultant anaesthetist had been allocated time to discuss and review complex acute pain patients. There remained no acute pain team service out of hours and at weekends however a junior anaesthetist would be allocated to cover this.
- The service undertook a Patient Controlled Analgesia (PCA) Pump Audit in March 2016. This was a re-audit from 2015 and demonstrated there was a need for improvement specifically relating to the recording of observations and a continued non-compliance with hourly checks. A further set of actions relating to recording were put in place with a re-audit planned for 2017.
- The service undertook an epidural (an injection into the back, which produces a loss of sensation below the

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

- Patients' records showed pain had been risk assessed using the scale found within the NEWS chart and medication was given as prescribed. Staff used a visual analogue pain tool. We observed staff asking patients if they were in pain and patients told us they were provided with pain relief in a timely manner and staff returned to ask if their pain had been relieved.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess patient's risk of malnutrition and if a patient was at risk of malnutrition or had specific dietary needs they were referred to a dietician.
- The trust standard was that all patients should have a MUST assessment made within four hours of admission or transfer to the ward. At PRH for the period from February 2016 to January 2017 we observed that Ansty Ward were completing this assessment 88% of the time and Albourne Ward 82%. There was evidence of a trust action plan to address this and additional training and a relaunch of MUST had been undertaken.
- Dietitians attended the wards at least weekly and dependent on patient need and were also present at some multi-disciplinary meetings. Staff on the wards could contact dietitians via an on line system. The dietitians would attend the wards daily where patients were receiving parental nutrition. Parental nutrition is a method of getting nutrition into the body through the veins.
- Pureed food was available for patients who were unable to take solid food we saw that nourishing drinks were also available.
- There was a process in place to ensure patients were appropriately starved prior to undergoing general anaesthetic, each patient was asked to confirm when they last ate and drank during the checking process on arrival to theatre. Generally the amount of time patients

Surgery

were kept nil by mouth prior to their operation was kept to a minimum, patients were allowed to drink clear fluids up to two hours prior to operation which was in line with best practice.

- The PLACE survey showed the trust scored 93%, which was better than the England average (88%) for the quality of food.
- For the Patients Voice Survey 2016 when asked 'How would you rate the hospital food' the service performed similar to the national average of (3.77) with a trust score of (3.76).

Patient outcomes

- Between October 2015 and September 2016, patients at PRH had a marginally higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.
- In the past twelve months trauma and orthopaedics have had 202 readmissions against an expected 207, this is 2.5% fewer readmissions than expected. Non-elective colorectal surgery had the lowest expected risk of readmission compared to the England average and was probably relevant to the small number of patients.
- Based on criteria used by the National Hip Fracture Database (NHFD) the directorate's most recent performance in 2016 showed the proportion of patients having surgery on the day of or day after admission had worsened from 88% in 2015 to 82% in 2016 with the national rate of 85%. The trust re-analysed the data and stated the 2016 performance was closer to 85%. The reasons for delay were further analysed showing four reasons including 'theatre capacity', 'diagnosis and investigation', 'stabilisation of patient' and 'other'.
- The length of stay had also worsened from 17.6 days in 2015 to 19.5 days in 2016, which was around the middle 50% of all trusts. The trust had further analysed this and based on date of admission to A&E considered the result for 2016 to be a mean (average) of 15.5 days.
- The proportion of patients not developing pressure ulcers was 94%, which falls in the best 25% of trusts but was worse than 99% in 2015.

- However, the risk adjusted 30-day mortality rate had improved from 4.9% in 2015 to 4.3% in 2016, which was better than expected.
- The perioperative surgical assessment rate in 2016 was 95%, which did not meet the national standard of 100% and was worse than the 99% in 2015.
- At our last inspection in April 2016, the National Bowel Cancer Audit 2014 showed only 65% of patients had a reversal of a stoma within 18 months. For April 2016 to March 2017, the trust showed a marginal improvement to 70%.
- As of May 2017 there were 454 patients awaiting elective colon surgery, with a median waiting time of 22 weeks.
- A local retrospective audit of stoma complications in patients awaiting reversal concluded that 50% of patients will have complications due to the wait and the recommendations were that there needed to be greater understanding and policy making regarding follow up and reversal of stomas.
- PRH had an ortho-geriatrician (a consultant with a combined role in orthopaedics and elderly medicine) to support the care of elderly patients suffering a fractured hip.

Competent staff

- We told the trust it must make improvements in ensuring all staff receive an annual appraisal. At this inspection, the trust had made some improvements. We found that at the end of March 2017 the overall trust staff appraisal rate was 85%.
- For nursing the appraisal rate in the abdominal and medicine directorate was 88%, musculoskeletal directorate 86%, head and neck directorate 82% and peri-operative directorate 90%.
- For medical staff the appraisal rates across the trust were lower than nursing rates. The highest completion rate was 88% within the abdominal surgery and medicine directorate, 79% in cardiovascular. The perioperative directorate was 65%. An annual audit showed the trust had a shortage in the number of appraisers for medical staff and this was being addressed with additional training to increase the number of appraisers.

Surgery

- We saw the trust maintained a database of nurse registration and revalidation dates due for all staff members. This meant there was a system which highlighted when registration and revalidation was due.
- We saw information for staff on how to revalidate including pocket guides and posters on what to do, these were displayed on wards areas, which showed staff, were being informed and supported to complete revalidation.
- All ward areas had the support of a clinical practice educator and staff told us this supported them in developing their skills and knowledge. Staff told us that there was a focus on continuing professional development.
- The trust had started work on a Beacon Ward pilot, which supported health care assistants (HCAs) to progress through their career. Staff on Twineham Ward were participating in this 12 month project. The project included eight study days, one to one coaching support and 15 skills sessions based on the ward.
- We saw Ansty Ward used a welcome pack for new nursing staff, agency and bank staff which included urology competencies and competencies for overseas nurses were in place.

Multidisciplinary working

- There were daily ward rounds on all the surgical wards involving nursing and medical staff together with the physiotherapist and other therapist as required. Staff told us these meetings were effective and all staff participated.
- There were daily trauma meetings which reviewed admissions over the previous 24 hour period. These were attended by trauma and orthopaedic consultants and other members of the medical team. Nursing and therapy staff also attended these meetings. Notes were made on the patient record allowing all staff to see progress and concerns.
- We saw the Enhanced Recovery Pathway (ERP) Joint Schools were held Monday to Friday 12pm to 12.30 at the SOTC. These teaching sessions were presented by the multi-disciplinary team (MDT) and included the ERP nurse, physiotherapist and occupational therapist. The

team provided information to patients undergoing hip and knee replacements and set expectations following their surgery outlining the rehabilitation process leading to their discharge.

- MDT meetings took place across the directorates for example the monthly colo-rectal MDT held with medical, nursing and other specialist nurses and allied health professionals used to discuss all patients.
- Discharge planning meetings was attended by nursing and other relevant members of the multi-disciplinary team with all actions and referrals documented within the patient's record.

Seven-day services

- There was a consultant presence seven days a week at the PRH site with ward rounds undertaken daily in order to improve the discharge rate in surgery.
- Newick Ward had daily multi-disciplinary team (MDT) meetings at 11am Monday to Friday to discuss and plan patients discharge and rehabilitation needs. In attendance was the nurse in-charge, physiotherapist and occupational therapist and the ward doctor. The MDT on Newick Ward (orthopaedic) was well established and there was a good collaborative culture in place.
- Physiotherapy was provided to patients seven days a week.
- Pharmacy services were available Monday, Wednesday and Friday 8.30am to 5.00pm, Tuesday 9.15am to 5pm, Thursday 9.30am to 5pm and Saturday 9am to 12pm for emergency services only and closed on Sunday.
- Requests for medicines at the PRH on a Sunday were triaged by the site manager or cross site emergency duty pharmacist. Where items were required, requests were faxed from the PRH to the dispensary at RSCH during opening hours and processed by the RSCH dispensary team. These were then couriered back to the PRH on a Sunday afternoon.
- The diagnostic imaging department provided a seven day on call service. This was in line with; 'NHS Services, Seven Days a Week, Priority Clinical Standard 5' (2016). This requires hospital inpatients to have seven day

Surgery

access to diagnostic services such as x-ray, ultrasound, Computed Tomography (CT) scan and Magnetic Resonance Imaging (MRI) and radiology consultants to be available seven days a week.

Access to information

- There were computers throughout the individual ward areas to allow staff to access patient information including test results, diagnostics and records systems. Staff were able to demonstrate how they accessed information on the trust's electronic system.
- There were arrangements to ensure staff had all the necessary information to deliver effective care. For example, risk assessments, physiotherapy notes, and dietetics referrals were included in patient notes. This meant staff, including agency and locum staff, had access to patient related information and records when required.
- Medical staff used the Patient Archive and Communication System (PACS) system to download and view images of patients x-rays and tests. The PACS system is a central repository for radiology and medical images and objects.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We told the trust it should make improvements in reviewing the consent policy and process to ensure confirmation of consent was sought and clearly documented.
- At this inspection, the trust had made some progress. We found the consent policy had been reviewed and consent champions had been appointed. A workshop was held in November 2016 to re-enforce the role of the consent champions who were responsible for training other staff on the updated policy.
- We saw that funding had been agreed for patient information and these leaflets were available for patients. Staff had been informed. Further action included a re-audit of consent was carried out in April 2017 the results of this audit were to be presented in July 2017.

- We reviewed eight consent forms for surgery. Patients and staff had fully completed, signed and dated the consents to ensure they were valid. The consents did state any risks of surgery and did not contain any abbreviations.
- In theatres we had seen that completion of the consent form was checked as part of the WHO safe surgery check list.
- Mental capacity training including Deprivation of Liberty Safeguards (DoLS) was part of the mandatory training requirement for clinical staff. Staff we spoke with told us they knew the process for making an application for DoLS and when they needed review. On the day of inspection we did not see any current DoLS application.

Are surgery services caring?

Good



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

- Staff were caring and compassionate to patients' needs, and treated patients with dignity and respect.
- Patients and relatives told us they received a good care and they felt well looked after by staff.
- The staff on the wards and in theatre areas respected confidentiality, privacy and dignity.
- Surgical and nursing staff kept patients up to date with their condition and how they were progressing. Information about their surgery was shared with patients and patients were able to ask questions.

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

- Feedback from patients and their families was positive about the way staff treated them.
- We observed that staff treated patients with compassion, kindness, dignity, and respect.
- Care and treatment was explained in ways patients and relatives could understand and patients were encouraged to make their own decisions.

Surgery

- Staff were aware of the need for emotional support for patients and this was enabled in a caring way.

Compassionate care

- The NHS Friends and Family test (FFT) is a satisfaction survey that measures patients' satisfaction with the healthcare they have received.
- We saw posters encouraging patients to give feedback so the service could improve the service it provided. Between February 2016 and January 2017 the Friends and Family Test, response rate for surgery at the trust was 17%, which was worse than the England average of 29%. For the Princess Royal Hospital, the response rate was 20%.
- The highest scoring ward at Princess Royal Hospital was the Day Surgery Unit scoring 100% for the percentage recommended for their service for nine of the 12 months. The inpatient ward's average response rate for the 12 month period was 23%.
- The trust carried out an inpatient survey called 'Patient Voice'. The survey asked the patient to rate fifteen aspects of the service including cleanliness, food and pain management. We saw results for all wards and departments including the rate of return of completed questionnaires.
- The overall results for all wards and departments were ranked each month and showed the trend for the year. For example, Ansty Ward was ranked second out of 39 departments, had the fifth highest rate of questionnaire returns and showed 97% of patients would recommend the hospital to relatives and friends. Results were displayed in all areas.
- We saw patients treated with care, compassion and respect as we followed them through the peri-operative pathway. We observed patients being collected for surgery by staff who were professional and caring.
- Patients told us staff were very caring and could not be faulted. One patient told us "I felt safe because I had confidence in the doctors and nurses and they were always there to help me when I needed it".
- We observed nurses, doctors and other professionals on all wards introducing themselves to patients and discussing with them reasons for their admission and

plan of care. We saw that medical and nursing staff would draw the curtains round the bed and try to ensure information was shared in a quiet voice to maintain confidentiality.

Understanding and involvement of patients and those close to them

- All patients we spoke with commented that they felt they were kept well informed and part of their plan of care.
- Patients in the day surgery unit told us they were treated in a very considerate manner and were given exceptional care whilst they were on the unit. They told us they were fully informed about their care and their relatives were also kept up to date on what was happening.
- One patient told us "The consultant has rung me personally and my quality of life had improved because of the consultants care".
- We saw information for patients and relatives about how to leave feedback. In addition, the trust website contains information on how to leave feedback, join the patient feedback panel or complete the family and friends test.

Emotional support

- The service used the butterfly scheme on its wards. This scheme supports patients with dementia and memory impairment. It aims to improve patient safety and wellbeing by teaching staff to offer a positive and appropriate response to people with memory impairment. We saw butterfly symbols were put by the patient's bed and remind staff to follow a special response plan.
- Patients told us "Staff are so good" and "They explain everything to me every time I come to the hospital".
- When required patients received support from clinical nurse specialists, such as the diabetes nurses, dementia specialists and Macmillan nurses.
- The hospital patients and staff could access the chaplaincy team who provided religious support 24 hours a day. There was also access to literature about other religions. There was a separate prayer room next

Surgery

to the chapel. Staff received training on the different faiths and had access to over 30 ward-based volunteers from a variety of faith traditions, who made weekly visits to most of the hospital.

Are surgery services responsive?

Requires improvement



When we inspected the Princess Royal Hospital in April 2016 we rated responsive as requiring improvement. This was because:

- The admitted referral to treatment (RTT) target was consistently below the national standard of 90% for all specialties.
- The length of stay for non-elective surgery was worse than the national average for trauma and orthopaedics, colo-rectal surgery and urology.
- The percentage of patients whose operations were cancelled and not treated within 28 days was consistently higher than the England average.
- Thirty one per cent of admitted patients were moved to other wards between 10pm and 6am.

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

- Whilst improvements had been made to reduce the admitted RTT to 82% it still remained below the national standard of 92% for all specialities.
- Patients on the waiting list for a specific colon surgery had started work to identify them and review treatment but there was still a backlog of patients waiting for surgery.
- The percentage of patients whose operations were cancelled and not treated within 28 days remained above the England average.

However:

- Patient individual needs were prioritised and there was good support for patients living with dementia and learning disabilities and other complex needs. Staff could access specialist nurse and team support when necessary.

Service planning and delivery to meet the needs of local people

- The abdominal and medicine directorate had recently reorganised its emergency services and there were now two teams for gastro-intestinal services including the PRH site dealing with emergency care. Two consultants undertook weekend ward rounds which increased the number of patients being discharged over a weekend period.
- Three new consultants had been appointed to the trust to tackle the backlog of patients in surgery by utilising the PRH site for more complex procedures. There were plans to transfer a range of emergency services to the PRH such as laparoscopic cholecystectomies, hernia repairs and abscesses so as to reduce the number of patients waiting for an operation at the Royal Sussex County hospital.
- The abdominal surgery and medicine directorate had a five year reconfiguration and development strategy to reduce the RTT and there were currently 82 patients still waiting more than 52 weeks for specific stoma surgery.

Access and flow

- At our previous inspection we told the trust it must make improvements in ensuring the 18 week RTT is addressed so patients are treated in a timely manner. At this inspection the trust had made some progress. We found at the end of March 2017 the overall 18 week RTT had improved to 84% which was still below the trust target of 92%.
- As of May 2017 there were 454 patients awaiting colon surgery, with a median waiting time of 22 weeks. The department (via the Patient Access Managers and Directorate Manager) tracked long waiting patients (any patient above 42 weeks) on a daily basis. Patients that breached the 52 weeks had a RCA undertaken and were reviewed as part of the Directorate Clinical Harm Review Process.
- The strategy proposed patients requiring stoma reversals would be listed on the current all day digestive diseases surgery lists Monday and Tuesdays. This would result in an additional three to four patients being operated on at the PRH.
- An audit looking at waiting time for surgery for acute cholecystitis (inflammation of the gall bladder) or acute

Surgery

pancreatitis (inflammation of the pancreas) showed the trust was not meeting NICE CG188/BSG guidelines. However, the percentage of cases being done laparoscopically versus open was meeting recommendations.

- Between February 2016 and January 2017 the trust's RTT for admitted pathways for surgical services has been worse than the England overall performance. The latest figures for January 2017 showed 67% of this group of patients were treated within 18 weeks versus the England average of 71%.
- Trauma and orthopaedics was 73% for admitted RTT (percentage within 18 weeks) which was better than the England average of 66%. All the other specialities were worse than the England average such as ENT 49%, which was worse than the England average of 68% and urology 71%, which was worse than the England average of 79%.
- Between November 2015 and October 2016 the average length of stay for surgical elective patients at Sussex Orthopaedic Centre was the same as the England average of 3.3 days. For surgical non-elective patients, the average length of stay was 2.6 days, compared to 5.1 for the England average.
- From September 2014 to August 2015, the average length of stay at trust level was mostly worse than the England average for both elective and non elective patients. For example, for trauma and orthopaedics the length of stay was seven days for elective patients, which was worse than the England average of three days. For non-elective patients in trauma and orthopaedics the length of stay was 18 days, which was worse than the England average of nine days.
- Cancelled operations as a percentage of elective admissions had been variable over the time period, and been above the England average for four quarters between quarter four 2014/15 to quarter three 2015/16. For example, quarter two was 1.4%, which was worse than the England average of 0.6%, and quarter three was 1.3%, which was worse than the England average of 0.6%.
- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within

28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

- For the period, quarter four 2014/15 to quarter three 2016/17 the trust cancelled 1,047 surgeries. Of these cancellations 158 (15%) weren't treated within 28 days. The trust performance was improving but worse than the England average for the entire reporting period.
- Cancelled operations as a percentage of elective admissions for the period quarter four 2014/15 to quarter three 2016/17 at the trust were better than the England average. Cancelled operations had been significantly reduced with 21 operations being cancelled in March 2017.
- Theatre utilisation at the PRH site between October and December 2016 was on average 84%, which ranged between 81% and 89%. Day surgery was performing between 90% and 100%.

Meeting people's individual needs

- Patients who attended the pre-operative assessment clinic were given information leaflets regarding anaesthetic, preventing thrombosis, (blood clots) wound care, pain management and fasting instructions.
- Patients told us nursing staff were very visible, enthusiastic and responded quickly to their needs. They told us they felt safe.
- The trust had a named dementia lead and learning disability lead. Staff confirmed they were able to readily contact these staff to discuss any concerns and to receive advice.
- The butterfly scheme was used to discreetly identify patients living with dementia. The use of the symbol enabled staff to identify patients who had a dementia diagnosis and ensure additional care and support were available.
- Twineham ward had a six bedded bay dedicated for those patients living with dementia which allowed more intensive care to be provided to ensure these patients were safe. Staff used specific care plans for patients living with dementia called 'Reach Out to Me'. The environment included a dining table and chairs for

Surgery

patients and appropriate memorabilia. There were dementia friendly signs which supported patients as they used pictures as well as large writing to prevent patients wandering into inappropriate areas.

- For patients living with dementia, they could be assessed via a Dementia Nurse Specialist assessment, a Dementia Occupational Therapist Assessment, a Consultant Geriatrician, a Consultant Psychiatrist or a Mental Health Nurse or ward staff who had undertaken dementia training.
- All patients living with a learning disability were referred to the Disability Liaison Team where information would be captured onto an electronic system for use when patients were being admitted and treated. The learning disability team would accept referrals from the wards, patient carers, community services and GPs.
- The trust reported mixed sex breaches and we saw from the period August 2016 to January 2017 there was only one occasion when this had occurred affecting one bay on a surgical ward. Staff reported they did not generally have mixed sex bays on surgical wards and we did not observe any during our inspection.
- We saw bariatric equipment such as chairs and wheelchairs were available on Albourne and Twineham Wards for patients when needed. Bariatrics is the branch of medicine that deals with the causes, prevention and treatment of obesity.
- We saw there was a choice of food options for patients, for example there was access to vegetarian, vegan and kosher meals.
- The trust used a wide range of communication support services for patients at the hospital including face-to-face interpreting for patients for who English was not their first language. Staff we spoke with told us they could access translation services from the trusts intranet when necessary. The trust produced a report showing the number of occasions communication support was required including braille, British sign language and over forty language translations.
- There was a variety of information leaflets on display on the wards about different types of conditions and treatments and in many cases, these contained information about how to access the same information in different languages.

Learning from complaints and concerns

- The trust had a policy for the Management of Formal and Informal Complaints from Patients and their Representatives, that set out the need for close collaboration between Patient Advice and Liaison Service (PALS) and the trusts complaint services to ensure a means of resolving patients concerns. We saw 'How to Complain' posters were displayed on the wards we visited.
- Between February 2016 and February 2017, there were 1,374 complaints received trust wide. The trust took an average of 73 days to investigate and close complaints, this was not in line with their complaints policy, which stated complaints should be responded to within 40 days.
- There was a monthly serious complaints and safeguarding meeting which contributed to a report presented to the safety committee and we saw this comprised of the number of complaints and highlighted any complaints at stage two and any learnings.
- From April 2017 to March 2017 the directorates received 59 complaints. The abdominal and medicine directorate had 16 complaints, the head and neck directorate had six complaints, the peri-operative directorate had two complaints and musculoskeletal had 32 complaints. Complaints were discussed at the surgical quality governance meetings. The themes identified at the PRH site were mainly due to a lack of communication and delay in treatment.
- Written complaints were managed by the matron and at directorate level. A full investigation was carried out and a written response provided to patients. Some staff told us that outcomes, lessons learnt and actions were not always fully cascaded to the staff within the wards or theatres.
- The ward sisters received all the complaints relevant to their service and gave feedback to staff at ward team meetings regarding complaints in which they were involved.
- Notice boards on the wards included 'You Said We Did', in response to patient comments.

Are surgery services well-led?

Surgery

Good



When we inspected the Princess Royal Hospital in April 2016 we rated well led as requiring improvement. This was because:

- There was no overriding strategy for the service and each directorate had their own individual strategy, this gave a perception of the service being disjointed.
- The service had experienced a reconfiguration of its neurological and fractured neck of femur services and had started to get its governance systems in place but this was in its early stages and needed further embedding.

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

- Each of the four directorates had strategies and business plans in place which could demonstrate progress over the last year.
- The reconfiguration of neurological and fractured neck of femur services had established and started to embed its governance systems.
- At a local level senior management teams were seen as visible, approachable and supportive. Staff spoke of a collaborative supportive culture.
- Risk registers were established for all four directorates, staff were aware of risks in their own department and there was assurance risks were kept under review at board level.

However:

- The plan for improving staff engagement following the staff survey was not yet fully implemented.

Leadership of service

- As of January 2017 each of the four directorates had a lead clinical director, a directorate lead nurse, directorate manager and a number of clinical leads. For example the peri-operative directorate had six clinical leads.
- Each ward and theatre had a manager who provided day to day leadership to staff members. There were matrons for the different surgical specialities who staff

said were responsive and supportive. Matrons kept staff informed of trust wide developments through ward manager meetings and provided guidance where required.

- Junior surgical doctors said that consultant surgeons to be supportive. Junior doctors told us they felt well supervised by their senior colleagues.
- The nursing teams, diagnostic team, physiotherapy team and administration team communicated well together and supported each other. Staff told us the local leadership were visible and approachable. They were not aware of the senior management team visiting the ward and department areas. Staff were aware there had been a lot of changes at senior management level and going forward were hoping for a period of stability.

Vision and strategy for this service

- The trust had a plan for the redevelopment of the hospital. There was a clinical strategy in place dated January 2017 which set out the vision to be a centre of excellence and the first choice for patients, families and staff. This also set out the values of the organisation and an immediate, medium term and long term strategy.
- Each directorate had either a strategy or a business plan for their services. For example, the abdominal and medicine directorate had a strategy to improve theatre utilisation, reduce its referral to treatment time (RTT) and ensure surgical beds were used for surgical patients.
- The peri operative directorate had a business plan, and told us their strategy was to ensure recovery was used appropriately, to deliver an efficient theatre and emergency service. They were actively involved in the new build and the expansion of the theatre department.
- The ear, nose and throat (ENT) service within the head and neck directorate had undergone a number of resource challenges but were settling in a new team and governance processes and had a business plan to look at new initiatives including cross hospital working. This directorate had a nursing strategy, vision and philosophy that incorporated the six Cs of care, compassion, competence, communication, courage and commitment.

Surgery

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

Governance, risk management and quality measurement

- Each directorate had established its own clinical governance meetings. We reviewed minutes of each directorates meeting and saw these included incident and complaint review, audits, policy updates and training.
- These meetings were well attended by members of the multidisciplinary team and minutes were available for those that could not attend. There was management representation from surgical areas including consultants, matrons, and directorate managers.
- Feedback from directorate leads was that trust governance was being better established with a regular monthly cross directorate meeting where major issues were discussed.
- The trust had completed local and national audits. For example, environmental audits were conducted and compliance with the World Health Organisation 'Five Steps to Safer Surgery' checklist was monitored in line with the trust's policy and national standards.
- The PRH had systems in place to identify risks. Directorates held their own risk register and clinical leads we spoke with were able to identify the top risks. Risks included inability to achieve 18 week RTT and surgical beds being used for medical patients, control measures included daily monitoring, daily ward rounds to include multi-agency staff and a review by the discharge team.
- We could see evidence of risk scoring and that information was updated and actions were taken. The directorate risk registers were seen to feed through to the trust risk register and a corporate risk summary analysis report which analysed the register and level of control in place giving the board assurance of risk across the organisation. This demonstrated transparency of risk.
- The musculoskeletal directorate risk register included a lack of medical staffing and lack of operating theatre time. The peri-operative directorate included a lack of anaesthetic cover at PRH, originally scored as high risk this had been mitigated following a review of rotas, but was seen to be still under review. Two out of three instrument washers needed replacement and this risk was mitigated by support from Royal Sussex County Hospital until new washers were purchased.
- The head and neck directorate listed the lack of a particular equipment service contract as a risk. We saw that actions had been taken to mitigate risk and that this would be resolved by both putting a contract in place and considering purchase of new equipment.
- Clinical leaders in the directorate told us they had oversight of all incidents. For example, the perioperative directorate maintained a log of serious and moderate incident with actions taken. Minutes were seen of the perioperative quality, safety and patient experience showing audit results, case presentation and reviews of mortality and morbidity.
- Staff said they received information regarding incidents and were involved in making changes as a result of incident investigations. Staff understood and felt involved in governance processes.
- The trust had a Quality Performance Committee and a performance monitoring system in place arranged under the five CQC domains. There was visibility of scorecards for the senior management team. Each clinical directorate had a clinical scorecard that was produced quarterly with comparism from the previous quarter.
- At directorate level the scorecard recorded monthly scores for example under caring there were scores for the number and time taken to answer complaints and those still open after six months. Well led had results of completed appraisals, vacancy rates, staff turnover and costing. In the safe domain amongst other measurements never events and serious incidents were recorded. We saw the scorecards displayed in ward and department offices.

Culture within the service

- Staff were enthusiastic about working at the PRH. Staff told us they felt respected and valued. Staff were proud to work at the hospital.

Surgery

- Staff said they felt the trust had improved over the last year and they felt listened to and involved in changes within the PRH; many staff spoke of involvement in staff meetings.
- Senior managers said they were well supported and there was effective communication with the executive team. There was a culture of openness and transparency.
- We were told by some staff that the Human Resource (HR) department were much more supportive and responsive with any behaviour concerns. The values and behaviour programme had been helpful and staff felt more able to challenge behaviours. Some staff described cumbersome recruitment processes and poor processes to manage long term sickness.
- The trust had a 'Raising Concerns and Whistle Blowing' policy. On ward areas, we saw information on how to report concerns, bullying and harassment and detailed the role of the new freedom to speak up guardian.

Equalities and Diversity – including Workforce Race Equality Standard

- The trust completed a Workforce Race Equality Standard (WRES) report in 2016 with an action plan due to be completed by 30 June 2017 in time for the next WRES submission. The Equality Annual report was presented to the board in January 2017.
- The trust had established an Equality and Diversity in Services Committee and we saw the terms of reference dated February 2017. This meeting involved the freedom to speak up guardian. Staff told us that the appointment of a speak up guardian was a positive development.
- The trust had a current 'Equality, Diversity and Human Rights' policy and an annual report which was presented at board level.
- The trust had a Lesbian, Gay, Bisexual and Transgender (LGBT) forum equality and diversity action plan. This showed actions such as involving the LGBT forum in the development of HR policies. We saw the trust commitment to support the Trans pride and the LGB Pride events.

Public engagement

- The trust and staff recognised the importance of the views of patients and the public. They used surveys and questionnaires to gather information to enable service improvement.
- The hospital participated in PLACE audits. These assessments invite local people go into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance.

Staff engagement







- The results of the National Staff Survey 2016 showed the trust performed worse than other trusts in a number of categories. Possible scores ranged from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's engagement score was 3.62 which was in the lowest 20% when compared with trusts of a similar type. Effective team working scored 3.59 compared to an average of 3.75 and staff satisfaction with resources and support scored 3.10 compared to 3.33.
- Following the National Staff Survey 2016, the HR department had presented a paper to the senior management team analysing results and detailing actions to be taken to improve staff engagement, for example the development of staff engagement events and how that was communicated across the trust. The action plan was reviewed in March 2017 and was still ongoing at the time of the inspection.
- Staff at PRH told us they were proud of their teams and hospital. They described the hospital as friendly and that they supported each other.
- We were told by staff about the Health, Employee, Learning and Psychotherapy (HELP) service that have been used by staff to support debriefing sessions after clinical incidents when it has been identified as traumatic meaning that staff may need support.
- The trust presented a conference for health care assistants, assistant nurse practitioners and clinical technicians at the end of April 2017. This showed how the trust was going to support those staff who wanted to progress their careers. This was well attended and had positive feedback from those attending.

Surgery

- Staff told us there has been a focus on training with a two day values and behaviour course called 'Leading the Way' and a rapid improvement workshop involving staff at all levels.
- We saw an annual brochure for staff and patients called 'Best of BSUH' outlining achievements over the past year and including patient stories.
- The PRH had developed a pathway for cold shoulder and elbow trauma at SOTC in response to progressive difficulties performing surgery in a timely fashion at RSCH. A weekly half-day shoulder and elbow trauma rota staffed by five shoulder and elbow surgeons had been running since April 2016. An audit six months after the project commenced showed that there had been no cancellations at SOTC of the trauma patients and that there had been no complications to date of patients operated on.

Innovation, improvement and sustainability

Critical care

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

Information about the service

The CQC previously inspected the Princess Royal Hospital (PRH) in April 2016. This was part of a comprehensive inspection of the whole of the Brighton and Sussex University Hospitals Trust. That inspection rated the critical care core service at PRH as requires improvement. The purpose of this inspection was to see what, if any improvements had been made since the last inspection. The inspection of the PRH took place on 27 April 2017.

The critical care service at the PRH is part of the Acute Floor Directorate. The critical care department comprises of eight intensive care unit (ITU) beds and four high dependency unit (HDU) beds on level one of the main hospital building. There was one bed in a side room which, is predominantly used for patients who presented an infection control risk.

The critical care department had 532 admissions in the year prior to the inspection. Due to the nature of the patients being cared for on the ward we were only able to speak with one patient and the family members of one patient. We also spoke with a total of nine staff from a range of roles including nurses, junior doctors, members of the critical care outreach team, housekeeping staff, health care assistants and consultants. We observed a number of periods of direct patient care. We also spoke with the Acute Floor senior leadership team. We reviewed a total of seven sets of patient records.

Summary of findings

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

- Inconsistent nurse staffing levels that did not always meet the safe standards established by the Faculty of Intensive Care Medicine and the Royal College of Nursing.
- Staff did not always understand or use incident reporting processes and investigations did not always result in demonstrable learning.
- There was inconsistent and sometimes limited input from a multidisciplinary team of specialists with significant shortfalls in pharmacy, dietician and occupational therapist cover.
- There was a demonstrable lack of communication and understanding between the executive team and local leadership.

At this inspection, we have retained the rating of requires improvement. This is because:

- There were gaps in the recording of fridge temperatures used to store drugs and the checking of medication expiry dates had not been recorded in January and February 2017.
- The critical care department across both hospital sites had a large incident report backlog dating back to 2015 that still required investigation. At the time of

Critical care

the inspection there were 242 outstanding incidents to be investigated, dating back to 2015. Between February 2015 to January 2016 critical care reported 331 incidents; this meant that 73% of these incidents were not investigated.

- There was not a dedicated dietician which could have a significant long-term impact on patients.
- There was insufficient pharmacy cover on the unit and the stock rotation system was ineffective.
- The ICU at the Princess Royal Hospital still did not fully meet the requirement of National Institute of Health and Care Excellence (NICE) CG83.
- Provision of information in languages other than English was extremely limited.
- There was no formal vision and strategy in place at the time of the inspection with the senior leadership team waiting for the trust wide vision and strategy to be announced.

However:

- There had been improvements with regards to cleanliness and infection control, particularly around hand hygiene.
- Performance as described in the measures defined by the Intensive Care National Audit Research Centre (ICNARC) was either better or similar to the national average for units of a similar size.
- Multi-disciplinary working was well established and we saw examples of members of the therapy teams being available and having input into patient care
- Staff treated patients and visitors to the unit with compassion and a real understanding for their own circumstances.
- Staff introduced themselves and explained who they were in order to put the patients at ease.
- Emotional support and counselling services were available to patients and their relatives, including on-site Chaplaincy.
- Each patient on the ICU had a 'patient diary'. This was a diary written to record what had happened to the patient and how they had been cared for.

- Clinical governance meetings were well attended and minutes were thorough. Any actions arising from these meetings had a named person responsible for taking it forward.
- There was evidence of a good culture amongst all staff where teamwork was seen as the key to an effective service.

Critical care

Are critical care services safe?

Requires improvement



When we inspected critical care services at the Princess Royal Hospital in April 2016, we rated safe as requires improvement. This was because:

- There was an inconsistent approach to reporting and classifying incidents. Learning from incidents was often vague or missing entirely.
- There was insufficient pharmacy cover on the unit and the stock rotation system was ineffective.
- Staff did not comply with national and European regulations on the safe storage and disposal of hazardous waste or on the safe storage of chemicals

At this inspection, we retained the rating of requires improvement because;

- The critical care department across both hospital sites had a large incident report backlog dating back to 2015 that still required investigation. At the time of the inspection, there were 242 outstanding incidents to be investigated, dating back to 2015. Between February 2015 to January 2016 critical care reported 331 incidents; this meant that 73% of these incidents were not investigated.
- Although the trust had employed a clinical risk nurse their focus was currently on clearing the incident backlog at Royal Sussex County Hospital (RSCH). There was no firm date when the backlog of incidents at PRH would be investigated.
- The records system was entirely paper based and was not the same as that used at the RSCH, the other hospital in the trust.
- Due to the limited storage available, the unit looked cluttered with some items stored on wooden pallets.
- There were gaps in the recording of fridge temperatures used to store drugs and the checking of medication expiry dates had not been recorded in January and February 2017.
- There was a lack of demonstrable improvement since our last inspection.

- The main door to the unit was not motorised and presented a challenge when moving patients or when visitors were attending the unit.

However:

- A nurse had taken the lead on collecting data for the patient safety thermometer and was able to devote one day per month to the task.
- There had been improvements with regards to cleanliness and infection control, particularly around hand hygiene.
- Record keeping was good with clear and detailed notes kept in all of those reviewed.
- The ITU had direct access to and from the surgical theatres and recovery area.
- Nursing staffing was consistently good with the majority of shifts filled with appropriately trained staff.

Incidents

- The hospital used an electronic incident reporting system. Staff would report incidents on this system when an incident occurred. Incidents were then investigated and discussed at management meetings. Where there was learning from the investigation, this was communicated to staff. We were told that there had been improvements in this area, particularly around feedback following an investigation.
- Between May 2016 and February 2017 there were 53 incidents reported across the ITU at PRH. Of the 53 incidents 14 were categorised as low harm, 35 were categorised as no harm: impact not prevented and four were categorised as no harm: impact prevented. The trust had appointed a clinical risk nurse to review, investigate and deal appropriately with all outstanding incident reports across critical care at both the Royal Sussex County Hospital and the Princess Royal Hospital. Plans in place at the time of the inspection were to have the clinical risk nurse in place for two years.
- The clinical risk nurse had been given full incident reporting and investigation training and in depth duty of candour training in order to be able to carry out their role fully.
- The critical care department across both hospital sites had a large incident report backlog dating back to

Critical care

2015 that still required investigation. At the time of the inspection, there were 242 outstanding incidents to be investigated, dating back to 2015. Between February 2015 to January 2016 critical care reported 331 incidents; this meant that 73% of these incidents were not investigated.

- Although the clinical risk nurse had started to tackle the backlog of incidents at RSCH, they had yet to start at PRH. Although no firm date had been set as to when they would start to cover PRH at the time of the inspection, it was anticipated that work would begin within six months. This meant that opportunities for learning had not been highlighted and the trust did not have assurances that there would be a reoccurrence of similar incidents.
- We were told how there were regular meetings held to look at feedback from incident investigations. These meetings were minuted. All staff were encouraged to attend and read the minutes. However, there was no formal arrangement to ensure that staff had read the minutes. This meant that there may have been opportunities for learning that were missed.
- The CQC inspection team were provided with minutes of the mortality and morbidity meetings for a two month period, December 2016 and January 2017. We reviewed the minutes and found they were thorough and included detailed case summaries, comments about human factors, system failures, and patient related factors. Information about diagnosis, mode of death (if applicable) and there were summaries of learning points and actions.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We saw that incident reporting meeting minutes showed that there was an understanding of when the duty of candour process should be used. Senior staff we spoke with showed clear awareness of the incidents that would need to be dealt with under the duty of candour process.
- There were no Never Events recorded at the Princess Royal Hospital in the year prior to the inspection.

- The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection took place one day each month.
- During the inspection, we spoke with a senior member of nursing staff that talked of their commitment to patient safety and how, as a result of expressing an interest, had taken the lead on the patient safety thermometer. One day per month was given to the lead to undertake this role.
- Information recorded using the safety thermometer was clearly displayed on the critical care unit and was accessible for staff and visitors to the units.
- Data from the Patient Safety Thermometer showed that the trust reported two new pressure ulcers, two falls with harm and three new catheter urinary tract infections between February 2016 and February 2017.

Cleanliness, infection control and hygiene

- There had been no cases of meticillin resistant staphylococcus aureus (MRSA) on the ITU since 2011. Unit acquired surgical site infections were better than the national average as there had been none in the ICU in the twelve months prior to inspection.
- There had been no incidents of Escherichia coli (E.coli) on the unit. The last case of clostridium difficile was reported in December 2016.
- During the inspection, we observed staff of all grades regularly cleaning their hands when appropriate and in line with World Health Organisation "Five moments for hand hygiene." There was a hand hygiene guide for visitors to the ITU in the relatives room
- Hand hygiene audits carried out between June 2016 and February 2017 showed that ITU at PRH had a compliance rate of between 96% and 100%. The hand hygiene audit carried out in April 2017 showed a 100% compliance rate.
- Information displayed in the corridor of the ITU showed the national cleaning score average for a very high risk area was 98%. The ITU score at PRH was 99.9%

Safety thermometer

Critical care

- The unit was visibly clean and items were marked with 'I am clean' labels. These showed the date that they had been cleaned. All dates observed were for the date of the inspection.
- We observed a housekeeper immediately cleaning the space that had been occupied by a patient when they had been taken for a scan.
- We spoke with housekeeping staff who described how they cleaned equipment and labelled everything with 'I am clean' labels. The housekeeping staff had a list showing the cleaning rota and when deep cleans were required.
- Curtains around the bed spaces were changed every six months unless there had been an outbreak of diarrhoea and vomiting when they were changed immediately.
- We saw that clinical and domestic waste was segregated into different coloured waste bags in line with national guidance regarding the management and disposal of healthcare waste, Health Technical Memorandum (HTM 07-01) Safe management of healthcare waste. This included the management of sharps.
- Infusion pumps were stored on racks, fully powered and ready for use.
- The central area of the unit was well positioned to allow staff to have a full view of all the patients on the unit. This area was clean and uncluttered.
- The central area also had a computer screen which transmitted observational information about each of the patients. This enabled staff to monitor patients physiological measurements at all times.
- There was a clearly defined role for the shift leader to check all the equipment on the unit. We spoke with the shift leader for the day who explained that they check the ventilators and ensure that any equipment that may be required is readily available. Staff told us that they always had sufficient equipment available.
- There were adequate supplies of pressure relieving mattresses available to assist staff prevent pressure ulcers to patients.
- The resuscitation trolley on the unit was checked daily to ensure the equipment was in full working order. We saw that there was a record of these checks being carried out. The checklists were signed as done by the person checking. It was sealed appropriately and all drawers were appropriately stocked.

Environment and equipment

- There was adequate security of access at the ITU at Princess Royal Hospital. The unit was accessed by a buzz entry system which included video identification of those being admitted. During the inspection we observed the system in practice when seeking entry to the unit.
- The door to the unit itself was not motorised so had to be physically held open to move a patient in or out of the unit. This meant that more staff were required to carry out any moves that were to take place. This also presented a challenge to anyone who was not physically strong enough, or had limited mobility, to hold the door open.
- Storage capacity on the unit was limited. This meant that the corridor areas were cluttered. We saw that haemofiltration fluids were stacked on a wooden pallet. There were three oxygen cylinders and zimmer frames stored in the corridor. Although there were items stored in the corridor, they were stored safely and did not represent a hazard.
- The ITU at the PRH did not have a technician to ensure stocks of equipment were maintained and all the equipment they did have was in date. The responsibility for this fell to the clinical staff across the unit. Stock we checked during the inspection showed that randomly selected items were in date and stored adequately.
- In the absence of a technician at PRH, all routine and short notice maintenance of medical machinery was carried out by the manufacturers of the machine.
- The ITU had direct access to and from the surgical theatres and recovery area. This allowed for the swift transfer of patients when necessary.

Medicines

- We reviewed two medication administration records during the inspection. These showed what medications had been given, what risk assessments had been carried out and the reasons for the administration. The charts

Critical care

were clear; sheets were in the correct part of the notes and were signed and dated. These met the Nursing and Midwifery Council (NMC) standards for medicines management.

- Medicines were securely stored in a room behind the nurses' station. Entry was gained with a swipe card. Inside the room there were fridges which were unlocked. These contained sedation and paralysis agents.
- It was noted that there were gaps in the recording of fridge temperatures.
- The ITU kept a monthly record of the checking of medication expiry dates. We saw during the inspection that these checks had not taken place in January and February 2017.
- Controlled drugs were checked daily and handed over to the next shift. Checks on the controlled drugs had not been recorded for three consecutive days in February 2017. This suggested that the checks had not been carried out
- We noted that Midazolam (Midazolam is a drug used for anaesthesia, sedation and severe agitation) was stored in a bag to identify separation. This had been done in response to a medication error.
- A medication security audit which carried out by the matron and pharmacist in April 2017, just prior to the CQC inspection showed that the hospital was complying with its obligations in relation to the storage and recording of the use of controlled drugs. There was an acknowledgement that the drug fridges were left unlocked. However, this was qualified by the fact that leaving the fridges unlocked has been risk assessed and the locking of the room, where access could only be gained with a swipe card mitigated the risk.
- The audit also showed that errors in the controlled drug register had been crossed out. This did not comply with the legislation regarding controlled drugs. The issue of crossing out errors was raised with the ward manager and action to remind staff of the requirements was taken. It was also found that nursing staff were not familiar with how to re-set the fridge thermometer.

- The audit also demonstrated that intravenous fluids were stored in a lockable clinical area / cupboard. The flammable gases and liquids were stored securely. Small oxygen cylinders were stored in designated racks and no empty oxygen cylinders were stored on the unit.
- The inspection team also saw that medications were being frequently 'borrowed' by wards during both the day and night.
- Guidelines for the Provision of Intensive Care Services (GPICS). Section 2.2.6, standard 1.4.1 of GPICS state that there must be a critical care pharmacist for every critical care unit. The critical department did not have a pharmacist exclusively working in critical care. This meant that access to the pharmacist was inconsistent although one was available in the hospital between 9am and 5pm.
- The pharmacist was not able to attend any ward rounds at PRH. Pharmacy was unable to meet the standard relating to multidisciplinary ward rounds and had no pharmacy technicians to support the service.

Records

- Records at PRH were entirely paper based. We reviewed seven sets of patient records.
- On one set of records we observed that Do Not Attempt Resuscitation (DNAR) documentation was prominent at the front of the records. There were full details of the plan for the patient as well as multi-disciplinary team (MDT) discussions. The patient's thoughts and wishes had also been recorded clearly.
- Other records we reviewed showed that hourly observations had taken place including vital signs, infusions, sedation scores, fluid balance and arterial blood gases.
- Notes were organised sequentially and we saw that blood results, microbiology results, medical notes, nursing notes, physiotherapy and dietitian notes were all clearly recorded.
- The records we reviewed were all well-ordered and consistent in their quality. The notes were appropriate, clear, legible, signed and dated.
- The record keeping system at PRH was not the same as the Royal Sussex County Hospital. This meant that staff who worked across the two sites were not fully

Critical care

conversant with each site's record keeping system. This meant that there was a risk that records would not be kept properly which could in turn have compromised patient safety.

Safeguarding

- There were safeguarding and deprivation of liberty safeguards (DoLS) flowcharts displayed prominently on the both level five and level seven. The flowcharts showed the contact details of the trust's safeguarding team. There were also references to online resources where staff could get more information.
- Nursing staff in critical care were required to complete level two in child safeguarding. Compliance with this training was 76% better than the trust target of 75%. Although the target for mandatory training was 75% and this was met, the target itself was low.
- Nursing staff in critical care were required to complete adult safeguarding training. Compliance with this training at 94% was better than the trust target of 75%.
- Medical staff in critical care were required to complete level two safeguarding children training. Compliance with this training was good.
- Medical staff in critical care were required to complete adult safeguarding training. Information received from the Trust showed that 16 of the 17 consultants in critical care had received safeguarding training. At the time of the inspection 81% of medical staff had completed this against a trust target of 75%. Although the target for mandatory training was 75% and this was met, the target itself was low.
- Safeguarding training for both adults and children incorporated a section on female genital mutilation.

Mandatory training

- Mandatory training included fire safety, infection control, mental capacity training, safeguarding adults at risk level one, safeguarding children level one to three, equality and diversity, blood transfusion, health and safety, information governance, and basic life support. Staff told us how they had annual mandatory training days. They were alerted to the need to complete mandatory training by their line manager and there were posters in the staff room.

- At the time of the inspection, compliance with mandatory training across critical care was low, senior staff were aware of the need to improve this. To do this they had started a system where a number of the mandatory training courses were completed in one day. There were seven of these days scheduled per year at the PRH. Some nursing staff had some mandatory training modules that were over a year out of date. We were told that the system for recording mandatory training would flag if a member of staff was due to undertake mandatory training. However, we were told that due to a glitch in the system, staff who had undertaken mandatory training would sometimes show that they had some courses outstanding. As a result of this, the critical care team had implemented their own system to record when staff had attended their mandatory training.
- Senior staff told us that they had been in frequent contact with the team who facilitated the system that recorded who had completed mandatory training. This was with a view to getting per extra permissions that would allow the staff to enter their own information.

Assessing and responding to patient risk

- The trust used a system of patient track and trigger. To do this they used the National Early Warning Score (NEWS) to identify deterioration in a patient's physiological condition. The outreach team could assess patients in the ward environment and support staff in the management of a highly dependent patient. Ward staff could also contact the outreach team about any patient that may be causing them concern. It would be expected that any referral would be made using the SBAR framework. SBAR is an acronym for Situation, Background, Assessment, Recommendation; a technique that can be used to facilitate prompt and appropriate communication.
- The trigger for calling medical staff was a NEWS score of five. At this early stage minimal intervention had been shown to have maximum benefit to the patient by reducing their morbidity and mortality. Early intervention or NEWS also facilitates the timely identification of patients who may require transfer to an area of higher care e.g. Level 2 and 3.

Critical care

- The outreach team did not have admitting rights to ICU/ HDU but could have referred a patient to the Critical team (in collaboration with the parent team) for assessment for admission.
- All referrals had to go through the ICU registrar. The patient was then be assessed and discussed with the consultant in charge of ICU. Once accepted for admission the aim was to admit the patient within one hour. The most recent data available, covering a period between 1 January 2016 and 31 December 2016 showed that the hospital failed to meet this target on 73 occasions, representing 14% of all admissions.
- The outreach team could assist with the transfer of critically ill patients within the hospital, ensuring that the patient was appropriately monitored. Where possible this could be used as a learning opportunity for nursing and medical staff.
- In exceptional circumstances, the outreach team could provide support for the transfer of level three patients to other hospitals. The decision would be made in discussion with the nurse consultant or ICU consultant or clinical service manager. The decision was considered carefully against risk of leaving no outreach cover at the base site.
- The critical care outreach team (CCOT) aimed to support ward staff caring for patients who had recently been discharged from ICU/HDU. CCOT also assisted the patient and their families with the often difficult transitional process from an area of higher care to the ward.
- CCOT aimed to review all patients discharged from ICU at least once.
- Appropriate risk assessments such as venous thromboembolism (VTE) and patient allergies were routinely carried out and this was evidenced in the records that we reviewed.
- There was evidence in patient notes that patient pressure area risks were considered and patient comfort scores were recorded
- The ICU at Princess Royal Hospital reported their staffing numbers from January 2017. There was a vacancy rate of 1.09 Whole Time Equivalent (WTE) staff. The number of staff in post was 42.29 whole time equivalents against the trust establishment of 43.38.
- We observed that for a sustained period, there was one member of nursing staff to each patient.
- We were told by a senior member of nursing staff that the ITU was, at the time of the inspection trying to recruit more nursing staff to be able to fully staff the four HDU beds that were on the unit.
- At the time of the inspection the ITU at PRH, on occasions had more staff than they required if none of the four HDU beds were in use. This meant that staff would be asked to cover other wards across the hospital or be sent to the ITU at the Royal Sussex County Hospital (RSCH). Informal visits for staff to the ITU at RSCH had been arranged to help with orientation to that site. This arrangement was unpopular with some staff although contracts of employment did say that they may be required to work elsewhere.
- As at January 2017, Brighton and Sussex University Hospitals NHS Trust reported a turnover rate of 13.3% in Critical Care; this is similar to the trust average of 13.38%. This equated to 23.7 WTE critical care staff that have left the trust.
- Gaps in any shift rotas were filled with bank and agency staff. Between February 2016 and January 2017, Brighton and Sussex University Hospitals NHS Trust reported a bank and agency usage rate of 9% in Critical Care.
- Bank and agency staff usage in critical care has been consistently low over the time period, the lowest usage rate was 2% in July 2016 however there was a spike in October 2016 where the usage rate reached the highest at 36%, as of January 2017 it was at 9% which is higher than the trust average of 7%
- In January 2017, the most recent month prior to the inspection that we were provided data for showed that during the day, the hospital had a total of 2676.5 hours worked against a target of 2495.5 hours. This meant that staffing for the unit was at 107%. During the same month, during the night, against a planned 2495.5 hours, the hospital had 2472.5 hours worked. This

Nursing staffing

- At the time of the inspection, there was sufficient staffing to provide safe care.

Critical care

meant staffing for the unit was at 99.1%. The data for the preceding three months showed that daytime staffing for October 2016, during the day was at 92.3% and at night was 91.2%. In November 2016, daytime staffing was at 102.8% during the day and at 91% at night. In December 2016, daytime staffing was at 87.4% and at night was at 82.3%.

- The hospital used the safer nursing care tool (SNCT). This was based on the critical care patient classification (comprehensive Critical Care, DH 2000). We were provided with a copy of the acuity capture template which was a patient acuity and staffing snapshot taken at 2pm and referred to the past 24 hours. This was a comprehensive document that allowed staff to report the acuity of each patient by bed number. Also recorded were the number of staff and the roles they performed.
- Staff worked well together and ensured that each person got a break and cover was arranged when they took their breaks.

Medical staffing

- As at January 2017, Brighton and Sussex University Hospitals NHS Trust reported a vacancy rate of 24.5% in Critical Care; this is above the trust average of 6.4% it also varied between staff groups, the vacancy rate for specialty registrar was 48%.
- Between February 2016 and January 2017, Brighton and Sussex University Hospitals NHS Trust reported a bank and locum usage rate of 1.6% in Critical Care; this is below the trust average of 6.7%
- Bank and locum staff usage has been consistently low over the time period. There was an increase in usage rate from September to November 2016 with a peak in October 2016 with the highest usage rate of 7.7%.
- The hospital had a standard that 100% of patients would be reviewed by a consultant within 12 hours of admission. However, there was no information provided about whether this had been met.
- During the inspection, we noted that there were two consultants available. This was better than the 1:8 patient ratio as recommended by the Faculty of Intensive Care Medicine. Consultant cover was provided 24 hours a day.

Major incident awareness and training

- The critical care unit at PRH had a copy of the major incident plan. This was stored at the nurses' station in a red file. The red file also contained information regarding what to do in the event of a fire and how to evacuate ventilated patients.
- All policies and procedures relating to dealing with major incidents were available online as well as in hard copy.
- Staff we spoke with were clear about what to do in the event of a fire and how they would respond to a major incident at the hospital. We were shown how different areas of the unit could be isolated in the event of a fire and how patients could be safely evacuated.

Are critical care services effective?

Requires improvement



When we inspected critical care services at the Princess Royal Hospital in April 2016, we rated effective as requires improvement. This was because:

- Multi-disciplinary input into patient care was sporadic, inconsistent and did not occur reliably. Occupational therapy cover was significantly restricted.
- The unit did not have a full time, dedicated dietician and out of hours support was limited. This meant the unit was not compliant with the British Dietetic Association's guidance.
- The unit did not meet the requirements of the National Institute of Health and Care Excellence (NICE) clinical guidance 83: rehabilitation after critical illness in adults because there was no formal follow up clinic.

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

- The ICU at the Princess Royal Hospital still did not fully meet the requirement of National Institute of Health and Care Excellence (NICE) CG83.
- The hospital failed to meet their own standard / key performance indicator in relation to the discharge of patients with a rehabilitation prescription.

Critical care

- Performance against the South East Coast Critical Care Network Commissioning for Quality and Innovation (CQUIN) measures was mixed with the majority of targets missed.

However:

- Performance as described in the measures defined by the Intensive Care National Audit Research Centre (ICNARC) was either better or similar to the national average for units of a similar size.
- The hospital had access to the simulation room at Royal Sussex County Hospital (RSCH) to assist in the recruitment and development of staff working across the ICU at PRH.
- Multi-disciplinary working was well established and we saw examples of members of the therapy teams being available and having input into patient care.

Evidence-based care and treatment

- During the inspection, we were provided with the Critical Care Scorecard for the PRH. This showed how the hospital was performing against a range of measures linked to national guidance.
- The critical care department at PRH based their rehabilitation after critical illness in adults on the National Institute for Health and Care Excellence (NICE) guideline CG83. However, this standard was not achieved as certain elements of the pathway were funded by different teams. It was acknowledged that the department needed its own team to be able to fully meet the guideline.
- The trust informed us that they had carried out audits which demonstrated compliance with the following local and national audits. However, we did not review these during the inspection;
- National Audit, ICNARC
- NICE guidance CG103, CG50, IPG386, PSG002
- NCEPOD Acute Problem, and Just Say Sepsis
- DOH HII CVC insertion, PVC, CDiff transmission, VAP rates, Enteral feeding (in line with other units), Antimicrobial stewardship, Healthcare records

- Local Trust Identified Audits Readmission, referrals, unplanned admissions, MET calls, NeuroICU nurse numbers, Management of traumatic brain injury, out of hours discharge quality audit, Pain, VTE, DOLS, Organ Donation, Medication errors.
- The hospital had a standard key performance indicator (KPI) that 100% of eligible patients would be discharged with a rehabilitation prescription, in accordance with the National Institute for Health and Care Excellence (NICE) Guidance CG 83, rehabilitation after critical illness in adults. The critical care scorecard we received covering the period from April 2016 to December 2016, showed that the hospital had failed to meet this KPI in any of the months in this period. Performance ranged from a low of 19% in June 2016, and a high of 74% in September 2016.
- The latest data provided by the South East Coast Critical Care Network (SECCCN) covering April 2016 to January 2017, showed the hospital's performance in three key Commissioning for Quality and Innovation (CQUIN) measures. These were: completion of rehabilitation needs assessment, completion of a rehabilitation pre-discharge assessment and number of patients requiring a documented pathway. In each CQUIN, the target for completion was 95%. In the completion of a rehabilitation needs assessment, the CQUIN was not met in any of the months between April 2016 and January 2017. Performance against the 95% target varied from 58% in July 2016 to 81% in December 2016. For the rehabilitation pre-discharge assessment, CQUIN the hospital failed to achieve the target of 95% in any of the months. Performance against the target ranged from 54% in May 2016 and 79% in January 2017
- For patients that required a documented pathway the hospital met the CQUIN in all months except for October 2016. However, actual numbers were low ranging from 11 in December 2016 and 1 in October 2016. As such, these should be considered as neutral findings.
- We saw from checking patient records that the staff had completed agitation and delirium screening tools to assist in decision making about the patients care. This was done in accordance with section 1.5 of NICE guideline CG103, Delirium: prevention, diagnosis and management.

Pain relief

Critical care

- While reviewing the patient records we saw that there were appropriately completed pain assessment tools. If a patient was recorded as being in pain, pain relief was given accordingly.
- Nurses attended the acute pain study day as part of local induction and receive training in patient controlled analgesia pumps (PCA) pumps and epidural pumps.
- We observed a patient seen as part of the ward round. When their pain was assessed it was noted that the patient required analgesia. This was then given accordingly.

Nutrition and hydration

- Guidelines for the provision of intensive care services (GPICS) standard 1.5.1 states that 'There must be a dietitian as part of the critical care multidisciplinary team.' The dietetic service at PRH was not provided to the recommended hours. However, there had been no reported clinical impact of the service running below that of the recommended standard. The hospital did have a dietician available who was employed on a part time basis as 0.5 of a whole time equivalent.
- On reviewing patient records we saw that as part of the hourly observations, fluid balances were recorded. Dietitian notes were also routinely kept in the patient records.
- Those patients that were unable to take oral intake had nutrition support (enteral or parenteral) commenced on admission to the unit, to ensure adequate nutrition in with the GPICS guidelines.
- Patients that were awaiting transfer to a ward or who could eat and drink independently were able to order food that was suitable to their needs.

Patient outcomes

- The trust has two units which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2016/17 Annual Report.
- The ICNARC data was displayed prominently in the ITU.

- For Intensive Care Unit at The Princess Royal Hospital, Haywards Heath, the risk adjusted hospital mortality ratio was 0.91. This was within the expected range. The figure in the 2016 annual report was 1.07.
- For the Intensive Care Unit at PRH, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.91. This was within the expected range. The figure in the 2016 annual report was 0.97.
- The trust had a standard KPI that less than 1.2% of patients would be the subject of an unplanned admission 48 hours after discharge. From April 2016 to March 2017, the trust failed to meet this KPI in August and December 2016 and January 2017. However, the KPI was met in all nine of the other months where there were no readmissions.
- The critical care department participated in a number of local audits including catheter related blood-stream infections, ventilator acquired pneumonia and a potential organ donor audit.

Competent staff

- ITU on level seven at RSCH had a simulation suite where staff training for staff across the trust, including PRH, was undertaken. The simulation room had a control room that was fitted with one way mirrors and two way speakers, allowing observers to monitor the performance of staff using the simulator and offer guidance where necessary.
- The room was also used in the recruitment process for band five nurses to enable potential recruits to demonstrate their clinical skills. The practice educator would take an active role in any simulation exercises that formed part of the recruitment process.
- For all new outreach staff, an individual review of developmental needs in line with the job description and critical care outreach competencies took place within two weeks of appointment, with the Nurse Consultant. Ongoing review was conducted annually, in the form of an appraisal. In-between the annual appraisal regular reviews took place 3-6 monthly or by arrangement with the individual outreach nurse and the critical care nurse consultant. The critical care outreach team could also access clinical supervision to support their professional development.

Critical care

- The critical care outreach team (CCOT) lead and participated in teaching on the ACUTE course, tracheostomy and Transfer of the critically ill patient.
- CCOT also participated in teaching on programmes at a local university related to care of the highly dependent patient (e.g. acute care module and Intensive care course).
- CCOT utilised informal teaching opportunities with ward staff at the patient bedside as appropriate.
- CCOT contributed to the critical care education programme (as requested by the practice educators).
- CCOT acted as assessors on the intensive care course for relevant skills such as transfer of the critically ill patient.
- We were told by a member of nursing staff that new nursing staff were given a comprehensive competency booklet that they had a year to complete. Competencies would then be signed off when the member of staff had demonstrated they were competent.
- Clinical based training included ventilator, hemofiltration, cardiac output monitoring, thermoguard cooling device, indwelling central lines, bronchoscopes, and advanced airway equipment. Training and competency was assessed as needed according to backgrounds and experience of trainees. Training was delivered by consultants, senior nurses and practice educators.
- Local induction was a four week supernumerary period and involved training on
 - Arterial blood gas machine by Point of Care Team
 - Solar monitors by intensive care technician
 - Ventilators (DraegerXL and Hamilton G5)
 - BiPAP machines: focus and V60
 - Arterial lines and transducers
 - Central lines and transducers
 - Intubation equipment
- All Band 5 nurses who are on the intensive care course and senior nurses who had completed the intensive care course had further training and assessment on ventilators, non invasive equipment, PiCCO (PiCCO is a cardiac output monitor that combines pulse contour analysis and transpulmonary thermodilution technique) and haemofilters. At annual appraisals staff were requested to self-assess competence on equipment used in Critical Care.
- We were told how lots of work had been done to improve the appraisal process. We also heard that the trust format was much better. Staff told us they had become more engaged and had provided reflective practice pieces as part of the changes. Reflective practice pieces were also used for revalidation purposes.
- Senior staff had had input into changes to the trust's paper work for appraisals. We were told that there was more emphasis being placed on how staff conducted themselves in line with the trust's values and behaviours in the appraisal process.
- At the time of the inspection, appraisal rates for critical care staff at the Princess Royal Hospital was 92%. This was better than the trust's target of 75%.
- The trust had a target of 50% of all nursing staff should have a post registration award in critical care nursing. The trust had met that target at the PRH with 59% of nurses having a post registration award in critical care.
- We spoke with a member of staff who had transferred to the ITU. They reported that the induction was good. They had worked supernumerary for a period of one month and had named mentors.

Multidisciplinary working

- During the inspection, we saw staff from a range of disciplines attending to patients including a speech and language therapist and a physiotherapist. We directly observed and saw evidence from patient notes that the different teams worked well together. However, due to the low numbers of staff, there could be delays between visits by members of the team to individual patients.
- The critical care department at the PRH employed one physiotherapist full time, a speech and language therapist as 0.2 of a whole time equivalent (WTE) and a dietician as 0.5 of a WTE.

Critical care

- During the inspection, we observed a patient that was being prepared to be taken for an MRI scan. The consultant, two nurses and hospital porters were in attendance. The patient was then taken to have the scan. The process was noted to be calm and efficient.
- While we were on the ITU we spoke with the speech and language therapist. They explained to us how they assisted the nursing staff with communication strategies for those who were sedated or intubated and would have been difficult to communicate with.
- The critical care outreach team (CCOT) at Princess Royal Hospital were available 24 hours a day, seven days a week.
- There was a multi-disciplinary rehabilitation meeting weekly on a Wednesday where members of the team would discuss the patients in the unit. These meetings had been long established and would be the only chance the MDT would have to meet. They were viewed as useful by all members of the MDT.
- Follow up rehabilitation meetings for patients from the PRH and RSCH were held at an independent site away from either hospital.
- Rehabilitation was provided by a multi-disciplinary team. There would be visits to patients by physiotherapists, neuro physiotherapists, dietitians, speech and language therapists and members of the outreach team.

Seven-day services

- Due to the nature of patients, being cared for the ICU at RSCH was staffed fully, 24 hours a day seven days a week. There was a consultant available across the ITU 24 hours a day, seven days a week, although out of hours this was on an on call basis.
- There was access to out of hours physiotherapists and pharmacists on call 24 hours a day, seven days a week.
- Access to imaging was not available 24 hours a day seven days a week.

Access to information

- Patient records were not kept electronically at the PRH and were kept in paper form only. Old notes were

accessed through a ward clerk who could retrieve them from storage. This meant that there could be a delay in obtaining these records and the associated risks that this brought.

- Access to policies and procedures relevant to critical care could be accessed through the intranet. Key policies were available in paper form from the nurses' station. There was also information posted in paper form in the staff room.
- A significant number of the documents providing information to visitors to the ITU did not show dates of when they were created. This did not provide anyone reading the information the re-assurance that it was recent or still relevant.

Consent and Mental Capacity Act including Deprivation of Liberty Safeguards

- Deprivation of Liberty Safeguards flowcharts were displayed prominently across the ITU. Staff we spoke with were familiar with the process to be followed in the event that they need to consider depriving someone of their liberty.
- We were told how, in the event that a mental capacity assessment needs to be carried out to assist with an application for power of attorney, the clinical staff would be able to seek the input from the trust's medico-legal team.
- Training rates for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were not site specific but were instead provided for the critical care team across the Brighton and Sussex University Hospitals Trust.
- Nursing staff across critical care were provided with training in the MCA and DoLS. The most recent data available showed that of a total of 414 staff, 344 had completed the training. This represented 83% of nursing staff.
- Medical staff across critical care were provided with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The most recent data available showed that of a total of 37 staff, 26 had completed the training. This represented 70% of medical staff.
- Records reviewed showed that patients were consented correctly and consent was well documented.

Critical care

Are critical care services caring?

Good



When we inspected critical care services at the Princess Royal Hospital in April 2016, we rated caring as good. This was because:

- Staff at all levels demonstrated dignity, kindness and compassionate when speaking with patients, their relatives and visitors.
- Families we spoke to told us staff were courteous and respectful and they felt involved in the treatment decision making process.
- Emotional support and counselling services were available to patients and their relatives, including on-site Chaplaincy.

At this inspection, we maintained the rating of good because:

- Staff treated patients and visitors to the unit with compassion and a real understanding for their own circumstances.
- Staff introduced themselves and explained who they were in order to put the patients at ease.

Compassionate care

- We observed the ward round and saw that all members of the team introduced themselves to the patients and ensured that their dignity was maintained at all times by entering and leaving the bed space carefully. This ensured that the patients were comfortable and understood what was happening to them.
- We also noted that the staff had developed a good rapport with patients. This was particularly evident in one particular case where a long term patient had clearly developed close bonds with the staff on the unit.

Understanding and involvement of patients and those close to them

- We heard from one family member who told us that their relative had received great care, the staff had all been welcoming and they had been kept well informed with regular updates.

- On reviewing one patient's records, we saw clear and well documented evidence of the staff understanding the patient and the patient's loved ones. Key decisions were fully explained with the patient's needs fully understood. This meant that the patient had been able to build strong relationships with a wide range of staff. We saw first-hand that the understanding between the clinicians and the patient were based on trust and mutual respect.
- During the inspection we observed a nurse that was caring for a patient who was being weaned off sedation. As the patient was becoming more aware of their environment, the nurse spoke to the patient constantly in order to orientate the patient to time and situation. We also saw that when alarms went off on other beds, the nurse was there to re-assure the patient.
- The local survey between March 2016 and April 2017 showed that over that period between 60% and 80% of people received a welcome to the unit, were able to ask questions or talk to a nurse and were informed of their friend or relatives condition. Between 50% and 55% waited between zero and 30 minutes to receive detailed information on the patient and 55% - 60% had had the opportunity to talk to a doctor.
- We noted that each different bed had different colour aprons for the staff to use. This meant that it was easy to identify which staff were caring for which patients
- At the entrance to the unit there was a board with the names and photographs of the senior members of the team. There were no names or pictures of any other staff on the unit. This did not reflect what was displayed at the RSCH.
- The nurse in charge of the unit wore a red armband so they were clearly identifiable to all staff and visitors.

Emotional support

- A chaplaincy service was available to those patients and their loved ones who wanted to use it. Ward staff were able to contact the chaplain to ask them to attend.
- Patients had access to post discharge counselling services to help them recover and understand what had happened during their stay in hospital.
- Patients could access a local branch of a national charitable support network (ICU Steps) for people

Critical care

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

Are critical care services responsive?

Good



When we inspected critical care services at the Princess Royal Hospital (PRH) in April 2016, we rated responsive as good. This was because:

- The unit had responded proactively to changes in the acuity of patients admitted, such as after the move of urology and fractured neck of femur services to the hospital.
- Facilities for patients and relatives in the unit included a kitchen area with snacks, two quiet rooms and toilets.
- There was a good working relationship between critical care staff and a transplant coordination team.
- Numerous link nurses were in post to support individual needs, such as people living with dementia and learning disabilities.

At this inspection, we maintained the rating of good because:

- The service offered a follow up clinic for patients that had been discharged, run by the nurse consultant.
- Clocks that displayed the time, day and date were visible from all part of the unit which would help patients orientate themselves when they woke.
- Each patient on the ICU had a 'patient diary'. This was a diary written to record what had happened to the patient and how they had been cared for.
- The bed occupancy rate had been below or in line the England average for nine of the 12 months prior to the inspection period.

- No critical care patients had been admitted to recovery or other area due to lack of critical care bed in the period April 2016 and May 2017.

However:

- Provision of information in languages other than English was extremely limited.
- The hospital had difficulty in discharging patients in a timely manner.

Service planning and delivery to meet the needs of local people

- The ICU at PRH had eight beds and could care for a maximum of six ventilated patients at one time.
- At PRH there was a large amount of elective work which was mainly specialist orthopaedics and urology comprising around 60% of the activity. This equated to 1-2 major electives being admitted to the ICU each day.
- There was limited space for loved ones to stay overnight although there were some small rooms available that could be used if needed.
- Relatives had access to a kitchen if necessary where they could prepare basic foods should they be staying for a prolonged period of time.
- Since the move of neurosciences to the RSCH, the ITU at PRH took an acute medical take from the emergency department, elective complex orthopaedic patients, urology, spinal and a small number of gynaecology patients. However, the number of patients coming through had not been as high as expected. This was because some of the services that were due to be provided had been moved to other hospitals.

Meeting people's individual needs

- The service offered a follow up clinic for patients that had finished their treatment. This was led by the consultant nurse. We were told that the numbers attending the group were small. The follow up clinic was used as a way to then signpost patients to other, appropriate services for their needs.
- We saw a 'what to expect' folder that was in the relatives room. This contained a range of information that would help those with friends or family in the ITU.

Critical care

- We observed the ward round on the ITU and saw that the whole team were very responsive to each individual patient's needs. We saw that staff took into account the patient's wishes and made the patient the centre of the discussions. Time was taken to listen to what patients wanted to say.
- There was a comfortable, small relatives' room near to the entrance to the unit. In this room there was a 'welcome to the unit' board which had information for friends and relatives on it.
- There was one toilet on the unit that was for use by patients and visitors. This toilet had no disabled access and any patient or visitor that required a disabled toilet would have needed to be taken downstairs to the main hospital reception area.
- There were clocks visible from every bed space across the ITU. These displayed the day, date and time. This would have been particularly helpful for those coming out of sedation or if a patient had dementia.
- Each patient on the ICU had a 'patient diary'. This was a diary written to record what had happened to the patient and how they had been cared for. The patient could then take this with them when leaving the unit. This meant that the patient would be able to know what had happened and provide a timeline to their recovery.
- If the ICU had a patient with a mental health illness, they could access the psychiatric nurse from the emergency department. However, the psychiatric nurse would only attend if the patient was medically fit. A decision would then be made as to where would be suitable for the patient to move to.
- The majority of the patients the ITU cared for did not have advanced care plans. However, we were told that they do have access to the rapid discharge team in the trust who they can seek advice from. We were told how they had been able to get a dying patient home on a ventilator to enable them to die at home.
- Provision of information in languages other than English was extremely limited. There were a number of leaflets that were available for patients and visitors, however, for those that could not read English would have difficulty knowing what information was available. In some leaflets there were statements in other languages directing people where they could access further

information but this relied on people looking at the leaflet. This meant that those that did not speak or read English as a first language could miss the opportunity to access further support.

- Interpreters were available on request through a telephone interpreting service or, if appropriate, an interpreter could be booked to attend the hospital if patients or visitors needed to discuss particular issues.

Access and flow

- When patients' needed to, they could access a bed on the ITU at PRH. However, timely discharges from the unit were more problematic.
- Between February 2016 and January 2017, the trust has seen adult bed occupancy fluctuate, since November 2016 it was above the England average of 83%, however the bed occupancy rate had been below or in line the England average for nine of the 12 months.
- The majority of patients that were stepped down from the ITU would move on to Pyecombe ward at PRH.
- Other than the eight beds on the ITU, there were four HDU beds at the end of the corridor. At the time of the inspection one of these beds was being used for a patient who was recovering from surgery. However, this was not the norm and we were told that the bed spaces were not used as often as anticipated.
- We were told that the planned throughput had not materialised. It was planned that they would take urology patients, fractured neck of femur patients, spinal and complex orthopaedic patients.
- On the unit, there were 2,920 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 5.58%. This compares to the national aggregate of 5.16%. This meant that the unit was in the worst 5% of units nationally.
- PRH had 77 patients documented with a delayed admission of which 66 patients were admitted within four hours.
- There were 460 admissions to the unit, of which 1.3% had a non-clinical transfer out of the unit. Compared with other units this unit was within the expected range. The figure in the 2016 annual report was 1.47%.

Critical care

- On this unit, 4.4% of admissions were non delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. Compared with other units, this unit was within the expected range. The figure in the 2016 annual report was 3.69%.
- The trust had a standard key performance indicator (KPI) that over 57% of patients would be discharged within four hours of a consultant's discharge decision. This KPI had been met in April, May and June 2016 and January 2017. It had not been met in any of the other months between April 2016 and March 2017.
- There had been 12 elective operations cancelled due to a lack of a critical care bed space for the period between April 2016 and March 2017. January 2017 saw eight operations cancelled. The majority of other months in the period did not have any cancelled elective operations.
- The trust had a standard KPI that between 70-80% of bed spaces would be used per month. This was met for April, May, June, August October and November 2016. However they did not meet this target in the other months. This did not always mean they exceeded the 70-80% target as there were months when bed occupancy was below 70%.
- No critical care patients had been admitted to recovery or other area due to lack of critical care bed in the period April 2016 and May 2017.
- The PRH had 77 patients documented with a delayed admission of which 66 patients were admitted within 4 hours (92%) according to the guidelines for the Provision of Intensive Care Services (GPICS): Core Standards for ICUs.
- The trust had a standard KPI of less than 6.3% of patients to be discharged at night (between 10pm and 6:59am). The PRH had achieved this KPI between April and October 2016 as well as in December 2016 and February 2016. The highest percentage of night time discharges occurred in March 2017 when 12% of patients were discharged at night.

Learning from complaints and concerns

- A senior member of staff told us that there had been no complaints received in the last year. This was because if there were any concerns raised by patients or families, they were addressed without the need for a formal complaint to be made.
- An information leaflet called the visitors' code was available for patient and visitors alike. This gave details of the Patient Advice and Liaison Service (PALS) and how to raise concerns with them.

Are critical care services well-led?

Requires improvement



When we inspected critical care services at the Princess Royal Hospital in April 2016, we rated well led as requires improvement. This was because:

- There was evidence of a breakdown in communication between the executive team and the directorate team, which resulted in the inability of local senior staff to obtain approval for urgent issues, such as nurse recruitment.
- Staff were not able to obtain human resources support in a timely manner.
- Staff described "limited communication" from senior leaders and said they rarely got together or had the opportunity to meet.

At this inspection, we maintained the rating of requires improvement for well led. This was because:

- There was no formal vision and strategy in place at the time of the inspection with the senior leadership team waiting for the trust wide vision and strategy to be announced.
- There was a lack of planning and vision to the service. Therefore there was a lack of demonstrable improvement since our last inspection.
- The PRH, at the time of the inspection did not have an IT system that was the same as was available at the RSCH
- The senior management team had not been able to fully deal with the issue of staff being reluctant to travel to the RSCH to work, partly due to the lack of robust human resources support.

Critical care

However:

- Clinical governance meetings were well attended and minutes were thorough. Any actions arising from these meetings had a named person responsible for taking it forward.
- There was evidence of a good culture amongst all staff where teamwork was seen as the key to an effective service.

Leadership of service

- The critical care department was part of the Emergency Floor directorate and was led by a triumvirate that was included the Directorate Lead Nurse, the Medical lead and the General Manager.
- There was a lack of planning and vision to the service. Therefore there was a lack of demonstrable improvement since our last inspection.
- The leadership team in the service had asked for support from the human resources team in how to manage staff that were unwilling to work in other areas of the hospital or travel to the trust's other ITU site at the Royal Sussex County Hospital. At the time of the inspection this had not been resolved.
- The matron for critical care covered both the Royal Sussex County Hospital and Princess Royal Hospital. The Matron had been appointed to the post having submitted an expression of interest in the role to cover a long term absence.
- Below the Matron there was a team of five band seven nurse who managed the nursing staff across the critical care department.
- Staff we spoke with were positive about the local management.

Vision and strategy for this service

- The Senior Management Team (SMT) from the Emergency Floor Directorate told us that the vision and strategy for this service had not been finalised and would be led by the overall trust strategy. The trust strategy had never been embedded due to the changes in the trust executive team since 2014. We were also told that the SMT were targeting the move to a new 54 bed single floor unit in 2021 to provide the vision and strategy that would develop the service. There was a

general acceptance among the SMT that an interim strategy was needed. The SMT were optimistic that the recent changes in the executive team would provide the impetus that would help with the vision and strategy.

- Although the ITU at Royal Sussex County Hospital (RSCH) and the Princess Royal Hospital (PRH) are part of one department, sharing senior management staff as well as nursing staff, the sites do not share a common patient IT system. The system in use at RSCH is not available at the PRH. The SMT wanted to replicate the system at both sites but were constricted by a lack of funding.

Governance, risk management and quality measurement

- The Critical Care department had a monthly clinical governance meeting with a representative from all areas and roles across the department. The meeting was chaired by the clinical lead for critical care. It was attended by the matron, nurse consultant, practice educator, infection control lead, physiotherapist, technician, data manager and pharmacy. The focus of this meeting was to consider risk. These meetings were minuted and any issues were disseminated to the wider team by those present in smaller meetings, for example, at handover from shift to shift. There were also band seven staff away days when there would be wider discussion in order for the band seven's to feedback to their teams. Topics covered in these meetings included, but were not limited to incident reporting, infection control, feedback from the morbidity and mortality meetings, education, staffing and clinical audit. We reviewed minutes of these meetings. The minutes were clear and when action was required, the person responsible was identified.
- It was acknowledged by the senior management team that the biggest risks to the critical care unit at PRH were the lack of an electronic record and information system and the under-utilisation of the four HDU beds on the unit. At the time of the inspection there were no immediate plans to bring the electronic recording system to the PRH in line with the RSCH primarily due to budgetary constraints.
- The trust had appointed a sepsis lead nurse in November 2016. Although they were the lead on sepsis across the trust they were based in critical care and managed by the critical care nurse consultant. Since the

Critical care

lead sepsis lead nurse had been in post they had started a project to increase awareness across the trust. They had provided drop-in sessions for staff and had held awareness days. As a result of this, there were 32 sepsis champions across the trust. Because the role was based at RSCH and the limited time the holder of the position had, there had not been the same level of work carried out at the PRH at the time of inspection.

Culture within the service

- During the inspection, there had been a challenging situation that had involved a number of the team. We were told by staff that it had been handled well by senior staff and they had been offered the opportunity to talk to someone. Senior staff told us that they had considered a formal de-brief but most staff were happy to reflect in their own way.
- There was a clear culture of mutual respect between all of the clinical and non-clinical staff. We were told of instances where good teamwork had come to the fore and that the ICU was generally a pleasant place to work.
- The emphasis on good teamwork that we were told about was reflected in what we saw during the inspection. This had had the effect of staff being willing to raise concerns and report any incidents that occurred.

Public engagement

- The critical care department had their own charitable fund. This was set up as patients and families wanted to make monetary donations as a thank you to the staff and hospitals. Any person who had made a donation to the unit, regardless of the amount would be written to personally by the matron.
- The fund had been used to create and furnish a quiet room for use by visitors to the unit at PRH. They had also been able to purchase a piece of equipment that could be used in critical care and also across other areas of the hospital.
- The hospital, had an ICU specific section on its website for loved ones to access. This have a comprehensive

overview of what a stay in ICU may entail and what they may expect to see when visiting, what would happen after leaving the ICU and a chance to provide feedback. The content of the website was clear and explained in a way that was not clinical.







Staff engagement

- The SMT told us that they emailed a newsletter to staff with key themes covering a range of topics and would check with staff on their rounds to get assurance that their messages had been disseminated effectively. This was hard to quantify during the inspection as there was no way of evidencing that all staff had read the communications that had been sent.
- The deputy chief nurse ran patient improvement meetings with the band seven nurses across the trust.

Innovation, improvement and sustainability

- The critical care SMT told us how they were working on a plan to improve the flow through critical care. They had begun making plans for a Rapid Improvement Pathway which will enable those patients well enough to move to a ward or leave the hospital to do so more quickly. The plans had had multi team representation to bring together, make the change and implement. When the plans were completed, they would need to be ratified by the trust board.
- The critical department were also looking to employ two academics to join the team. They would need to be both researchers involved in clinical practice.
- The trust had appointed a Clinical Risk Nurse for critical care. The role was intended to work across the trust although at the time of inspection they were only working at the Royal Sussex County Hospital. The role was full time and planned to last for a minimum of two years. The role was developed as there were concerns among senior managers that themes from incidents reported would not be picked up and learning opportunities to prevent a repeat would be missed.

Maternity and gynaecology

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

Information about the service

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

Brighton and Sussex University Hospital NHS Trust has 79 Maternity beds across the two sites. Of these beds 35 are located within two wards at Princess Royal Hospital (PRH) and 44 are located within two wards at Royal Sussex County Hospital (RSCH).

The gynaecology unit has 21 beds across the two sites. These are located within one ward at PRH and within one ward at RSCH. From April 2016 to December 2016, 1788 women delivered their babies at PRH.

Maternity is based in the main hospital building. Antenatal clinic and Day Assessment Unit are on the ground floor. The Early Pregnancy Unit (EPU), Bolney Ward (Antenatal and Postnatal) and Central Delivery Suite (CDS) are on the second floor. Horsted Keynes (gynaecology) ward is on the second floor.

The rate of births at PRH remained constant in the nine months between April and December 2016. On average there were 199 deliveries a month.

PRH provides gynaecology services including outpatient clinics and an early pregnancy unit for women experiencing difficulties in the first few weeks of pregnancy.

Horsted Keynes ward is a 12 bedded gynaecology ward for women before and after surgery. This ward had a six bedded bay and six side rooms, mainly used for women experiencing miscarriages. There is no emergency gynaecology service at PRH.

Antenatal services include a range of clinics for pregnant women attending for a first booking appointment and for women considering the options available for the birth of their baby. There are consultant-led clinics and clinics for conditions such as diabetes. There are a range of specialist midwifery led clinics including: teenage pregnancy; homelessness; and substance misuse.

The antenatal clinic has a DAU, a triage service, and an eight-bedded labour ward, with mostly ensuite facilities.

Bolney ward is a combined antenatal and postnatal ward with 27 beds. There is a level 1 neonatal special care baby unit (SCBU) at PRH. However, women likely to deliver their babies before 34 weeks gestation would give birth at the RSCH in Brighton where there is a neonatal intensive care unit (the Trevor Mann Baby Unit).

Three teams provided community midwifery services, covering the Brighton and Sussex University Hospitals NHS Trust community area.

We spoke with over 20 members of staff at PRH from both gynaecology and maternity. We spoke with specialist midwives and managers working at ward level at PRH. We spoke with eight patients from the gynaecology and maternity service. We also looked at 12 sets of patient records.

Maternity and gynaecology

Summary of findings

During our last inspection we rated the service as requires improvement. However, during this inspection we rated the service good because:

- During our last inspection we found mandatory training figures were low in many areas across maternity and gynaecology services. There was some improvement, and overall services were meeting the trust mandatory training target of 75%.
- During our previous inspection a range of guidelines were out of date and past their review dates. However, we found all guidelines had been reviewed and were in date with monitoring in place for further reviews.
- There had been issues with multidisciplinary working when the hospital was last inspected, with some poor behaviour from staff including consultants. However, this was widely reported as improved with a new consultant body and we saw a much improved multidisciplinary approach across the directorate.
- The last inspection highlighted some issues around consent, this had been addressed through a variety of means and we saw consent was given the appropriate importance and that staff followed trust policy.
- Although there was no midwife led unit for women the staff were committed to providing and promoting normal birth. Women were offered a choice of birthing options and the trust had high homebirth rates.
- The trust employed a dedicated preceptorship midwife and a midwifery placement educator who met with midwives throughout their employment. They also helped with the training development of student and newly qualified midwives.
- Feedback from women and their families which was positive about staff kindness and compassion.
- Staff treated patients with dignity and respect.
- Patients were involved in their care and treatment.
- Women were supported in making informed choices about birth settings which were appropriate to their clinical needs.
- Patients had access to services to support their emotional wellbeing.
- During our previous inspection we found Referral to treatment times (RTT) were not being met for admitted patients pathways completed within 18 weeks. However, the percentage rates were seen to be improving during this inspection with RTT targets being met 94% compared to the national average of 95% reported in February 2017.
- All patients received diagnostic tests with six weeks between July 2016 and February 2017, which was better than the national target. This showed an improving picture and that the gynaecological needs of women were mostly delivered in a timely way.
- During our previous inspection we found women were often being transferred and units were being closed due to lack of staff. This had improved as there were no closures reported at PRH from April 2016 to January 2017.
- There had been no occasions between April 2016 and December 2016 when the central delivery suite (CDS) had needed to send women to RSCH. This was an improvement from April to December 2015 when the CDS had been sending an average of two women a month to RSCH.
- There was adequate support in place for dealing with patients with complex needs, learning disabilities, and dementia patients seen on the Gynaecology wards.

We also found:

- Incident reporting had improved since our previous inspection in April 2016. We found feedback was routinely given via a number of methods. However, we did see some incidents not categorised in line with trust policy and some incidents that did not have actions to mitigate risks recorded.
- Staff felt they were under pressure despite an increase in staff numbers. Last time we inspected staff felt that patient safety was compromised by low

Maternity and gynaecology

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

- Some staff in maternity services were wearing denim jeans in clinical areas. This was not in accordance with the trust's dress code policy.
- We viewed a range of equipment on the Central Delivery Suite (CDS) and found daily checks were not recorded regularly.
- Babies on the CDS were not tagged and although there was secure door entry with CCTV there was a risk babies could be removed from the ward without staff being alerted.
- There has been no further development of a midwife led birthing unit (MLU) since our last inspection.
- Complaints were not dealt with in a timely way and within the trust's published policy timescales.
- We still found that there was not clear leadership from the top of the organisation to the bottom.
- There were no assurances that all staff were engaged in feedback from the trust although staff were positive about departmental leadership.
- Prior to our inspection maternity and gynaecology services were self-rated. However, the ward staff and divisional managers we spoke to had no input into these self-ratings; this demonstrated a lack of consultation with staff by the executive team.
- The directorate did not take part in morbidity and mortality meetings. This could mean that any deaths within the service were not robustly reviewed to identify learning or shortcomings in practice.

Are maternity and gynaecology services safe?

Requires improvement



During our last inspection we rated the service as requires improvement for safe because:

All areas of the service had staffing shortages; midwives had to attend the obstetrics theatre to provide assistance for elective caesarean sections; some consultants did not engage with each other in the safety aspects of the service; there was a high use of locum doctors; attendance at mandatory training was affected by staff shortages, with compliance from medical staff being particularly poor.

During this inspection we still found services required improvement because:

- We found incident reporting had improved since our previous inspection in April 2016. We found feedback was routinely given via a number of methods. We did see some incidents not categorised in line with trust policy and some incidents that did not have actions to mitigate risks recorded.
- On our previous inspection staff felt that patient safety was compromised by low and exhausted staff. This time we saw an improvement in staff numbers. However, the maternity department had not used the nationally recognised, maternity specific, acuity tool to determine the numbers of midwifery staff needed.
- During our last inspection we found mandatory training was low in many areas across maternity and gynaecology services. There was some improvement on our recent inspection and overall services were meeting the trust mandatory training target.
- Some staff in maternity services were wearing denim jeans in clinical areas. This was not in accordance with the trust's dress code policy.
- We viewed a range of equipment on the Central Delivery Suite (CDS) and found daily checks were not regularly recorded.

Maternity and gynaecology

- During our previous inspection we found safeguarding training was below the trust target. The rates of staff attending safeguarding training had improved and were meeting the trust's target of 75% for levels one and two adults and children.
- Babies on the CDS were not electronically tagged; this posed a security risk as staff were not alerted if babies were taken off the ward.

Incidents

- The maternity and gynaecology service used an incident reporting system widely used in the NHS. We found incidents were consistently reported across teams; and staff used the reporting system appropriately. There was a comprehensive process of review and monitoring for incidents at the monthly 'Women's Services Quality and Safety Meeting,' this was a directorate meeting attended by directorate and ward leads.
- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. Between March 2016 and February 2017, the trust reported one incident which was classified as a Never Event for Maternity and Gynaecology. The incident occurred in November 2016 at the PRH. The incident was in relation to a retained swab after a spontaneous vaginal delivery. There was no documentation within the notes regarding intended retention or a plan for later removal. The swab count was signed as correct.
- We viewed the root cause analysis (RCA) in regards to the never event in November 2016. This documented actions the trust had taken in regards to the investigation of the never event. The investigation identified "care and service delivery issues" and found the root cause of the incident to be clinicians not taking clear responsibility for the swab count; and a plan of removal of the swab was not documented in the patients' notes. Lessons learnt, an action plan, and timescales were in place in response to the never event, including: the clinicians receiving supervision on documentation and communication; a review of the culture of the service around swab counts; offers of refresher training for staff; further training for doctors; and an audit of documentation. The investigation report and action plan was disseminated to staff at the February 2017 'Women's Services Quality and Safety Meeting,' and plans were in place for this to be monitored at subsequent meetings.
- In accordance with the Serious Incident Framework 2015, PRH reported two serious incidents (SIs) in Maternity and Gynaecology which met the reporting criteria set by NHS England between March 2016 and February 2017.
- We reviewed the last four months of reported incidents and found most were reported as 'no harm: impact prevented'. On review we found that this was sometimes not in line with trust guidance. For example the trust policy 'Incidents should be graded according to the actual harm caused'. The policy gave examples of appropriate measures of grading, stating 'no harm' as 'no injury (either prevented or not prevented)' and 'low harm' as, 'Minor injury or illness requiring limited medical treatment /extra observation'.
- We reviewed an incident report where a baby was returned to PRH accident and emergency department on day 15 with an injury which was identified as a fractured clavicle, (collar bone), due to birth injury. However, this was documented as 'no harm' on the incident report. This posed a risk of incidents being classified incorrectly and could lead to trends and themes not being identified.
- The trust incident policy provided guidance for staff on reporting, investigating, learning lessons, implementing and sustaining change as a result of investigation findings and analysis of incidents'. On review we found that incidents were not always investigated in accordance with the trust policy. For example, an incident dated 19 February 2017 recorded a grade 2 pressure sore on a patient in Horsted Keynes ward. The incident log did not record the details of whether this was a hospital acquired pressure sore; and there was no information in regards to whether the incident had been reviewed or action plan recorded to mitigate the risk of patients developing pressure sores. There was a further incident dated 17 February 2017 which involved a patient having four blisters underneath a dressing, the incident record recorded that the ward manager had

Maternity and gynaecology

requested the patients notes; but, there were no actions recorded on the incident log in regards to the investigation of the incident and actions the ward had taken to mitigate the risk to the patient.

- We found that staff were recording some incidents for trend analysis, this enabled the trust to monitor the frequency and types of incidents to assist in identifying risks to patients. For example, 5 August 2016 staff on Horsted Keynes ward had recorded a patient having their surgery cancelled due to the unavailability of a theatre, and the patient being re-booked. The incident report recorded that the incident was 'recorded to aid trend analysis'.
- We found that most incident reports involved staffing shortages. This was a change from our previous inspection in April 2016, when staff had reported that staffing shortages were not being recorded. We also saw a trend in documentation incidents being recorded across maternity services.
- Maternity and gynaecology services had introduced weekly incident review meetings. The meetings were to review incidents across services and identify learning. We saw information displayed on Horsted Keynes ward listing the venues and dates of the meetings in 2017.
- All incidents were discussed at this meeting including ongoing investigations and learning from incidents. 'Lessons of the week' were identified at the meetings and fed back to both the maternity and gynaecology departments via the 'message of the week' newsletter. We saw these displayed on the wards and in the staff rooms and members of staff across the service confirmed they were useful.
- The trust's adverse incident policy carried guidance and templates for staff on incident reports, recording and reporting; as well as patient safety case reviews (PSCR), these were reviews of incidents where patient safety may have been compromised. PSCR's were led by governance leads and reported at monthly governance meetings. PSCR's were action plan driven. Staff on Horsted Keynes ward told us they received an email when incidents were closed on the electronic reporting system.
- We saw a 'lessons learned' folder in the staff office. This contained information on the 'never event' investigation dated November 2016. The folder also contained

information on patient safety case reviews dated 29 February 2016, 14 March 2017, and 30 March 2017. Staff told us the folder was used to disseminate learning from incidents to staff. However, there was no system in place to ensure staff had read the folders contents.

- The service had introduced a series of newsletters to disseminate learning from incidents. For example, we reviewed the service's 'Quality Tweet' monthly newsletters from January to March 2017. The newsletters carried summaries of patient case studies and lessons learnt from the incidents identified in the case studies. The newsletters were displayed on staff noticeboards.
- The duty of candour is a regulatory duty under the Health and Social Care Act (Regulated Activities Regulations) 2014, that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of "certain notifiable safety incidents" and provide them with reasonable support. Duty of candour was included in new staff induction training. Staff on Horsted Keynes ward told us they had received training in the duty of candour 18 months ago. Overall, staff we spoke with across maternity and gynaecology were aware of their responsibilities in regards to the duty of candour.
- The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and other providers; these include safety alerts, Chief Medical Officer (CMO) messages, drug alerts, 'Dear Doctor' letters and medical device alerts. The Women's Directorate scorecard dated April 2016 to January 2017 recorded that there had been no breaches of implementation of CAS alerts across all of the trust's hospital and community sites in the period.

Safety thermometer

- The NHS Safety Thermometer is a monthly audit of avoidable harm including new pressure ulcers, catheter urinary tract infections and falls.
- The NHS Safety Thermometer information for measuring, monitoring and analysing harm to patients and harm free care is collected monthly. We saw a poster on the noticeboard on Horsted Keynes ward with

Maternity and gynaecology

details of infections on the ward and details of information the ward supplied for the safety thermometer. The poster was dated for the period of May 2016 to April 2017 and recorded that there had been no cases of Methicillin-resistant Staphylococcus Aureus (MRSA), no cases of Clostridium Difficile (C diff), five falls and no occurrences of pressure damage grade three or above.

- We viewed Women's Services Directorate scorecard for the period April 2016 to January 2017, this confirmed that there had been no cases of MRSA, no cases of C diff, no occurrences of pressure damage grade three or above recorded, and no falls resulting in severe injury or death, across the directorate during the period.
- There were also no incidents reported on the Safety Thermometer for Bolney Ward and the Central Delivery Suite (CDS) for the same period.
- The Women's Services Directorate scorecard recorded that between April 2016 and January 2017, Women's Services had consistently not met the trust's 95% target for venous thromboembolism (VTE) risk assessments, these are assessments of whether patients are at risk of formation of blood clots in the vein. The compliance rates during this period ranged from 87% to 91%.

Cleanliness, infection control and hygiene

- The service had not met the national specifications for cleanliness (NSC) during our previous visit in April 2016, due to all staff not having a work schedule. The NSC states: 'Management of staff - All levels of the cleaning team should be clear about their roles and responsibilities. Each member of staff should have a clear understanding of their specialised responsibility, in the form of a work schedule'. However, the ward manager at Horsted Keynes ward showed us work schedules the trust had produced and these were accessible on the trust's intranet. We also viewed cleaning schedules for Bolney ward and the central delivery suite (CDS). This meant staff would be aware of what tasks other staff had completed and minimised the risk of areas not being cleaned.
- We saw a cleaning board on the Central Delivery Suite (CDS) which clearly defined staff roles and

responsibilities in regards to cleaning tasks. The board also displayed the contact numbers for the hospital's housekeeping staff, portering services, and the hospital's estates department.

- The cleaning and infection control noticeboard on the CDS displayed that the ward had a cleanliness score of 98.75% compliance with the trust's IPC standards. We viewed the trust's audit spreadsheet for IPC. This recorded the CDS as having 98% compliance for the period 6 February 2017 to 27 March 2017. This was above the trust's IPC target of 95%. Figures for other units in the same period were: Theatres (99%); and Horsted Keynes ward (99%). Bolney ward had an IPC compliance rate of 97%.
- Clinical staff were required to comply with the, "five moments for hand hygiene" as set out by the World Health Organisation (2009) and with the trust's hand hygiene policy. We saw alcohol based hand sanitizer was available on all the wards and units in maternity and gynaecology at PRH. We saw staff, patients, and visitors using hand sanitizer.
- We viewed hand hygiene audit results from all maternity and gynaecology services dated from February to April 2017. All services regularly achieved 100% compliance with hand hygiene.
- We saw the results of hand hygiene audits on Horsted Keynes ward from May 2016 to April 2017, the average score during the period was 97.9%.
- Maternity and gynaecology services were using, "I am clean," stickers on equipment to indicate that the equipment had been cleaned and was safe for use, as well plastic covers to protect clean equipment.
- Sharps bins were available in treatment areas in accordance with Health and Safety Regulation 2013 (Sharps Regulations), 5 (1) d. This requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw labels on sharps bins had signatures of staff, and records of when the sharps bin was constructed, by whom and on what date.
- Horsted Keynes ward had an isolation room with en-suite facilities available for infectious patients.

Maternity and gynaecology

- We saw staff in clean uniform, bare skin below the elbows with long hair tied back on Horsted Keynes ward. This was in line with the trusts uniform policy.
- However, we saw some staff in maternity services wearing denim jeans in clinical areas. This was not in accordance with the trust's 'Dress Code Policy, 6.1, Clothing', May 2015, which states, "Trousers should be tailored and smart. Jeans, ski pants, leggings, jeggings or combat style trousers are not permitted."
- We saw a doctor enter a room where we were interviewing staff with a face mask tied and hanging around their neck. The doctor then returned to the theatre. This also carried a risk of contamination.

Environment and equipment

- During our previous inspection staff reported a shortage of Cardiotocography (CTG) machines for recording foetal heartbeat and uterine contractions on the labour ward and on Bolney Ward. The service informed us that the Head of Midwifery (HOM) had reviewed the number of CTG machines and was content there were sufficient CTG machines at PRH. In the event of the sensors not working these had been ordered and replaced. Three of the sensors measuring contractions were broken and were sent for repair.
- We viewed a range of equipment on the Labour ward and found daily checks were not regularly recorded. For example, the week commencing 10 April 2017 there were no records of equipment having been checked; the week commencing 17 April 2017 there were two days when equipment check records had not been completed. We also found a range of dates between 3 March 2017 and 17 April 2017 when daily equipment check records were incomplete. This meant staff could not be sure that the equipment they were using had been checked and was fit for use.
- Maternity and gynaecology services had asset register of equipment for servicing and repair. The asset log was held by the equipment store and technicians, who informed the ward when equipment was due for servicing. Equipment had stickers in place which recorded when equipment was next due for servicing.

- Staff had an over-ride key for the lifts between floors. This ensured patients could be transferred to theatres on the first and second floors. Staff said the lift was not used often for the transfer of patients, and was used mainly out of hours.
- Community midwives had access to cars to use when in the community. Midwives checked equipment in the car at shift changeover.
- The Women's Risk Register dated 1 March 2017 identified a "significant risk" due to delivery beds on the labour ward requiring replacement. The register recorded that a business case had been developed and charitable funds were identified to purchase half of the beds needed, (a total of 15 beds for both RSCH & PRH). However, the risk was reviewed on 14 March 2017 and remained on the risk register as half the beds were still in need of replacement.
- At our last inspection we found the doorways to some maternity services side rooms were too narrow to allow a bed to pass through. The service informed us that the doors to the side rooms still did not facilitate the movement of beds. However, in mitigation the service risk assessed women, so only low risk women went into these rooms. Transfer trolleys were also available should a woman require moving via a bed.
- We saw emergency equipment was available and ready to use. Records confirmed that the equipment had been checked on a regular basis every day.

Medicines

- Intravenous fluids on Horsted Keynes ward were stored in a secure area with keypad entry. The drug fridge was locked and secure and the contents were in date. Staff checked the fridge temperature daily, and we saw that it was in the correct range from March 2017 to April 2017.
- When we inspected medicines on Horsted Keynes ward in April 2016, we found various medications stored together without original packaging. In response the ward had placed laminated notices in medicines cupboards to remind staff to record dates and return drugs to their original packaging. We found drugs had dates recorded and were in their original packaging. However, we found the dates when medicines were opened were not always written on liquid medicines on Horsted Keynes ward.

Maternity and gynaecology

- Medicines were stored securely and were within their expiry dates.
- CD cupboards were locked, the stock was correct, and records indicated the appropriate checks had been completed. Staff told us they would record any differences between controlled drugs stocks and those recorded on the trust's electronic incident reporting system. Six monthly CD audits were undertaken to monitor use of CD medicines.
- Staff checked and recorded medicines required in an emergency on one record. We saw all drugs were stored and recorded appropriately. Staff told us the pharmacist visited daily to ensure drugs were stored and recorded.
- Wall mounted lockable cupboards, were available on the Bolney and Horsted Keynes wards to keep personal pain relief medication securely by the bedside. Staff told us when women brought their own medicines to the hospital that two nurses would check and record the medicines.
- The labour ward were not recording ambient room temperatures. This created a risk that drugs could be stored at inappropriate temperatures at times of inclement weather.
- Administration records showed no missed doses of medicines, although intentionally omitted doses were not always recorded in line with trust policy. We reviewed a prescription chart on Horsted Keynes ward and found this was legally valid and contained information about the person's allergies.
- We found waste medicines were handled appropriately.
- Staff told us that pharmacy staff, both pharmacists and technicians, provided information to people about their medicines.
- Staff on the obstetric and gynaecology wards told us they had to complete paper based admission and discharge records for three separate systems. Staff said this was confusing and time consuming.
- The Women's Risk Register dated, 1 March 2017, identified a "significant risk" due to maternity records being held in pigeon holes where staff and the public could access them as there were no security controls in place. To mitigate the risk the register recorded that the area was locked at night. The risk had been on the register since the 30 June 2011. On 22 December 2012 the register noted that this was being "progressed." However, even though the register recorded that the risk was reviewed in March 2017, there were no further updates on the progress, which indicated that the risk was not addressed in a timely manner.

Safeguarding

Records

- Pregnant women had handheld records that they kept with them and they took to antenatal appointments and a "red book" for their baby's medical records. We looked at three sets of patient records on the postnatal ward and a further three sets on the gynaecology ward.
- We found a high standard of record keeping. Records contained reason for admission, initial assessments of needs, short and long term goals and care plans.
- The service had a dedicated midwife for safeguarding, who worked 30 hours a week, covering maternity and the neonatal services. The lead was also a supervisor of midwives. Staff told us safeguarding issues in the community would be referred electronically to the safeguarding team by the community midwives.
- The trust had a named nurse and named doctor for safeguarding. The lead director for safeguarding was the Chief Nurse.
- Staff were aware of how to refer safeguarding concerns to the local authority safeguarding team.
- In situations where a woman had complex needs or there were domestic abuse issues, the safeguarding midwife would support the community midwives.
- The safeguarding midwife attended case conferences and core group meetings in the absence of the community midwife.
- Comprehensive pre-birth plans were developed and these were in place from 36 weeks of pregnancy.
- Since September 2014, it has been mandatory for all acute trusts to provide a monthly report to the Department of Health (DoH) on the number of patients who have had female genital mutilation (FGM) or who have a family history of FGM. In addition, where FGM was identified in NHS patients, it was mandatory to record this in the patient's health record. The service had a

Maternity and gynaecology

clear process in place to facilitate the reporting requirement. The trust had protocols in place to guide staff on the reporting of FGM. Training in FGM was also part of staff mandatory training.

- Training data supplied by the trust indicated that 92% of eligible staff in this service had current training in safeguarding children and young people training at level 1, 87% eligible staff had completed level 2 and 44% of eligible staff were up to date with this training at level 3. Overall 87% of staff had current training in adult safeguarding.
- We saw policies that reflected automatic safeguarding referrals were made for pregnant children less than 14 years of age and consideration of referral for children up until they were 16.
- Community midwives received group supervision each month from the safeguarding midwife. Midwives attended level 3 training as part of the mandatory training days.

Mandatory training

- The trust set a target of 75% for completion of mandatory and statutory training overall. This is a lower target than similar NHS trusts. A breakdown of compliance for mandatory courses between April 2016 and February 2017 for medical, nursing and midwifery staff across maternity and gynaecology services found: fire safety (86%); infection control for clinical staff (91%); mental capacity training (81%); safeguarding adults at risk (87%); safeguarding children level one (92%), level two (87%), level three (44%); equality and diversity (89%); VTE (77%); health and safety (86%); information governance (94%); and adult basic life support (89%).
- Staff were given five days to complete training a year and training was by e-learning or booked training courses. Each day of training incorporated several aspects of the required training.
- Staff also received mandatory training in specific maternity safety systems, including responding to childbirth emergencies such as post-partum haemorrhage (excessive bleeding following delivery) and CTG interpretation as well as normal birth and infant feeding.
- We spoke to the nurse practitioner about mandatory training and she told us of a new initiative to make sure

staff completed training and the introduction of a new computer-based system which alerted managers of any staff members who were not up to date with training. However, the system was not fully integrated in maternity as it did not allow the addition of maternity specific training. Also, within gynaecology not all staff were on the system yet. Both these factors contributed to data not reflecting a true picture of the mandatory training figures.

- Staff were given advance warning of training days.

Assessing and responding to patient risk

- We noted that babies on the labour ward were not tagged, this posed a security risk as a baby could be taken by mistake or abducted.
- We found that where maternity staff were using the maternity early warning score (MEWS), this is a tool that measures the degree of illness of a patient based upon their vital signs, the scores had not been totalled and therefore staff could not make a judgement on a patient based upon their overall MEWS score.
- Horsted Keynes used the National Early Warning Score NEWS. There were monthly audits of nursing metrics on Horsted Keynes ward. This involved staff being observed undertaking patient observations including: blood pressure monitoring, recording of patients respiratory rate, National Early Warning Score (NEWS) being calculated, and observations by health care assistants (HCA) being signed by a qualified nurse. We viewed the trend analysis for the monthly audits and found from February 2016 to January 2017, there had been improvements in the wards performance in regards to nursing metrics, with a compliance rate for the year of 98%.
- There were systems in place to assess and manage risk, including venous thromboembolism (VTE) assessments for the risk of a blood clot forming. The Women's Services Directorate scorecard recorded that between April 2016 and January 2017, Women's Services had consistently not met the trust's 95% target for venous thromboembolism (VTE) risk assessments. The compliance rates during this period ranged from 87% to 91%.

Maternity and gynaecology

- Where surgery had been involved, we saw staff completed the WHO Five steps to safer surgery' checks and anaesthetic records.
- The Princess Royal Hospital had completed an audit of the World Health Organisation (WHO) Five steps to safer surgery checklist in March 2016. The results of the audit were rolled out to surgical staff as a presentation. We viewed the presentation and saw that areas of non-compliance were highlighted, with attention being given to the question, "Has the neonatal team been called?", as compliance with this checklist question was found to be below 50%. In response there was an action plan to introduce audits of the WHO checklist on an annual basis.
- The nursing staff information board on Horsted Keynes ward had a sepsis, blood poisoning, guide for staff. This provided information on early identification of the signs and symptoms of sepsis. The information board also informed staff that work was in progress to introduce a new Sepsis Screening Tool.
- The staff information board also gave staff emergency contact numbers for the emergency team in medical emergencies.
- Staff used monitors to assess the foetal heart during pregnancy and labour for women with a pregnancy regarded as high risk. These included women undergoing induction of labour or women with twin pregnancies.
- The department uses a system of 'fresh eyes' on all CTG monitoring. This is a system where a review of the CTG printout is undertaken by another midwife or medical staff to check there is agreement in its interpretation. This system helps identify possible misinterpretation. We spoke to staff who said they felt able to challenge colleagues if they disagreed with a reading.
- Situation, Background, Assessment, Recommendation; (SBAR) is a technique that can be used to facilitate prompt and appropriate communication. The tool was used during handovers where there were concerns about a patient on Horsted Keynes ward. We did not see the tool in use as there were no patients for whom staff had concerns at the time of our inspection. However, we did see guidance for staff in using the tool displayed on the staff information board.
- Staff at Horsted Keynes ward showed us 'Prompt Cards' on key rings they had been issued with. These carried guidance for staff on how to contact the trust's specialist palliative care team and acute oncology team, as well as actions to take in the event of a patient developing suspected Sepsis, blood poisoning. The cards also carried guidance on acute kidney injury and the use of the national early warning score (NEWS), a tool used to identify if a patient is deteriorating, as well as guidance on actions to take in response.
- Emergency evacuation equipment was available and ready to use in the birthing pool rooms.
- There was a dedicated triage service available 24 hours a day, women could call with any concerns or worries and for advice.
- An unwell baby in the first 24 hours of life could return to PRH labour or postnatal ward for assessment. An unwell baby over 24 hours old would go to the RSCH. If a baby required high dependency care it would be transferred to the RSCH.
- Babies born at home who required clinical assessment for jaundice, feeding difficulties or poor weight gain would be seen on SCBU and admitted to Bolney ward, if assessed as requiring inpatient admission.
- There had been one community maternal death reported in August 2016. This was of a mother discharged from the Royal Sussex County Hospital.
- All preterm deliveries over 33 weeks with an estimated foetal weight of over 2kg would be attended by a neonatal team doctor and a nurse. All preterm deliveries with an estimated foetal weight of 1kg would be attended by a consultant neonatologist, neonatal doctor and neonatal nurse.
- We viewed a 'message of the week' newsletter dated 30 May 2017 that advised community midwives about the use of aspirin in early pregnancy in the event of pre-eclampsia. The use of aspirin was also included in the trusts 'provisions and schedules of antenatal care, 2015.' The trust had also produced a leaflet for women which explained the benefits of aspirin for women at risk of pre-eclampsia.
- Women with high risk pregnancy were routinely attended by consultant obstetricians during birth to ensure the safety of mother and baby.

Maternity and gynaecology

- Women could access an early pregnancy unit (EPU) located at the RSCH if they had bleeding and/or pain. The EPU helped women identify the cause of symptoms and offered advice, support and any treatment which may be needed.

Midwifery and Nurse staffing

- Most approaches to planning staffing rely on quantifying the volume of nursing care to be provided on the basis of the size of population, mix of patients, and type of service and relating it to the activities undertaken by different members of the team. As of December 2016 the trust reported their maternity staffing numbers as 66.02 whole time equivalent (WTE) established staff, the actual number of staff employed in maternity at PRH was 65.34. This meant there was 0.68 less WTE staff in post than the actual number of staff required to provide care. Bolney Ward had 1.14 less WTE staff in post than the actual numbers identified to provide care.
- Managers told us there was a work force planning tool in use at the hospital to monitor 1:1 care of women in labour. The directorate were using the 'Shelford Safer Nursing Care Tool' to assess required staffing levels. However, maternity services were not using a recognised specific maternity acuity tool, such as Birthrate Plus. We found the tool informing the staffing and skill mix required on each shift was not applied appropriately at all times and found the acuity tool was incomplete.
- We reviewed an incident in which a manager was unable to review the workload for Bolney ward or triage as there was no daily staffing sheet for the ward and the triage log book for the 28th January 2017 was missing. The incident report recorded that there was 1:1 staffing on the delivery suite on this date. The manager recorded this as manageable, but said two patients with complex needs had also required 1:1 care, and the service had been unsuccessful in trying to source a bank worker and the shift remained unfilled. In response following the incident the service had made all staff aware of the escalation policy for staffing concerns; but this did not address the identified issues with the use of the acuity tool.
- Midwives on the maternity unit told us staffing could be an issue. However, shifts were covered by staff working extra shifts and the use of bank staff. We noted from our

review of the electronic incident record that staffing shortages were recorded as incidents. This enabled the trust and Women's directorate leads to monitor staffing levels in maternity services.

- We looked at the trust's fill rate indicator return dashboard for the period October 2016 to March 2017, for planned and actual staffing levels in maternity obstetrics. This indicated the actual staff hours on the maternity ward night and day were less than the planned hours for all nursing staff groups. The difference between planned and actual midwife hours for night time shifts in October 2016 was 717.5 hours. However, in regards to Horsted Keynes ward the dashboard only recorded the planned hours and we were unable to establish the levels of actual staffing in gynaecology from viewing the fill rate indicator dashboard.
- The planned midwife to birth ratio target was 1:30. From April 2016 to January 2017 this target was met all months. These targets were achieved with the use of bank staff when needed.
- The trust had a target of 100% 1:1 care in labour. The average rate for the hospital between April and December 2016 was 96%.
- We viewed the Women's performance scorecard for the period April 2016 and January 2017. The scorecard gave divisional data across all the trust sites and was not specific to PRH. The scorecard recorded the vacancy rate across the Women's division as between 4.5% and 4.8% in the period April 2016 to January 2017. This was worse than the trust's target rate of 3.4%.
- In February 2017, the trust reported a turnover rate of 30% in Maternity and Gynaecology. The service did not use agency staff often but employed its existing staff undertaking additional shifts as part of the trust 'bank'.
- In February 2016 the trust reported a bank and locum usage rate of 7.9% in maternity and gynaecology.
- Staff on Horsted Keynes ward told us they had two health care assistant (HCA) vacancies and two qualified nursing, band 5, vacancies. The ward manager told us they had interviewed for the band 5 vacancies and the HCA vacancies were being advertised on NHS jobs website and the trust's website. However, the manager

Maternity and gynaecology

said there were localised difficulties recruiting nursing staff, due to potential recruits having the option to work in Brighton or London. Staff told us the vacancies had made staffing “challenging.”

- Staff on Horsted Keynes ward told us they could use the trust’s bank to fill vacant shifts, and if these could not be filled by bank, they could request agency staff. Agency staffing had to be authorised by the Matron. The ward manager also told us they would cover clinical work if the ward was short staffed. Staff told us they always recorded staffing shortages on the trust’s electronic incident reporting system.
- We saw rotas for planned staffing levels for Horsted Keynes ward from January to April 2017. We found that, in most cases the planned and actual hours were similar. The ward manager told us staff vacancies were mostly being covered by the ward staff covering additional hours.
- Between April 2015 and March 2016, the trust reported a sickness rate of 3% in maternity and gynaecology.
- We observed a ‘safety huddle’ on Horsted Keynes ward. This was attended by nursing staff and the ward manager. Staff were updated on all patients on the ward, including the results of any tests patients had undergone.
- Midwives were acting as scrub nurses in theatre for caesarean sections. However, the service had engaged theatre nurses to perform this task from June 2017. This meant midwives would be in theatres for the mother and baby only.

Medical staffing

- As from February 2017, the trust reported a vacancy rate of 13% in medical staffing for maternity and gynaecology. This represented 1 WTE vacant speciality doctor post at the Royal Sussex County Hospital and 1 WTE consultant post at PRH. The trust has subsequently informed us the consultant post at PRH has been filled.
- As from February 2017, the trust reported a turnover rate of 55% in maternity and gynaecology. However, the turnover rate of 55% might not be a true reflection for maternity and gynaecology service as the one speciality doctor changed twice in one year giving the trust a higher rate.

- Between April 2015 and March 2016, the trust reported a sickness rate of 4% in maternity and gynaecology.
- As from November 2016, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was slightly higher. However, a consultant we spoke with told us PRH was fully staffed with doctors at the time of our inspection.
- Obstetricians, paediatricians and anaesthetists were available 24 hours a day. Consultant presence was provided on-site seven days a week for 14.5 hours a day, with a consultant available on call for the remainder of the time. PRH were meeting the trust target of 40 hours dedicated consultant cover on the CDS.
- There was consultant cover Monday to Friday from 8.30am to 5pm. Out of hours consultant cover was off-site. However, staff told us the consultant was easily contactable. There was a consultant on call for 24 hours, Monday to Friday, the consultant was resident and on call from 08:30 - 17:00. There was a registrar and junior doctor on call, for CDS, 24 hours a day from 08:30 to 20:30 and 20:30 to 08:30. There was a junior doctor covering post-natal and DAU. However, staff told us the consultant was easily contactable.
- The consultant on call also covered gynaecology. During the day Monday to Friday between 08:30-17:00 there was a separate registrar and junior doctor on call covering gynaecology. At the weekends the registrar and junior doctor covered both obstetrics and gynaecology.
- A few staff told us junior doctors felt pressurised by some consultants to work extra shifts, in November and December 2016, due to winter pressures. However, this had reduced due to an increase in consultant numbers and winter pressures easing.
- Staff told us medical staffing had improved, due to a more stable group of registrars and consultants and a reduction in the use of locum doctors.
- We observed a handover meeting on the maternity unit. This was attended by a registrar and junior doctor, as well as the midwife in charge, the safeguarding midwife, and incoming midwives. Staff discussed safeguarding

Maternity and gynaecology

concerns about a woman who was in labour, as well as updating incoming staff on women on all the other women on the ward. Staff told us anaesthetists also attended ward rounds and handovers.

Major incident awareness and training

- We saw a copy of the trust wide emergency preparedness, resilience and response policy which included a business continuity plan. Staff we spoke with told us major incident planning information was available to all staff on the trust intranet. A ward manager showed us how staff could access it.
- Compliance for completing major incident training courses was low. Between April 2016 and February 2017, 61% registered nurses and midwives; 60% HCAs; 47% medical staff had completed this training. Managers had received a training update on major incident procedures at the directorate operational meeting on 7 April 2017.
- We saw the major incident plan dated August 2016 to December 2018 in Horsted Keynes ward. We also saw a major incident card in the Horsted Keynes ward office. This meant staff would have access to guidance in the event of a major incident on their roles and responsibilities.

Are maternity and gynaecology services effective?

Good



During our last inspection we rated the service as requires improvement because; 78% of clinical guidelines and protocols were due for review; staff told us doctors did not interpret protocols in the same way, which caused variation in patient management; some challenging behaviours in the multidisciplinary staff group were an obstacle to team working.

During this inspection were rated effective as good because;

- We found all guidelines had been reviewed and were in date with monitoring in place for further reviews.
- There had been issues with multidisciplinary working when the hospital was last inspected, with some poor

behaviour from staff including consultants. However, this was widely reported as improved with a new consultant body and we saw a much improved multidisciplinary approach across the directorate.

- The last inspection highlighted some issues around consent, this had been addressed through a variety of means and we saw consent was given the appropriate importance and staff followed trust policy.
- Although there was no midwife led unit for women the staff were committed to providing and promoting normal birth. Women were offered a choice of birthing options and the trust had high homebirth rates.
- The trust employed a dedicated preceptorship midwife and a midwifery placement educator who met with midwives throughout their employment. They also helped with the training development of student and newly qualified midwives.
- We saw the targets for elective caesarean sections were below the trust target during our last inspection. Recent figures showed improvement and figures were in-line with national averages.

Evidence-based care and treatment

- In the executive summary to the women's services audit strategy 2017, the service set out the strategic direction and plan for clinical audits within women's services at the trust for 2017. This had been developed following the ongoing review of governance that had taken place since 2015 to ensure practice was in accordance with national best practice standards. For example, planned audits in 2017 included: National Maternity and Perinatal Audit (NMPA) and the Maternal, Newborn and Infant Outcome Review Programme (MBRRACE). The strategy also highlighted that the service were reviewing gynaecology services to identify areas where audits may improve outcomes for women due to an absence of planned national audits in gynaecology.
- The Women's Directorate also had an ongoing programme of local audits. These audits demonstrated the trust was achieving outcomes in line with national standards.
- We viewed minutes from the Women's Directorate audit/clinical governance meeting from 9 November 2016. The minutes recorded work in progress on a range

Maternity and gynaecology

of audits, and these had been discussed at the meeting, including: an audit of the Early Pregnancy Unit (EPU) guidelines and a retrospective audit of 'cases of ectopic pregnancy from April 2014 to April 2016.'

- Women using the services of the trust were receiving care in accordance with the National Institute for Health and Care Excellence (NICE). For example, routine antenatal care was delivered in accordance with NICE standard 22, this included screening tests for complications of pregnancy. We also found there was appropriate use of the world health organisation (WHO) checklist for women requiring surgery; this is a tool for clinical teams to improve the safety of surgery by reducing deaths and complications.
- In our previous inspection in April 2016, we found 78% of maternity and gynaecology clinical guidelines were out-of-date and this was recorded on the risk register. However, information displayed on Horsted Keynes ward informed staff that 100% of protocols and guidelines had been updated and were up to date in April 2017.
- The Women's Directorate informed us that they had reviewed guidance for staff as part of a service review in 2015-2016. The service provided us with a range of guidance the directorate had produced in response to the review. For example, we saw an update report dated January 2016 which carried practice guides for staff on dealing with screening incidents, birth stories, and the service's complaints process. The directorate also explained that the review was part of an ongoing process of quality improvement across maternity and gynaecology services.
- Patient leaflets were produced in line with National Institute for Health and Care Excellence (NICE) guidelines. For example, one leaflet provided information on miscarriage and referenced the Royal College of Obstetricians and Gynaecologists (RCOG) and NICE clinical guidance.

Pain relief

- A variety of pain relief was available to pregnant women. Women had access to a range of pain relief methods following NICE guidance CG190. This included Entonox (gas and air) and Pethidine (a morphine-based injection) for medical pain relief during labour.

- Epidurals were available 24 hours seven days a week. Women generally received epidurals within 30 minutes of request.
- Women could bring their own transcutaneous electrical nerve stimulation (TENS) machines, (these are machines which are used as an alternative to medication, and they can ease pain in some people with certain types of pain).
- Women had access to two birthing pools, which can make contractions during labour less painful for some women.
- Doctors were available to insert epidurals if required.
- Pregnant women had hand held notes which provided information on pain relief. There were also leaflets available in the clinics and on the trust website. The leaflets set out options such as using Entonox 'gas and air' or pethidine pain medication.
- We spoke to patients on the gynaecology ward who told us they had received good pain control after surgery.

Nutrition and hydration

- Figures released by NHS England for quarter three (Q3) 2016-2017 showed the trust had a breastfeeding initiation rate of 88%, which was better than the trust target of 85%.
- The malnutrition universal screening tool (MUST) was used to identify patients at risk of becoming malnourished or obese. Staff told us patients at risk would be referred to the dietician.
- Staff at the maternity service told us midwives, maternity care assistants, and nursery nurses would offer support to women with baby feeding.
- Women we spoke with across maternity and gynaecology services were positive about how their nutritional and hydration needs were being met by the services.

Patient outcomes

- The total number of deliveries at PRH from April 2016 to December 2016 were 1,788, an average of 199 a month.
- There were no patient outcomes that fell considerably outside of the England averages for the trust as at January 2017.

Maternity and gynaecology

- Twenty three babies, an average of three a month, were transferred to the Special Care Baby Unit (SCBU) at PRH between April 2016 to December 2016. An average of 4% of term babies were admitted to SCBU in the period.
- In the same period there were no intrapartum stillbirths and four antepartum stillbirths, this was an average of zero per month. There were no full term neonatal deaths within seven days in the period.
- Home birth rates for PRH was an average of 2.7% of births a month for the period April 2016 to December 2016. The average rate for the Trust overall for this period was 5.6%.
- The rate of elective caesarean section at PRH was 15.2% of births at the hospital, which is higher than the trust target of 10%. The emergency caesarean section rate was an average of 13.8% at PRH from April 2016 to December 2016 which was slightly higher than the trust target of 13%. The rate peaked for the period in December 2016 when it was 18.7%. Caesarean section figures, although worse than the trust targets, fell within national averages.
- The hospital had a 56% success rate for women opting for normal deliver following a caesarean section at the hospital between April and December 2016, this was worse than the trust's target rate of 70%.
- In relation to other modes of delivery between April 2016 and December 2016 the trust had 16.4% other/emergency deliveries. There had been four breech births during the period, leading to an average monthly rate of zero. The service had 11.5% forceps and ventouse deliveries in the period; other forceps deliveries were better than the England average at 0.4%, compared to the England average of 3.8%; ventouse (vacuum) deliveries were 6.7%, compared to the England average of 5.5%; normal non-assisted deliveries were worse than the England average at 55.9%, compared to the England average of 59.8%; other/unrecorded methods of delivery at 0.2%, were similar to the England average of 0.4%.
- From April 2016 to December 2017, the third or fourth degree tear rate was 3.2% for all patients.
- From April 2016 to December 2016 PRH had 11 postpartum haemorrhages above 2.5 litres, this equated to 0.6% of patients at the hospital.
- In the 2015 National Neonatal Audit Programme (NNAP) the PRH performance for all babies of less than 28 weeks gestation had their temperature taken within an hour of birth was 67%. The NNAP standard of 98-100% was not met, though the sample size was very small, (eligible number) with only three babies included.
- In the NNAP the PRH did not meet the NNAP standard for all mothers who deliver babies between 24 and 34 weeks gestation inclusive given any dose of antenatal steroids at 82%, this was slightly worse than the NNAP standard of 85%.
- There were 6518 women booked for screening with the trust from April 2015 to April 2016, a report for 2016 to 2017 was being compiled at the time of our inspection. In the same period 5785 women gave birth at one of the trust's sites. In regards to sickle cell and thalassaemia screening, 100% of fathers considered to be at risk were offered testing with 78% being tested, of those not tested the report recorded the number of fathers tested elsewhere and number not tested due to miscarriage.
- The report also recorded that 90% of women were offered screening for Hepatitis B, and 100% of babies where the mother tested positive for Hepatitis B, received their first vaccination within 24 hours of birth. 90% of women were screened for HIV; 53% of women susceptible to rubella were immunised prior to leaving hospital, other women declined the vaccination.
- The trust had also introduced a programme of collating data on the number of women who declined infectious diseases prevention screening who were re-offered screening within 28 weeks of birth, the data was being collated at the time of our inspection for the 2016-2017 antenatal and newborn screening programme report.
- As of February 2017 we reviewed data submitted by the trust and found there were no active maternity outliers. We viewed the maternity table for measuring medical outliers, this indicated that between the period April 2012 and February 2017 there was no evidence of risk for elective or emergency caesarean section, neonatal readmissions, peuperal (relating to childbirth) sepsis and other peuperal infections or maternal readmissions.

Competent staff

- Between April 2016 and January 2017, 76% of staff within maternity and gynaecology at the trust had

Maternity and gynaecology

received an appraisal, this was worse than the trust target of 85%. None of the staff groups achieved the trust target. The average appraisal rate had however improved in comparison with the average appraisal rate for April 2015 to March 2016, when the average appraisal rate was 59%. Broken down this equated to: 85% of administrative and clerical staff; 62% of medical staff; 88% of nursing and midwifery staff; 72% of support staff.

- We viewed three sets of minutes from the Women's Directorate audit/clinical governance meetings dated October 2016, November 2016, and January 2017. We saw that the meetings regularly offered medical staff opportunities for learning. For example, minutes from the meeting dated 9 November 2016 recorded that a presentation had been given to medical staff from across the Women's Directorate. This involved a case study of the misdiagnosis of early pregnancy; lessons learnt from the case were disseminated to staff at the meeting. This approach offered staff opportunities for learning during daily routines and enabled staff to remain up-to-date with educational developments.
- The trust employed a dedicated preceptorship midwife and a midwifery placement educator who met with midwives throughout their employment. They also helped with the training development of student and newly qualified midwives.
- There were quarterly 'away days' for staff working in gynaecology and we saw from meeting minutes that these were well attended. Staff told us previous themes at away days had included safeguarding and 'Prevent' training. The ward manager on Horsted Keynes ward told us the October 2016 'away day' had looked at a case study of a patient who had suffered a fall. Staff had looked at lessons learned from the incident including the investigation that had followed the incident.
- The annual report for antenatal and newborn screening, published in 2016, recorded that 95% of key staff attended educational programmes appropriate to their involvement in screening on an ongoing basis, this was better than the target of 80%.
- Staff told us they were supported by the maternity and gynaecology services and the trust to maintain their registration with the nursing and midwifery council (NMC). The manager on Horsted Keynes ward showed us a spreadsheet which highlighted when qualified staff registrations were due for renewal. We saw that all qualified staff on the ward had registrations that were in date.
- Staff in gynaecology told us they felt the preceptorship programme for newly qualified band 5 nurses was effective. Band 6 nurses monitored their progress and supported them with their competencies.
- Staff told us they were encouraged to work towards promotion. For example, a band 6 uro-gynaecology nurse had a development plan to develop their skills to band 7 competences, this included working with a specialist uro-gynaecology team at a London hospital.
- Staff told us funding was available for staff to complete education and qualifications in excess of mandatory training. For example, the clinical manager in midwifery had received funding and support to complete a post-graduate degree.
- Medical staff told us they had access to good supervision and support. Medical staff told us there had been problems with junior doctors feeling unsupported by registrars in the Early Pregnancy Unit (EPU). However, this was reviewed by the lead consultant for gynaecology, and as a result they had reviewed the junior doctors' induction to include training for the EPU.
- A consultant also told us there had been tensions with the junior doctors and a tutor had resigned over new contracts. However, the consultant said the issues had been resolved as five new consultants had joined the trust and this had reduced the demands on junior doctors.
- Staff on Horsted Keynes ward told us team meetings were 'ad hoc'. The ward manager said this was due to it being difficult to get all the staff together. However, the ward had introduced a communications board and communications book to enable the cascading of information to staff.
- Midwives and junior doctors completed an electronic cardiotocography (CTG) training package annually, however, consultants only completed this training once every three years. We spoke to a consultant who felt their training should be in-line with other staff and be

Maternity and gynaecology

completed every year. In addition doctors and midwives received mandatory training in CTGs. Cardiotocography (CTG) is an assessment of a baby's heart rate in the third trimester.

- The service had regular multi-professional caesarean section (CS) meetings which reviewed CTG's every Friday afternoon at PRH. Staff were rostered to attend the meetings. The meetings were also part of junior doctors training.
- The maternity service had introduced 'birth stories'; this was a process of staff learning and improving practice based on a case study approach. We saw examples of birth stories and the lessons learnt by staff from this approach.
- The trust provided specialist services for maternity including, a practice development midwife, a perinatal mental health midwife, alcohol and substance misuse midwife, a teenage pregnancy midwife, an infant nutrition midwife, a breastfeeding lead, bereavement midwives and safeguarding midwives.

Multidisciplinary working

- In our previous visit in April 2016 some staff told us multidisciplinary working was poor between some consultants and the rest of the team. However, staff told us the situation had improved due to changes in the medical staff team at the trust.
- The hospital had introduced regular safety huddles, these are short multidisciplinary briefings designed to give clinical and non-clinical staff opportunities understand what is going on with each patient and anticipate future risks to improve patient safety and care. We saw staff attending safety huddles across maternity and gynaecology services.
- Medical staff told us that the advanced neo-natal nurse practitioners (ANNP) on the neo-natal unit (NNU) told were highly skilled, and worked well with maternity staff.
- There was a multi-disciplinary review of incidents every Tuesday for maternity and gynaecology. Minutes of the meetings were displayed on the staff notice boards across maternity and gynaecology services.

- We saw shared working within the midwifery team and between clinicians and midwives on the Central Delivery Suite (CDS) at PRH. We spoke with staff providing support with diabetes, maternity support, and breastfeeding.
- PRH provided a multidisciplinary, "one stop" clinic twice a month at the hospital for maternity patients with substance misuse issues. Patients who attended this clinic benefitted from additional time for antenatal appointments, and had the opportunity to meet with allied health professionals including mental health nurses and social workers. This reduced the number of separate appointments patients needed to attend.

Seven-day services

- Consultant cover and midwife support was available 24 hours a day, seven days a week at the hospital. The community midwife team also ran a homebirth team, 24-hours a day, seven days a week.
- Maternity services offered a 24 hour telephone triage service.
- The gynaecology assessment unit provided a service 24 hours a day, seven days a week.
- There was a radiographer available 24 hours a day seven days a week. Ultrasonography was available 24 hours a day, with paediatric cover from a registrar twenty four hours of the day seven days a week, with support from an on-site consultant between 9.00am and 5.00pm, and an off-site consultant out of hours.

Access to information

- Staff told us they could access policies, protocols and other information they needed to do their job through the trust intranet. They also had internet access to evidence-based guidance from bodies such as NICE and the (NMC). We saw computers available to allow them to do this.
- Community midwives had remote access to the trusts information systems.
- Staff told us the trust was working towards a paperless system. Staff on Horsted Keynes ward said they had received an extra computer in January 2017. Staff also said there was work in progress to develop electronic discharge summaries. Consultants used an electronic system for patient histories and scan results.

Maternity and gynaecology

- Women who used maternity services had hand-held antenatal records that they brought with them to all appointments. This allowed multi-disciplinary staff to access up-to-date records to enable ongoing care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We asked the trust to make improvements to the consent policy and process to ensure confirmation of consent was sought and clearly documented. We saw evidence that an audit of consent processes had taken place and an action plan including the availability of patient information had been undertaken. We found the consent policy had been reviewed and consent champions had been appointed. A workshop was held in November 2016 to re-introduce the consent champions. A consent audit was scheduled in April 2017 the results of this audit would be presented in July 2017.
- We saw staff verbally gaining consent before commencing any treatment. Staff were seen fully explaining procedures and the associated risks of accepting the treatment or not.
- A session on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) was included in midwives and qualified nursing staff induction training.
- Staff told us the community midwife completed the consent paperwork for antenatal screening at the woman's first booking appointment. We saw copies of signed consent forms in records we looked at.
- We saw completed consent paperwork in medical records we looked at. Staff could describe the process of completing a separate consent form for termination of pregnancy and showed us where they were kept.
- Maternity staff demonstrated awareness of Gillick competence for young mothers under the age of 16 years.
- Women were provided with a variety of information on options for care and treatment to enable them to fully consent to treatment.

Are maternity and gynaecology services caring?

Good



During our last inspection we rated the service as good for caring because; we saw feedback from women and their families which was positive, midwives and doctors were described as caring and kind, we saw patient dignity and privacy maintained at all times.

During this inspection we still found the service good because;

- Feedback from women and their families which was positive about staff kindness and compassion.
- Staff treated patients with dignity and respect.
- Patients were involved in their care and treatment.
- Women were supported in making informed choices about birth settings which were appropriate to their clinical needs.
- Patients had access to services to support their emotional wellbeing.

Compassionate care

- We saw feedback from patients on the Horsted Keynes ward collected via the 'Patient Voice' for gynaecology. From February 2016 to February 2017, 572 patients had given feedback 95% of these patients said they would recommend the ward; 92% said they were "always" treated with kindness and compassion; none of the patients who responded to the 'Patient voice' survey said they were "rarely" or had "never" been treated with kindness and compassion.
- Overall the Friends and Family Test (FFT) results for antenatal, birth and postnatal wards were in line with the England average. Postnatal community rates however were slightly worse than the England average.
- Between January 2016 and January 2017 the trust's maternity Friends and Family Test (FFT) (antenatal) performance was generally similar to the England average. In December 2016 the trust's performance for antenatal was 100%, this was better than the England average of 95%. In December 2015, January 2015 and January 2016, the trust did not submit any data. From February 2015 to December 2016 the trust performance was mostly in line with the England average.

Maternity and gynaecology

- Between February 2016 and November 2016 the trust's maternity FFT (birth) performance was generally similar to the England average. In December 2016 the trusts performance for birth was 97% this was the same as the England average of 97%. The trust's recommendation rate was mostly in line with the England average, throughout the period.
- Between February 2016 and January 2017 the Maternity Friends and Family Test (postnatal ward) performance was generally similar to the England average. In January 2017 the departments performance for postnatal ward was 97% compared to the England average of 94%. Performance was generally in line with England averages. In April 2016 recommendation rates at the trust was 10% lower than the England average; 84% compared to an England average of 94%.
- Between February 2016 and January 2017 the trust's maternity Friends and Family Test (postnatal community) performance was generally worse than the England average. In January 2017 the performance for postnatal community was 94% compared to a national average of 98%. The trust did not submit any data for February 2016. From March 2016 to January 2017 trust performance was mostly below the England average, trust rates were on average 9% lower than the England averages.
- We saw staff pulling curtains around patients before undertaking examinations or providing care maintaining patient's privacy and dignity.
- Overall, women we spoke with during our inspection reported that staff had treated them with kindness and compassion. For example, a typical comment from a woman on Horsted Keynes ward was, "All the staff have been very kind."

Understanding and involvement of patients and those close to them

- Staff communicated with women and their families and care partners making sure they understood their care and treatment, and any risks associated with this. We saw staff on Horsted Keynes ward explaining women's options in regards to food and drink.
- The trust performed better than the England average in the CQC Maternity Survey in November 2015 for the

question, 'If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted? The trust scored 9.8 out of 10 for this question.

- Overall, women we spoke with confirmed that staff had explained their care and treatment.

Emotional support

- There was a specialist bereavement midwife at the hospital working one day a week to cover the maternity and the gynaecology wards. The bereavement midwife offered support to women with subsequent pregnancies after a pregnancy loss. In addition to this, staff could refer women and their families to local charitable organisations offering bereavement counselling.
- Experienced midwives ran a 'Birth Stories' clinic for women who had previously experienced a traumatic birth.
- Women undergoing termination of pregnancy were offered support and counselling before and after procedures.
- Staff on Horsted Keynes had access to a quiet room for breaking bad news. Staff said if the room was in use they could also use the doctors' clinical room.
- Staff on Horsted Keynes ward told us they could refer women to the hospital Chaplaincy for emotional support. Staff also said they had a very good relationship with the local authority social work team and would refer women in need of emotional support to a social worker, to ensure women had access to information on community support on discharge from hospital.

Are maternity and gynaecology services responsive?

Good



During our last inspection we rated responsiveness as requires improvement because; the trust failed to meet national referral to treatment (RTT) waiting time targets for gynaecology. Low midwifery staffing numbers meant the unit was unable to maintain a 24-hour maternity triage service.

Maternity and gynaecology

During this inspection we rated responsive as good because:

- During our previous inspection we found referral to treatment times (RTT) were not being met for admitted and patients pathways completed within 18 weeks. However, the percentage rates were improving during this inspection with RTT targets being met 94% compared to the national average of 95% reported in February 2017.
- All patients received diagnostic tests with six weeks between July 2016 and February 2017, which was better than the national target. This showed an improving picture and that the gynaecological needs of women were mostly delivered in a timely way.
- During our previous inspection we found women were often being transferred and units were being closed due to lack of staff. This had improved as there were no closures reported at PRH from April 2016 to January 2017.
- There had been no occasions between April 2016 and December 2016 when the central delivery suite (CDS) had needed to send women to RSCH. This was an improvement from April to December 2015 when the CDS had been sending an average of two women a month to RSCH.
- There was adequate support in place for dealing with patients with complex needs, learning disabilities and in gynaecology, patients with dementia.

We also found:

- There has been no further development of a midwife led birthing unit (MLU) since our last inspection.
- Complaints were not dealt with in a timely way and within the trust's published policy timescales.

Service planning and delivery to meet the needs of local people

- From October 2015 to September 2016, 5,591 women delivered their babies at the trust. This was higher than most other NHS trusts in England. The labour ward at Royal Sussex County Hospital (RSCH) saw women with 'high-risk' pregnancies at the trust as RSCH had a level

three neonatal intensive care unit (NICU). High-risk pregnancies included women with underlying medical conditions, such as gestational diabetes or pre-eclampsia, and women with multiple pregnancies.

- The service informed us that the women's directorate had a challenging few years following some historical cultural issues, which they said were also identified during the previous CQC visit in April 2016. The service said that during a directorate review of clinical governance to identify key local quality improvements, it became clear that basic governance systems, process and procedures needed to be developed and embedded within the service. This had been the key priority in the previous 12 months, and formed the basis of quality improvements within the service. As a result of the review the service had introduced a number of flowcharts to guide staff practice. For example, an update report dated January 2016 carried a number of flowchart appendices including 'practice guide 4' this was a flowchart on actions staff should take in the event of a screening incident.
- PRH maternity services were consultant led, the trust did not have a midwifery led birth unit (MLU). This restricted choice over place of birth for low-risk women planning a normal birth in their local area. This was identified as "low" risk on the Women's Directorate risk register. The register recorded that this had been raised with the Chief Executive. The Director of Strategy was due to take forward the trust plans, including the MLU, but no date was set for this.
- The trust's community midwives ran an award winning homebirth service for women who chose to give birth at home.
- There had been a shortage of theatre nursing staff and this had resulted in midwives performing the role. However, staff told us midwives would not be acting as scrub nurses in theatres from July 2017, as the trust had engaged theatre nurses in the theatre team to complete this role.
- Women saw a midwife at 22 weeks of pregnancy to discuss the options available to them at the midwife led clinic, and commenced planning for their forthcoming birth. Women then saw a consultant or registrar for review at 34 weeks of pregnancy.

Maternity and gynaecology

- The service had opened an Early Pregnancy Unit (EPU) in February 2017. The EPU nursing lead was an experienced theatre nurse, who had spent time training with the British Pregnancy Advisory Service (BPAS) and at the Royals Sussex County Hospital in Brighton. The service offered a nurse led early pregnancy clinic on Mondays, Wednesday and Fridays; and a consultant led clinic on Thursdays.
- Staff told us Bolney ward allowed partners to stay overnight following the birth of their child.
- Termination of pregnancy (ToP) was offered at PRH. The service provided figures for ToP from April 2016 to February 2017. During the period PRH completed nine medical abortions and 36 surgical abortions.
- The midwives coordinating the “one stop” clinic also provided specialist antenatal care for travellers and homeless women living in hostels or other temporary accommodation.
- The trust had lead midwives for teenage pregnancy, travellers, and substance misuse. Staff also had access to a domestic violence advisor. Staff told us any woman who was vulnerable as a result of her circumstances was able to request antenatal appointments at home.
- The labour ward had two birthing pool rooms, which gave women an option of giving birth in a pool.
- Work was in progress for the hospital to introduce a ‘one stop’ service for cystoscopies, (this is a procedure which examines the urinary bladder via the urethra). Work was also in progress to introduce a ‘one stop shop’ for the surgical management of miscarriages.
- The trust had introduced a nurse led urogynaecology service. The service’s nurse worked in tandem with the urogynaecology consultants.
- The trust had also introduced a new hysteroscopy nurse, (this is a procedure that examines the uterus in order to diagnose and treat causes of abnormal bleeding), this is with a remit of developing the hysteroscopy service.
- There was a Facebook page for mothers to get support from peers and meet new people. Staff and patients said this had been a useful tool in helping new mothers feel more prepared and supported.
- Between quarter (Q2) 2015 to 2016 and quarter three (Q3) 2016 to 2017 the bed occupancy levels for maternity were generally higher than the England average, with the trust having 79% occupancy in Quarter Q3 2016 to 2017 compared to the England average of 59%.
- Women could be referred by community health services, GPs, or could self-refer to maternity services.
- The Directorate Lead Nurse informed that all efforts were made to ensure women who were below 34 weeks gave birth at RSCH. If they were admitted and stable they would be transferred. This included antenatal but not in labour if there was a suspicion that they may go into labour. Once they reached 34 weeks a decision was taken on the most appropriate place for them to give birth.
- Women in labour on arrival to PRH below 34 weeks were assessed as to whether they were safe to be transported to RSCH or the neonatal team would be informed of their imminent birth. The expectation was that the transfer could take place following birth, if necessary.
- There were no closures of the maternity unit or neonatal intensive care unit (NICU) from April 2016 to January 2017. There had been 23 inter-utero transfers to other providers in the same period, this was an average of three transfers a month.
- We noted from our review of incidents that the maternity triage had been closed on a number of occasions in 2016 and women were triaged from the delivery suite. However, staff told us this had been reviewed, and the service had introduced a policy whereby staff would only record this as an incident if the triage closure was due to staffing levels and not due to a lack of women attending the ward.
- Women’s services failed to meet its waiting times for referral to treatment (RTT) in the period April 2016 to January 2017 for the percentage of 18 week admitted RTT pathways completed within 18 weeks, with the average in quarter four (Q4) 2016-2017 being 80% this was worse than the national average of 90%.
- During Q4 2016-2017 1% of patients had their operation cancelled at the last minute, this met the trust target of 1%.

Access and flow

Maternity and gynaecology

- There had been no occasions between April 2016 and December 2016 when the central delivery suite (CDS) had needed to send women to RSCH due to the CDS being full. This was an improvement from April to December 2015 when the CDS had been sending an average of two women a month to RSCH.
- Some women chose to use the enhanced recovery programme following surgery on Bolney and Horsted Keynes wards. Research suggests if a patient gets out of bed, eats and drinks as soon as possible, their recovery from surgery is quicker and complications are less likely to develop. The ward was usually able to discharge women on the enhanced recovery programme one day after elective caesarean section if they were well enough. A short hospital stay following surgery may reduce the risk of complications associated with a longer stay, as well as improving patient flow on the ward. The postnatal ward worked with women to support them in this approach and we saw written information was available.
- On Horsted Keynes ward, medical patients sometimes occupied beds. We saw a policy stating clear acceptance criteria for medical outlier admissions to the ward. Staff told us medical patients would have to be mobile and not from the accident and emergency (A&E) department. Staff said medical patients usually came from the acute wards to free up acute ward beds. However, staff told us the bed management team sometimes put pressure on them to accept patients who did not meet the criteria. The ward manager said the ward would accept a patient if a bed was available, but that medical outliers were only an issue during the winter pressure months.
- Horsted Keynes ward had reconfigured from 12 beds to 11 beds and a trolley bed in April 2017. Staff told us this was to aid timely start to theatre lists and facilitate a better space for patients. Staff told us the reconfiguration was working well.
- Staff on Horsted Keynes ward told us the theatre lists were all elective. Women requiring emergency surgery would go to the RSCH. Staff told us patients who had procedures cancelled would be re-booked immediately.
- There was no dedicated space on theatre lists for the surgical management of miscarriages. Staff told us women usually waited for a week if they chose the surgical option.
- The scorecard indicated an improving trend in the number of patients waiting six weeks or longer for diagnostic tests. During our previous inspection the rate had been 33%. However, in Q4 2016-2017 the rate had fallen to 0%. This was better than the trust target of 1%.
- The trust reported 5488 or 84% of women had a foetal anomaly scan by a local obstetric ultrasound specialist in the 23rd week of their pregnancy within three days of referral. Of the 76 women suspected of having a foetal anomaly and referred to a local specialist, 49 were seen within three days, 12 were seen over three days as there was no clinical need to be seen before this and the women were happy to wait, seven women asked for later appointments, and eight went over three days. A further 14 women were referred to a local specialist following a scan when they were over the 23rd week of their pregnancy and 11 were seen locally following a scan before the 20th week of their pregnancy.
- Midwives sent discharge summaries to community midwives and GPs when a woman and baby went home from hospital. This enabled ongoing care within the community.

Meeting people's individual needs

- The lead obstetrician ran a weekly multidisciplinary mental health clinic at the hospital, along with a psychiatrist, mental health nurse and administrator. Community midwives referred women with mental health needs to the clinic. Staff on Horsted Keynes ward told us they could access the PRH site mental health team if a patient required a mental health assessment. Staff also told us they could access community mental health teams and gave examples of how they had worked with both the site mental health team and the community mental health team.
- Interpreters were available for patients whose ability to speak or understand English was limited throughout the trust from a professional interpreting service. We the inspection were using English and not requiring an interpreter.

Maternity and gynaecology

- Women had access to written information on how to obtain information in other languages on the wards. Leaflets also carried information in other languages on how the public could get the leaflet in their first language.
- The trust had lead midwives for teenage pregnancy, travellers alcohol and substance misuse. There was also an independent domestic violence advisor in the trust, to whom women could self-refer.
- A teenage pregnancy specialist midwife was in post; her role was to offer extra support and education to younger people who were pregnant. This included ensuring single rooms being offered to younger mothers and parents being able to stay with them at all times.
- The service included bereavement training as part of mandatory training and improved links with Child Death Overview Panel (CDOP) and The Trevor Mann Baby Unit (TMBU) in Brighton a specialist unit for the care of premature and sick newborn babies. This helped to ensure all losses received the appropriate care.
- The department had two bereavement midwives across both sites. Their role included attending 'Stillbirth and neonatal death' (SANDS) meetings and working with the SANDS guidelines to provide women with adequate support following the loss of a child.
- There was a separate bereavement room away from the main labour ward which had a cold cot, this allowed parents to spend as much time as needed post birth.
- Staff on Horsted Keynes ward told us they occasionally cared for patients living with dementia. The ward had two dementia link nurses and one dementia link health care assistant (HCA) who specialised with dementia patients. However, all staff did not receive dementia training as mandatory. The ward manager told us the ward staff could ask for support from staff on Hurstpierpoint Ward, and older person's ward, if an older patient presented symptoms of cognitive impairment.
- There was a lack of bariatric equipment available on Horsted Keynes ward. Staff told us they had never had the need for a bariatric bed as the beds they had in place were appropriate to the needs of the women they provided care for. Staff said if a bariatric bed was

required they could ask the trust's equipment supplies team, who could hire equipment from private sector equipment suppliers and have it delivered on the same day.

Learning from complaints and concerns

- Between January 2016 and February 2017 there were 74 complaints in regards to maternity and gynaecology services. The trust took an average of 54 working days to investigate and close complaints, this is not in line with their complaints policy, which states that 90% of complaints should be responded to and closed in less than 40 days. Only 35% of complaints were responded to and closed in less than 40 working days. Most complaints 78% of all complaints were about deliveries (20%), care and treatment (19%), staff attitude (15%), treatment pathways (12%), communication (8%) and delays in treatment (4%).
- The trust website provided clear information on how to complain, as well as details of local advocacy services available to support patients and carers who wished to pursue a complaint. The trust website also gave information and contact details for the patient advice and liaison service (PALS). PALS contact information was also available on the wards and units we visited.
- Ward managers told us they received monthly updates on complaints at the Quality and Safety Meeting. Meeting minutes we viewed confirmed that complaints were a regular agenda item at these meetings.

Are maternity and gynaecology services well-led?

Good



During our last inspection we rated the service as requires improvement because: The directorate senior leadership team staff had not been involved in developing the vision and strategy. The strategy did not address issues of staff shortages and there were no timescales. Governance in gynaecology had no clear structure and staff from gynaecology rarely attended the safety and quality meetings for Women's Services. During this inspection we found services good because:

Maternity and gynaecology

- During the last inspection we saw a workforce which had conflict in the relationships between consultants. However, this inspection saw a change in the consultant body had led to a much improved culture among all staff.
- The women's directorate had a three, six and 12 month plans which were drawn up in March 2017. This included short and long term initiatives.
- Staff were positive about the role of the lead midwives and that they had had a positive impact on moving the department forward and had introduced many new initiatives.
- Staff felt that there had been improvements in the culture of the organisation since our last inspection. They all reported that it was a different place to work than a year ago and that positive changes to the consultant body and leadership had been the driving force behind the changes.
- Ward managers reported to a maternity and gynaecology manager. The directorate lead nurse, maternity and gynaecology manager and lead consultants reported to the clinical director of the service.
- Staff felt there had been a shift in the effectiveness of the directorate leadership. Staff told us this was due to the trust tackling a legacy of challenging behaviours from some members of staff in the service. We found both staff and managers reported improved team working and improved channels of communication across the Women's directorate.
- The staff and managers we spoke with in maternity and gynaecology felt there was visible leadership from the clinical director and said this was as a result of the trust tackling issues in the directorate, and supporting leaders in their roles. For example, ward managers told us they had received training in anti-bullying and a consultant told us about a new ethical code staff were expected to adhere to.

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

- There were no assurances that all staff were engaged in feedback from the trust although staff were positive about departmental leadership.
- There were improvements to the governance structure. However, we still found that services lacked clear leadership from the top of the organisation to the ward.
- The directorate does not take part in morbidity and mortality meetings. These meetings are an opportunity to review all deaths within the hospital to explore key themes and identify any trends or themes. This could mean that any deaths within the service were not given thorough review by a multidisciplinary team.
- Staff told us the directorate lead was visible and approachable. For example, a ward manager said, "The directorate lead is here on Monday. They've been around today to offer us support." Staff also told us the lead nurse at PRH held a meeting every Tuesday where staff were informed of any changes at the hospital or could raise concerns. However, some staff said they had not seen the new head of midwifery and said they did not feel they had made their presence felt at PRH.
- Staff were positive about changes to the trust's board. Managers told us the new board were, "making themselves visible." Managers told us the chief executive officer (CEO) had attended a directorate performance review meeting in March 2017, and the board chair had completed a 'walk around' of PRH maternity and gynaecological services in April 2017.

Vision and strategy for this service

Leadership of service

- We viewed a flow chart for the Women's Directorate; this clearly defined the management structure for maternity and gynaecology services from the wards to the executive board.
- The service has been through several changes to the governance structure. However, the service had managed the change and staff felt positive about the future of maternity and gynaecology services.
- Senior managers we spoke with told us work was in progress on a new vision and strategy for the Women's Directorate. The directorate had three, six and 12 month

Maternity and gynaecology

plans which were drawn up in March 2017. These included short and long term initiatives. For example, within three months the directorate planned to introduce gynaecology mortality and morbidity meetings; and within 12 months the directorate planned the development of a second obstetric theatre and the digitalisation of the community midwifery teams. However, these plans were relatively recent and not embedded.

- Staff we spoke with were aware work was in progress on a vision and strategy for the Women's Directorate. Staff were able to tell us about some upcoming improvements and most staff were enthusiastic about recent changes in the directorate.

Governance, risk management and quality measurement

- There were monthly safety and quality meetings, weekly incident review meetings and regular meetings on audit. The service had also introduced an 'action tracker' to track the implementation of action plans from the Women's Directorate operational meetings. The 'action tracker' tracked actions the directorate were taking to improve services, including: staffing needs, pathways and guidance, education and training, and equipment including IT.
- We viewed the 'action tracker' dated 6 January 2017. This highlighted that performance had improved in regards to referral to treatment (RTT) times. The 'action tracker' also identified obstacles to plans being implemented, for example, the service had identified that anaesthetists and surgeons were regularly not ready to start procedures at 8.30 as they were still seeing patients on the ward. In response the service were liaising with theatre co-ordinators and had communicated with theatre staff to be ready by 8.00am.
- We saw noticeboards for governance in every clinical area within maternity and gynaecology. These included information on recent serious investigations and recent learning from complaints. Staff were encouraged to read these but some staff we spoke to were aware of the noticeboards but could not tell us what information was on them.
- The directorate does not take part in morbidity and mortality meetings. These meetings provide opportunities to review all deaths within the hospital and identify any trends or themes. These meetings are an opportunity to review all deaths within the hospital to explore key themes and identify any trends or themes. This could mean that any deaths within the service were not given thorough review by a multidisciplinary team.
- Staff told us foetal loss would be reported to, "Each Baby Counts". This is the Royal College of Obstetricians and Gynaecologists (RCOG's) national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour. Foetal and maternal loss was also reported to, "Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK". This is a national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths.
- There was a divisional risk register in place. However, when we asked a ward manager to access this they were unable to locate it. The ward manager showed us and email they had been sent by the divisional lead in April 2017 which identified the divisional risks on the register. However, this did not identify actions the division were taking to mitigate the risks.
- We viewed the Women's Directorate risk register and this identified both the risks to the service and actions the trust were taking to mitigate risks. Risks on the register were rated using a traffic light system, (red, amber, green (RAG)). The risk register identified a risk of a financial overspend in the Women's Directorate, citing the main reason as the pay budget for nursing and midwifery. The register highlighted that budget setting for each grade of staff was set at the mid-point of the pay banding; but, some grades of staff (80%) were at top of the pay band, and the service were unable to stay within the allocated budget. The register recorded that as a result the only way the overspend could be addressed was via an increased budget. The risk had been reviewed in November 2016 by the directorate lead nurse, head of midwifery, and governance lead, when it was highlighted that the trust was in financial 'special measures' and the directorate were regularly meeting with the finance and performance team. However, the overspend remained an on-going risk which the trust board were monitoring.

Maternity and gynaecology

- Maternity services also held a weekly maternity risk meeting held on rotation across each site. Matrons and clinical services managers attended these meetings, as well as the head of midwifery. Risk meetings were open for all staff to attend if they wanted to. Midwives said they were often too busy to attend, but that they always received feedback on learning from these meetings.

Culture within the service

- We asked several doctors, midwives and managers about the professional relationships between consultants. The majority view was that there had been improvements in the relationships in the consultant body. A ward manager said, "The consultants are all very pleasant with the nursing staff." Another staff member said, "The culture has much improved."
- Managers told us that problems between a group of consultants in obstetrics and gynaecology had been resolved due to changes in personnel and the clinical director addressing conflict and tensions in an "open and honest way." The trust had also introduced new working ethics for the directorate.
- Medical staff said professional mediation had taken place and had led to more productive meetings between medical staff. All staff had signed a 'behavioural charter', to ensure relationships in the staff groups were professional and respectful. A consultant told us, "CQC came last year at a time of change in the trust. There was lots of stress on staff. The atmosphere has changed, it is more supportive now."
- Staff told us about the trust's 'freedom to speak up guardians', (this is part of an NHS initiative to raise the profile of staff raising concerns in their organisations). Staff also showed us the contact details for the guardians on the trust intranet. Staff across the directorate told us they had not had reason to use the guardians, but were aware of how to contact them.
- Staff told us there was less use of locum doctors and this had improved team work and communication across maternity and gynaecology services.
- Midwives felt they formed an effective team at each site and worked well with the community midwives. Staff

across maternity and gynaecology services said there was improved cross-site working with staff at the RSCH. For example, bi-monthly meetings between the EPU's at PRH and RSCH had been introduced.

- The women's services directorate had introduced governance notice boards on the wards which provided details for staff on how to contact the risk co-ordinator, governance lead, and birth stories midwife.
- We saw information displayed on Horsted Keynes ward advising staff of the trust's black and minority ethnic (BME) network emphasising that "discrimination" would "not be tolerated." There was also details of the 'listening ear' service for BME staff who had experienced abuse or harassment.

Equalities and Diversity

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

Maternity and gynaecology

months' was 32% this was worse than the average of 25% for acute trusts, and an increase on the 2015 result which was 29%. The percentage rates from white and BME staff were similar with 32% and 37% respectively.

Public engagement

- The Mid-Sussex Maternity Services Liaison Committee (MSLC) was a forum for women who had used maternity services at the Trust. The MSLC met bi-monthly with hospital staff to provide a service user voice to service improvement agendas. We saw recent MSLC meeting minutes that demonstrated how the forum was attended by community groups, service users and hospital staff. The September 2016 forum minutes recorded that the terms of reference for the group had been reviewed to ensure the forum was achieving its aims.
- On the gynaecology ward, we saw a 'You Said, We Did' board. This indicated the ward valued patient feedback from patients.

Staff engagement




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

- There was a weekly CEO newsletter that was e-mailed to staff with trust news and updates.
- We saw contact numbers and email addresses were available to the Black and Minority Ethnic (BME) network 'listening ear', this was a support line for BME staff who were suffering discrimination in the workplace.
- Prior to our inspection directorates were asked to self-rate their service. The staff we spoke to, even at senior level, had no input into these self-ratings, this showed a lack of engagement with staff from the executive team.

Innovation, improvement and sustainability

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

End of life care

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

Information about the service

We inspected this core service in April 2016 and rated it as good overall. We did not inspect this core service at this inspection

Summary of findings

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

Overall we rated the end of life care service at the Princess Royal Hospital as good. This was because:

- The hospital provided end of life care training for staff on induction and an ongoing education programme which was attended by staff. A current end of life care policy was evident and a steering group met regularly to ensure that a multidisciplinary approach was maintained.
- The specialist palliative care team were a dedicated team who worked with ward staff and other departments in the hospital to provide holistic care for patients with palliative and end of life care needs in line with national guidance.
- The Princess Royal Hospital and its staff recognised that provision of high quality, compassionate end of life care to its patients was the responsibility of all clinical staff that looked after patients at the end of life. They were supported by the palliative care team, end of life care guidelines and an education programme.
- The specialist palliative care team was highly thought of throughout the hospital and provided support to clinical staff. The team worked closely with the end of life care facilitator to provide education to nurses and health care assistants.

End of life care

- Medical education was led by the medical consultants and all team members contributed to the education of the allied healthcare professionals.
- The majority of end of life care was provided by clinical staff on the wards. The palliative care service worked as an advisory service seeing patients with specialist palliative care needs, including those at the end of life.
- Staff at the hospital provided focused care for dying and deceased patients and their relatives. Most of the clinical areas in the hospital had an end of life care link person. Facilities were provided for relatives and the patient's cultural, religious and spiritual needs were respected.
- Staff in the mortuary, bereavement office, PALS and chaplaincy supported the palliative care teams and ward staff to provide dignified and compassionate care to end of life care patients and their relatives.
- Medical records and care plans were completed and contained individualised end of life care plans. Most contained discussions with families and recorded cultural assessments. The DNACPR forms were all completed as per national guidance.
- There was evidence that systems were in place for the referral of patients to the palliative care team for assessment and review to ensure patients received appropriate care and support. These referrals were seen and acted upon promptly.
- The trust had an advance care plan which supported a patient to develop their wishes and preferences. The plan could be located in the patient's health record on admission and was accessible to the out of hour's community service.
- The trust had a Rapid Discharge Pathway (RDP) and the documentation for this process was available on the end of life care intranet site which staff could access. The discharge team worked closely with the specialist palliative care team and coordinated the discharge of end of life care patients trust wide. The response time for discharge depended on the patients preferred place of care and what area the patient lived in.

- The trust had a multi professional end of life steering group that oversaw the improvement plans that were in place to support the work towards meeting the five priorities of care for end of life, and also meeting the National Institute of Health and Care Excellence's (NICE) end of life guidance.
- The end of life care service had board representation and was well led locally. This had resulted in a well led trust wide service that had a clear vision and strategy to provide a streamlined service for end of life care patients.

However we identified that the service was required to improve for the following:

- The trust was not meeting the requirements of three key performance indicators of the National Care of the Dying Audit 2014. In their response to the audit in the End of Life Audit- Dying in Hospital 2016 the trust was worse than the national average for two areas.
- There were inconsistencies in the documentation in the recording of spiritual assessments, Mental Capacity Act assessments and recording of ceilings of care (best practice to guide staff, who do not know the patient, to know the patients previously expressed wishes and/or limitations to their treatment) for patients with a DNACPR.
- Patients did not have access to a specialist palliative support, for care in the last days of life, as they did not have a service seven days a week.

End of life care

Are end of life care services safe?

Good



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

Are end of life care services effective?

Requires improvement



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

Are end of life care services caring?

Good



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

Are end of life care services responsive?

Good



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






Are end of life care services well-led?

Good



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

Outpatients and diagnostic imaging

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

Information about the service

We inspected the Princess Royal Hospital (PRH) in April 2016, as part of a comprehensive inspection of the Brighton and Sussex University Hospitals Trust. At the time, we rated the outpatient and diagnostic imaging core service at PRH as requires improvement.

The purpose of this inspection was to see what changes and improvements had been made since our last visit. The inspection took place between 25 and 26 April 2017.

PRH offered outpatient appointments where assessment, treatment, monitoring and follow up were required. The hospital had medical and surgical specialty clinics, as well as paediatric and obstetric clinics. There were 203,053 outpatient attendances at the hospital between November 2015 and October 2016.

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

During the inspection, we spoke with 18 members of staff, which included consultants, managers, senior clinical staff, nurses, physiotherapists, administrative staff and allied healthcare professionals.

We spoke with one patient and reviewed patient comments on 59 feedback cards. We visited outpatient areas and all areas of diagnostic imaging.

Summary of findings

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

- Not all staff were confident to report incidents, incidents were not always discussed at staff meetings and there appeared to be no learning from incidents.
- Staff compliance with mandatory training was worse than the hospital target.
- We identified concerns about the storage and security of hospital prescription forms.
- Resuscitation trollies were not tamper proof and, although drugs were kept in sealed boxes, they were not stored securely.
- Confidential medical information was not always stored securely and around 4,500 medical records had gone missing each month.
- Patients were not always treated with dignity and respect. We saw staff did not always consider the privacy of patients. Staff did not always introduce themselves to their patients. We witnessed breaches of confidentiality in patient waiting areas.
- The trust had failed to meet the England standard for referral to treatment (RTT) times since September 2014. The trust had failed to meet cancer waiting and treatment times.

Outpatients and diagnostic imaging

- The pathology department was not providing diagnostic results for suspected cancer in a timely way. It had met the target time for suspected breast cancer results, but not others.
- Call centre data indicated almost half of all calls had been being abandoned and unanswered.
- Of all appointments cancelled by the hospital, 60% were cancelled with less than six weeks' notice.
- There was no monitoring of overrunning clinics by managers. Staff recorded clinic delays on an ad hoc basis.
- There was no formal strategy or vision in place in the outpatient department. Not all staff felt they could approach their managers for support. Senior managers and the executive team were not always visible to staff in the department.

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

- World Health Organisation (WHO) checklist audit compliance was worse than the target set in interventional radiology.
- Room cleaning checklists had variable rates of completion across the outpatient department.
- Staff understood their responsibilities to report incidents and near misses; however, incidents were not regularly discussed at team meetings.
- Patient records were not always kept securely.
- Mandatory training compliance rates were low.
- Staff appraisal compliance rates were worse than the trust target.
- The trust was not meeting national targets for patients that should be seen within 18 weeks of their referral.
- The trust was not meeting national targets for patients that should receive their cancer treatment within 62 days of urgent referral.
- There was no formal strategy in place for the outpatient department.

- Not all staff we spoke with were able to tell us which directorate they sat in.

However:

- We saw that prescription forms were stored safely and securely.
- Resuscitation trolleys were tamper proof.
- Privacy and dignity was maintained in all areas.
- Rooms in the diagnostic imaging department were consistently cleaned and documented.
- We observed good radiation compliance in accordance with national policy and guidelines during our visit.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement



When we inspected the Princess Royal Hospital in April 2016, we rated safe as requires improvement. This was because:

- Staff did not consistently report incidents and some staff were unsure of what they should report. Only 137 incidents were reported across the whole trust in outpatients last year. There was no regular discussion about incidents at team meetings and learning from incidents was not demonstrated.
- Staff were not consistently 'bare below the elbows' when dealing with patients. We did not see any staff washing their hands or using hand sanitizer.
- Not all cancer biopsies were fast tracked. The time it took for some cancer biopsies to be dealt with was not monitored and could cause a delay in diagnosis.
- Staff were not compliant in mandatory training.

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

- Mandatory training compliance, including safeguarding training, was low.
- World Health Organisation (WHO)' five steps to safer surgery' checklist compliance were worse than the target set in interventional radiology.
- Cleaning checklists had variable completion rates across the outpatient department and carpeted areas appeared dirty and soiled.
- Staff understood their responsibilities to report incidents and near misses; however, incidents were not regularly discussed at team meetings.
- Patient notes were not always stored securely.
- Many rooms were cluttered and some waiting areas were cramped.

However:

- No serious incidents were reported for this site.

- We saw that prescription forms were stored safely and securely.
- We observed good radiation compliance in accordance with national policy and guidelines during our visit.

Incidents

- Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Between March 2016 and February 2017, the hospital reported no incidents which were classified as Never Events for outpatients or diagnostic imaging.
- In accordance with the Serious Incident Framework 2015, the hospital reported no serious incidents (SIs) in outpatients or diagnostic imaging which met the reporting criteria set by NHS England between March 2016 and February 2017.
- Outpatient services reported 117 incidents across the whole trust between April 2016 and March 2017. This was 20 incidents less than the previous year, indicating either that there were less incidents occurring, or that the department was under reporting. All of the incidents were reported as low or no harm. Leaders told us that they felt empowered to escalate incidents and concerns to their line managers and they felt confident their teams would report concerns also. However, we did not see regular discussion of incidents at team meetings which meant that staff may not be able to learn from incidents. Safety huddles were not regularly taking place at this hospital.
- We saw that the diagnostic imaging department reported and investigated incidents under the Ionising Radiation Incidents (Medical Exposure) Regulations 2000 (IRMER). Eight incidents were reported to the CQC between April 2016 and March 2017. Six of these incidents were reported under the category of 'much greater than intended dose' and two were reported under 'unintended dose' and we saw examples that showed these incidents were discussed in the Radiation Safety Committee meetings in December 2016. For example, we saw that a much greater than intended radiation dose that occurred in October was discussed in December 2016.

Outpatients and diagnostic imaging

- Not all staff that we spoke with could describe the principle and application of duty of candour, Regulation 20 of the Health and Social Care Act 2008, which related to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant person) of 'certain notifiable safety incidents' and provide reasonable support to that person.

Cleanliness, infection control and hygiene

- Patient Led Assessments of the Care Environment (PLACE) are a system for assessing the quality of the patient environment; patients' representatives go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness, patients living with dementia or disability and general building maintenance. The PLACE assessment for cleanliness across five outpatient areas for the period 1 January to 31 December 2016 was 97%, which was close to the England national average of 98%. It was not possible to break this down further by area. The assessment of cleanliness covers areas such as patient equipment, baths, showers, toilets, floors and other fixtures and fittings.
- Infection prevention and control training formed part of the mandatory training all staff at the trust attended. Due to outpatient's staff sitting in several different directorates, it was not possible to break this down to an outpatient staff compliance figure, or to break this down by hospital site. The trust-wide compliance for infection prevention and control training in the head and neck directorate was low.
- Diagnostic imaging staff sat in the specialised medicine directorate and we were not provided with site specific data, therefore the training rates given were trust wide. The specialised medicine directorate had a low compliance rate for infection and prevention control training.
- Posters were displayed which explained the '5 moments for hand hygiene'. We saw staff that interacted with patients were 'bare below the elbow' which helped prevent the spread of infection.
- Alcohol-based hand sanitising gel was available both at the main entrance to the hospital and the outpatient clinic and blood test areas. We saw staff using the hand sanitising gel correctly, in line with the 'five moments of

hand hygiene' and National Institute for Health and Social Care Excellence (NICE) quality standard (QS) 61, statement three. This standard states people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care.

- In the corridor to the main entrance of the outpatients area there were eight trolleys containing clean linens and scrubs. These were covered with a thin plastic sheet, however several of these plastic sheets had been torn meaning patients or staff could access the linens through the plastic. This posed an infection control risk as they could not provide assurance these were kept clean.
- We observed cleaning checklists in the cleaning office within the fracture clinic, however both of the checklists labelled 'day hospital' and 'fracture clinic' were blank for the week commencing 24 April. This meant that either the areas had not been cleaned all week, or the checklists were not appropriately documented.
- We saw cleaning checklists in each room in diagnostic imaging that showed cleaning was completed daily.

Environment and equipment

- The Patient Led Assessment of the Care Environment (PLACE) for the period of 2016, which showed the hospital average, across five outpatient areas, scored an average of 80 %, for condition, appearance, and maintenance, which was worse than the England average 93%. The assessment for condition, appearance, and maintenance covers areas such as decoration, the condition of fixtures and fittings, tidiness, signage, lighting (including access to natural light), linen, access to car parking, waste management, and the external appearance of buildings and maintenance of grounds.
- We saw tamper-proof resuscitation trolleys that were fully stocked and had regular checks and documentation for these.
- The hospital conducted environmental audits of all areas of outpatients and diagnostic imaging. The audit consisted of 49 checks that were a combination of estates or nursing staff responsibility, including the

Outpatients and diagnostic imaging

availability of hand hygiene alcohol containers and chairs for each room or area. All outpatient and diagnostic imaging areas had a score of 97% or above which was better than the trust target of 95%.

- The blood test area was situated close to the main entrance of the hospital and was clearly signposted. However, the waiting area was small and cramped, and the carpet had multiple stains on it.
- In the fracture clinic waiting area we were able to access an unlocked room containing cleaning products which had a 'hazardous' label on, including floor, toilet and multi-surface cleaners. The door had key pad entry but had been left open.
- The kitchen in this area was unlocked and we were able to access cleaning products in the cupboard under the sink which were meant to be kept out of reach of children. We informed the nurse on duty who removed this.
- In the orthopaedic fracture clinic waiting area we saw that the wheelchair storage area was situated in the waiting room next to normal seating for patients and relatives. There was one wheelchair stored here with paper taped to it saying 'broken brakes and air in tyres unsafe' but was not secured. This meant that a visitor may still be able to access the unsafe equipment.
- We reviewed one piece of mobile equipment in diagnostic imaging and saw this had a documented cleaning log, which meant that the equipment was regularly cleaned.
- Waste in clinic rooms was separated and in different coloured bags to identify the different categories of waste. This was in accordance with HTM 07-01, Control of Substance Hazardous to Health and Health and Safety at Work Regulations 2013.
- We saw sharps bins available in treatment areas where sharps may be used. This was in line with Health and Safety at Work regulation 2013 (The sharps regulations), 5 (1) d. This requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area.

Medicines

- An audit to assess the security of the FP10 (medicine prescription form) was carried out in February 2017. The audit found that 100% (22) of the FP10s checked were stored securely.
- We checked storage of FP10 in the areas we visited and found all of these to be securely stored, along with their log books to record which FP10 was assigned to who and on what date. This was in line with NHS Protect: Security of prescription form guidance (2013).
- We checked the FP10 log books and found that all of the FP10s were accounted for and logged, however the documenting of these was chaotic, with some being recorded under hospital prescription pages that should have been FP10s and vice versa..
- Drug cupboards in outpatients were locked and only registered nurses held the keys for these. This was in line with National Institute for Care Excellence (NICE) guidance MPG32.
- Patient group directives (PGD) allow healthcare professionals to provide patients with certain medicines without the need for referring to a doctor for a prescription. In outpatients one PGD was used in the dermatology (skin) clinic. We reviewed this and found that it was correct and in date. This meant that staff could safely administer this.
- We reviewed the drugs cupboard in radiology, this was secure and we saw all drugs were within their expiry date.

Records

- Between January and December 2016, on average less than 1% of patients were seen without their full medical record across the trust. When the full medical record was not available, a temporary set was created and included full patient details, a copy of the most recent referral letter and any recent diagnostic tests that could be accessed from the electronic patient systems.
- In one area of outpatients we saw that a room containing in excess of 50 records was left with the door wedged open. This area was on a main corridor and both staff and visitors could easily walk in and out, without being noticed, as our inspectors did. We later saw that a staff member removed the wedge and closed the door. However this did not provide assurance that notes were always kept securely.

Outpatients and diagnostic imaging

- We reviewed one patient's record. We saw that all relevant documents were available including referral letters and diagnostic test results.
- A trust wide medical records audit to monitor compliance with the trust healthcare records policy was carried out between April 2016 to January 2017. We saw that the compliance had decreased from the previous audit, with 93% of case notes in good physical order, and 52% not having history sheets. These results were both worse than the trust target of 95%.

Safeguarding

- The trust had in date safeguarding adults and children policies which stated that managers were responsible for ensuring their staff had received up to date training in these areas.
- Safeguarding adults at risk and safeguarding children and young people training was part of the mandatory training required for all staff at the trust.
- Due to outpatient's staff sitting in several different directorates, it was not possible to break the level of safeguarding training compliance down to an overall outpatient staff figure of compliance. In the head and neck directorate, the compliance rate for safeguarding adults at risk training was low.
- Compliance for safeguarding children and young people level one training was low.
- Compliance for safeguarding children and young people level two training was low.
- Diagnostic imaging staff sat in the central clinical services directorate. Compliance for safeguarding adults at risk training was low.
- Compliance for safeguarding children and young people level one training was low.
- Compliance for safeguarding children and young people level two training was low.
- Staff we spoke to understood their responsibilities regarding safeguarding vulnerable adults and children and knew the process of how to do this. We saw safeguarding process posters on the walls in some clinic areas.

Mandatory training

- Due to outpatient's staff sitting in several different directorates, it was not possible to break down an overall outpatient staff figure of compliance with mandatory training. In the head and neck directorate, where a large number of outpatient's staff sit, the compliance was low.
- The diagnostic imaging department sat in the central clinical services directorate and reported a low compliance in mandatory training.
- The trust had recently started using a new electronic system to monitor and provider reminders to staff when their training was due. Staff told us that this system was useful and made it easier to access e-learning where available.

Assessing and responding to patient risk

- A Clinical Harm Review Panel had been set up to review any patients waiting longer than 52 weeks to see a consultant. We saw that since February 2016, 264 patients waited longer than 52 weeks, of which, three (1%) were known to have come to some harm. We saw that the oversight of these was discussed at executive board level in the quality and safety committee meetings.
- Patients referred on a two week wait pathway for suspected cancer had a dedicated booking team within the booking hub. Patients were consistently booked for an appointment within the two week time period, and we saw examples of patients that were contacted on the same day of their referral to arrange their appointments.
- We reviewed tamper proof resuscitation trolleys in outpatients and diagnostic imaging. We found that these had regular checks for the contents, and all consumables were found to be in date.
- In diagnostic imaging we saw that a radiation protection supervisor was on site for each diagnostic modality and there was a contract with a local NHS trust for provision of a radiation protection adviser. This was in line with the Ionising Regulations 1999 (IR99) and the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.

Outpatients and diagnostic imaging

- We observed good radiation compliance in accordance with policy and guidelines during our visit. The department displayed clear warning notices, doors were shut during examination and warning lights were illuminated.
- Diagnostic reference levels (DRLs) were performed and documented in diagnostic imaging. All diagnostic imaging procedures carry some level of radiation, and DRLs are used to help manage the radiation dose to patients so that the dose is appropriate for the type of procedure a patient is undergoing.
- For interventional radiology procedures (such as CT guided biopsies), World Health Organisation (WHO) five safer steps to surgery checklists are used to ensure the procedure is carried out safely. The checklist contains questions such as if the patient confirmed their identity, whether the patient had any allergies and if the side of the patient that the procedure is due to be carried out on been marked. We saw an audit of the WHO checklist dated June 2016 which showed that the hospital achieved 79% compliance with this audit, which was worse than the 95% target. However, it was noted that interventional CT procedures at the hospital achieved 100% compliance with this audit
- We saw notices in the changing rooms and in the department advising women who may be pregnant to inform staff.
- Basic life support training (emergency airway, breathing and circulation support) was part of the mandatory training for all clinical members of staff. We saw that in the Head and Neck directorate, only 59% of staff had completed this training which was low.

Nursing staffing

- During our inspection, we saw that the levels of nursing and radiographer staffing were sufficient for the clinics being run.
- Between February 2016 and January 2017, Brighton and Sussex University Hospitals NHS Trust reported a bank and agency usage rate of 1% in Outpatients, Head and Neck outpatient services at Princess Royal Hospital had the highest average agency and bank staff use of 3%.

- Outside of normal hours, radiographer cover on weeknights was available until 10pm. Radiographer cover at the weekend was between 8am and 10pm and we saw that actual shifts matched planned shifts throughout February 2017.

Medical staffing

- Consultants worked in the outpatient department during their individual clinic days.
- Trust-wide there were currently five consultant radiologist vacancies and 22 whole time equivalent (WTE) radiographer vacancies based on establishment of 108 WTE. This meant that diagnostic imaging had a 25% vacancy rate.
- Radiology consultants worked seven days a week, on a rota basis, to provide consultant-directed diagnostic tests and completed reports.
- On weeknights, outside of normal working hours, a specialist registrar (consultant radiologist in training) and a non-resident consultant radiologist was on site between the hours of 8pm and 8am, ensuring 24 hour access to radiology services. At weekends, a consultant was on site between 9am and 5pm, non-resident consultant 5pm to 8am and a specialist registrar 24 hours a day.

Major incident awareness and training

- We saw the head and neck directorate business continuity plan (BCP) dated June 2017. There was no version control, name of author or responsible individual recorded on the document, and no date for review. The contents of the plan included actions and mitigations to take in the event of various occurrences that would affect business continuity. However, the 'essential staff' section of the plan was left blank, which means in the event of a major incident, anyone using the policy may not know who the essential staff for the service were. The section where administrative staff who may be able to help the emergency control centre (ECC) in the event of a major disruption, was also left blank, indicating that this section may have been missed, or that no staff from the directorate would be available to support the ECC.

Outpatients and diagnostic imaging

- The imaging department BCP was version controlled and dated, and listed a responsible individual and author. We spoke to staff who knew how to access this policy on the shared electronic drive.

Are outpatient and diagnostic imaging services effective?

We do not rate effective for outpatient and diagnostic imaging. When we inspected the Princess Royal Hospital in April 2016 we found:

- The outpatients and diagnostic imaging departments had undertaken local audits to monitor the quality, safety and effectiveness of care. We saw that most staff had a good awareness of National Institute for Care Excellence (NICE) guidelines and this was demonstrated in their practice.
- We saw staff were competent to perform their roles.
- The diagnostic imaging department had policies and procedures in place in line with national guidance.

At this inspection we found:

- People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- Staff could access the information they need to assess, plan and deliver care to people in a timely way.
- We saw good examples of multidisciplinary care.
- The diagnostic imaging department had retained Imaging Services Accreditation Scheme (ISAS) accreditation.

However:

- Appraisal rates were variable across the outpatients department, with trust wide directorate compliance worse than the trust target.
- Consent was not always obtained in interventional radiology in line with best practice.

Evidence-based care and treatment

- The trust aimed to treat all suspected cancer patients in line with NICE guidance NG12 (Suspected cancer:

recognition and referral) which outlined the suspected cancer referral pathway timescales of two weeks to see a consultant, 62 days from referral to treatment and 31 days between decision to treat and treatment.

- The hospital offered a nurse led photodynamic therapy service. Photodynamic therapy is a type of light that is used to treat some skin cancers. We saw that this type of therapy was provided in line with NICE guidance IPG55
- We saw that physiotherapy staff used the Tinetti scale (a tool used to test a patient's balance and gait) in line with NICE guidance CG161 – Assessment and prevention of falls in older people.
- Diagnostic imaging services had been re-accredited in the Imaging Services Accreditation Scheme (ISAS). ISAS is a patient-focused assessment and accreditation programme that is designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments. A requirement of the programme was to audit services regularly. We saw that a variety of audits were ongoing in the imaging departments which could demonstrate that best practice was being achieved.
- The imaging department had policies and procedures in place. They were in line with regulations under Ionising Radiation (Medical Exposure) regulations (IR (ME) R 2000) and in accordance with the Royal College of Radiologists standards.

Pain relief

- If pain relief was required in the outpatient department, staff could give patients a prescription, which they could take to the pharmacy department within the hospital.
- We saw a variety of pillows and pads that were available to make patients as comfortable as possible whilst undergoing an examination in the diagnostic imaging department.

Patient outcomes

- Patient outcomes in physiotherapy were monitored by recognised outcome measures such as range of movement, pain scores and the quality of life measures in order to establish the effectiveness of treatment.
- Every patient that attended an outpatient clinic had an outcome form and we saw blank copies of these

Outpatients and diagnostic imaging

attached to the front of patient's notes at the start of clinics. Outcome forms were completed by the consultant during the appointment and given to the patient to hand back into reception staff at the end of the appointment. The form indicated the next step for the patient, whether this was for discharge, further follow up or diagnostic tests and reception staff would ensure the next stage is recorded and booked appropriately on the system.

- We saw the results of patient outcome audits undertaken by the trust which monitored the percentage of patient outcome forms that had been received and processed following clinic appointments. The first audit identified that ophthalmology and oncology had the worst compliance rates, with only 58% and 56% respectively of forms returned following appointments. This meant that patients could be lost to follow up. We saw that an action plan was in progress to follow up this audit. The next step was for one to one training with consultants regarding 18 week referral to treatment training and a re-design of the patient outcome form itself which was due by August 2017
- Patients undergoing photodynamic therapy for basal cell carcinomas (a type of skin cancer) would have two sessions of photodynamic therapy, two weeks apart. Photographs would be taken at the first treatment session, and then the second, to document improvement or progress. We requested copies of the clearance rate audits but we were not provided with this information.

Competent staff

- In the diagnostic imaging department we saw signed competency documents for superintendent radiographers.
- Appraisal rates were variable across the outpatient's department. As staff sat in several different directorates, it was not possible to break this down to an overall outpatient compliance figure. In the head and neck directorate, the overall compliance figure was 82%. This was worse than the trust target of 85%.
- The diagnostic imaging department sat in the central clinical services, which reported a 91% compliance in appraisals, this was better than the trust target of 85%.

- We saw evidence that staff in diagnostic imaging completed reflective lookbacks as part of their supervision paperwork. This was considered good practice and encouraged learning amongst staff.
- Nursing revalidation dates were recorded as part of appraisal paperwork. Revalidation is the process that all nurses have to go through in order to renew their registration with the nursing and midwifery council (NMC).
- A snapshot audit was taken to assess the quality of appraisals trust wide. We saw that of 14 appraisal documents reviewed in the head and neck directorate, all had documented that clear objectives and personal development plans were discussed. However, values and behaviour discussions did not always include specific examples and some showed that values and behaviours were not discussed at all, (7 out of 14), and not all appraisals (4 out of 14) had documented a level of achievement for the individual. There was a plan to do a second audit later on in the year to monitor compliance and see whether quality had improved.

Multidisciplinary working

- Plaster technicians who worked in the fracture clinic, also worked in the diabetic and plastics clinics. This enabled staff to treat patients not only with broken bones, but also patients with open wounds and non-healing skin conditions.
- The diagnostic imaging department offered trans rectal ultrasound (TRUS) fusion biopsies. This is where a TRUS is performed at the same time as an MRI to enable a consultant radiologist or (highly trained) advanced practitioner radiographer to target the best visualised area for a biopsy.
- The outpatient department ran 'one stop' clinics, where patients could attend and have diagnostic tests and consultations in one appointment slot. Examples of these included the fast-track gynaecological clinics that were supported by sonographers, and the sarcoma (rare type of cancer) clinic that was supported by radiologists. Medical, nursing and diagnostic imaging staff also worked together in the fracture clinics.

Outpatients and diagnostic imaging

- We spoke to clinical nurse specialists who liaised with cancer multi-disciplinary team co-ordinators regarding patient's pathways. This helped to ensure that patients received their care within the national cancer pathway targets.

Seven-day services

- The diagnostic imaging department provided a seven day service. This was in line with; NHS services, seven days a week, priority clinical standard 5, 2016. This requires hospital inpatients to have seven-day access to diagnostic services such as x-ray, ultrasound, CT and MRI and radiology consultants to be available, seven days a week.
- Radiology consultants worked seven days a week, on a rota basis, to provide consultant-directed diagnostic tests and completed reports.
- On weeknights, outside of normal working hours, a specialist registrar (consultant radiologist in training) and a non-resident consultant radiologist was on site between the hours of 8pm and 8am, ensuring 24 hour access to radiology services. At weekends, a consultant was on site between 9am and 5pm, non-resident consultant 5pm to 8am and a specialist registrar 24 hours a day.
- Radiographers worked seven days a week on a rota basis. Outside of normal hours during the week, two radiographers were on site, and at the weekend there was cover between 8am and 10pm.

Access to information

- We saw that some clinics such as the photodynamic therapy clinic staff had access to an electronic patient information system used by GPs and some community staff. Access to this system enabled these staff members to access referral lists from GPs and to check whether a patient has been referred, referral details and test results.
- Clinical staff were able to access results of diagnostic tests via a picture archiving and communication system (PACS). This is medical imaging technology which provides storage and access to diagnostic images from multiple machine types. Other areas of the hospital were able to access the PACS system when required.

- Ionising Regulations 1999 (IR99) and the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000 folders were accessible and staff knew where to access them.
- In diagnostic imaging we saw a non-medical referrers list that was up to date all staff knew how to access this list.
- Imaging Service Accreditation Service folders and standard operating procedures were all clear and up to date in the diagnostic imaging department and staff knew how to access these.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were expected to complete mental capacity act training as part of their mandatory training requirements. We saw that both outpatient and diagnostic imaging staff had achieved a low level of compliance with this training.
- Staff understood relevant legislation and guidance including the Mental Health Act 2005. Staff also demonstrated good knowledge of the Deprivation of Liberty Safeguards (DoLS) and were able to describe the process of dealing with a patient who may not have the capacity to consent to treatment.
- We saw that consent for interventional radiology procedures such as CT guided biopsies was taken immediately before the procedure. Best practice dictates that consent should be obtained well before the procedure is performed and away from the relevant departments it is felt that a lot of patients would find it difficult to change their mind so soon before a procedure. We reviewed one patient record that had a recent consent form in. We saw that this was complete, and was signed and dated by both the patient and referring clinician.

Are outpatient and diagnostic imaging services caring?

Good



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

Outpatients and diagnostic imaging

- Staff treated patients with compassion and care.
- We observed staff helping patients when they appeared lost or required assistance.
- We saw staff had processes in place to respect patient's dignity.

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

- Friends and Family test (FFT) results were better than the England average for four out of six months we reviewed.
- We saw positive, friendly interactions between staff and patients.
- Patient comment cards were consistently positive about the care they received.
- Privacy and dignity was maintained.

However:

- The Patient Led Assessment of the Care Environment (PLACE) score for privacy and dignity was worse than the England average.

Compassionate care

- The Patient Led Assessment of the Care Environment (PLACE) for the period of 2016, which showed the hospital average, across five outpatient areas, scored 63%, for privacy and dignity, which was worse than the England average 83%.
- We saw examples of the privacy and dignity questionnaire run by the diagnostic imaging department. These questionnaires were completed twice a year and we saw the results from July 2016 compared to January 2017. We saw that improvement in patient satisfaction was seen in the x-ray and ultrasound departments, but a decrease in patient satisfaction was seen in the CT and fluoroscopy departments.
- We reviewed the results of the outpatient Friends and Family Test for a six month period (November 2016 to April 2017). This data was at a trust-wide level and it was not able to split these by site. We saw that for four of the

months, the score was better than the 93% average for NHS trusts in England. However, in December 2016 the score dropped to 92%, and in January 2017 the score was 82%, both worse than the 93% average.

- We reviewed results of the Friends and Family Test run by the imaging department. We saw results from between April and November 2016 which showed that an average of 94% patients would recommend the CT department to family and friends.
- We saw a 'you said, we did' board in the orthopaedic fracture clinic waiting area. Patients had said that it was difficult to hear when staff called the patient's name. The hospital had responded by saying that this was discussed at a team meeting the importance of calling patient name in a clear and concise way. We observed patients being called in a clear and concise way. Staff members did not always introduce themselves but were observed to be friendly and asked how patients were.
- We reviewed 59 comments card completed by patients visiting the outpatient and diagnostic imaging department. Ten of these related to the imaging department, and all comments were positive including: "really good", "very friendly" and "accommodating". The other 49 comments related to the outpatient department and again were all positive with the exception of some referring to time waiting for their appointment, comments included: "excellent treatment", "delighted" and "staff polite".
- We saw "Attention – care in progress" signs on all consulting room doors and saw staff knocking and waiting for a response before entering. We saw where glass was used in consulting room doors, obscured glass was used to ensure patient's privacy and dignity was maintained.
- In the diagnostic imaging department we saw thank you cards from patients displayed on notice boards.

Understanding and involvement of patients and those close to them

- There was sufficient information available for patients to be able to understand their care and treatment choices.
- We saw chaperone posters in all areas of the outpatient department.

Outpatients and diagnostic imaging

- All of the patient comment cards we reviewed showed patients were satisfied with the clinical care they received at the hospital.

Emotional support

- Staff told us that in the fracture clinic that a psychology service was available for patients that had experienced trauma. This ensured patients' wellbeing was taken into account as well as their physical health.
- Clinical nurse specialists (CNS) supported patients attending clinics. CNS's formed part of a multi-disciplinary team to provide support to patients with a cancer diagnosis, as well as their families and carers. We spoke to a CNS who had level two training in psychological support. This training was designed to assess and detect psychological distress within patients following a cancer diagnosis and enable the staff member to provide a higher level of psychological support.
- The hospital had a chapel on the first floor of the main building that was open to anyone who wished to use it, day or night. Chaplains were on call to offer both religious and spiritual advice to patients and their families.

Are outpatient and diagnostic imaging services responsive?

Requires improvement



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

- The trust was failing to meet all three of the cancer waiting times targets and the England 18 week referral to treatment standard.
- The pathology department was not providing diagnostic results for suspected cancer in a timely way.
- Call centre data demonstrated that almost half of incoming calls had been abandoned and unanswered.
- Sixty percent of all cancelled clinics were cancelled in less than six weeks' notice.

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

- The trust was performing worse than the 90% standard for patients been seen with 18 weeks of a routine referral.
- The trust was performing worse than the operational standard of 85% for patients receiving their first treatment within 62 days of urgent GP referral.
- The trust could not provide us with data for the turnaround time of biopsies which meant there was no oversight of delays or issues within this department.
- Signage around the physiotherapy area within outpatients was poor and we observed patients getting lost.

However:

- The trust was performing better than the operational standards for both people being seen within 2 weeks of an urgent GP referral and for those patients waiting less than 31 days before receiving their first treatment following a cancer diagnosis.
- Call centre abandonment figures had significantly improved since our last inspection.
- The hospital now monitored waiting times for patients in clinic which meant they were aware of problem areas or clinics.
- The trust had introduced two way texting for patient appointments and had seen a significant improvement in number of calls abandoned by patients calling into the booking hub.
- All complaints were investigated and closed within the trust-wide target for investigating complaints.

Service planning and delivery to meet the needs of local people

- Since our last inspection, the trust had introduced a two-way text reminder for patients to confirm their appointment. This meant that patients could access information about their appointment through their mobile telephone, rather than relying purely on a paper letter. We spoke to two patients who advised us that they found this system met their needs.

Outpatients and diagnostic imaging

- The trust Access Policy stated that where it was necessary to cancel clinics, this should be done with at least six weeks' notice. Between October 2016 and January 2017, the hospital cancelled between 1% and 3% of clinics with less than six weeks' notice. The main reasons for these were sick, compassionate and annual leave. This had improved significantly since the last inspection where 60% of clinics were cancelled within six weeks.
- Since our last inspection, the trust had introduced a two-way text reminder for patients to confirm their appointment. This meant that patients could access information about their appointment through their mobile telephone, rather than relying purely on a paper letter.
- We observed two sets of patients coming into the outpatient department to try and locate the physiotherapy clinic and getting lost due to poor signage, however clinic staff were able to help direct patients to the right area.
- The names and roles of the staff working in the clinic were displayed on the whiteboards, and there was also a whiteboard stating that 'due to clinics being very busy, they may run late, we apologise in advance for any inconvenience caused' but no detail of actual wait time or how much the clinic was overrunning by.
- The trust performed better than the 93% operational standard for patients being seen within two weeks of an urgent GP referral in quarters one, two and three of 2016/17. This was an improvement from quarter 4 in 2015/16 where the trust fell below the operational standard.
- However, the trust performed consistently worse than the operational standard of 85% for patients receiving their first treatment within 62 days of urgent GP referral, and the performance had worsened in quarter 3 of 2016/17, dropping to below 75%.
- The trust performed consistently better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a cancer diagnosis.
- Patients should wait no longer than six weeks for their diagnostic test. Between February and December 2016, the percentage of patients waiting more than six weeks to see a clinician for a diagnostic test was worse than the England average. However, in January, February and March 2017, 99.7% of patients received a diagnostic test within six weeks. We saw a comprehensive appointment booking system in the diagnostic imaging department that consistently provided appointments to patients within six weeks of request, which met national targets.
- We visited the pathology laboratory which dealt with the processing and reporting of all biopsies for the trust and spoke with the site lead for Brighton histology. The trust aimed to process urgent biopsies within 24 hours, and non-urgent biopsies processed within seven days. We asked the trust to provide us with data on the targets for reporting and turnaround times for the reporting of biopsies, but were told they were unable to provide us with this information due to technological issues with the systems. This meant the trust was currently unable to monitor issues or delays with biopsy reporting.
- The pathology department tested specimens where a piece of tissue had been removed to provide a diagnosis. Turnaround time (TAT) is a measure of how quickly a diagnosis can be provided. The histology lead informed us that TATs of samples were impacted by having to manually track the status of samples. We were informed that a new piece of software had recently been purchased with the aim of allowing electronic tracking of samples to decrease turn-around times in future.

Access and flow

- Between November 2016 and January 2017 the trust's referral to treatment time (RTT) for non-admitted pathways was worse than the England overall performance. As of January 2017, 81% of this group of patients were treated within 18 week versus the England average of 90%. RTT times improved between December 2016 and January 2017. Non-admitted pathways are waiting times (time waited) for patients whose treatment started during the month and did not involve admission to hospital.
- Patients who have suspected cancer should expect to see a specialist consultant within two weeks of referral from their GP; should have received their cancer treatment within 31 days of a decision to treat the cancer being made; and overall should receive their cancer treatment within 62 days from being referred from their GP, in line with national standards.

Outpatients and diagnostic imaging

- Staff liaised with cancer services staff to ensure that cancer/urgent biopsies were processed within sufficient timeframes to avoid breaches of the 31 and 62 day cancer targets.
- Since our last inspection, the trust had introduced a two-way text reminder for patients to confirm their appointment. Calls into the booking hub had reduced from 20158 incoming calls received in September 2016, to 9605 incoming calls in February 2017. With this reduction in number of incoming calls, the percentage of calls abandoned unanswered had also improved, with 57% of calls abandoned in September 2016, and 8% of calls abandoned in February 2017. Since November 2016, abandoned calls had not gone above 10% of the total incoming calls. This indicated that patients were able to access their appointment booking more easily. We spoke to staff in the booking hub who were proud of this achievement.
- We saw that the number of calls coming into the booking hub over the last six months had decreased from 20158 in September 2016 to 9605 in February 2017. During this time the number of calls abandoned by patients reduced from 56% in September 2016 to 7% in February 2017, indicating that more patients were able to make contact with the team regarding their appointment during this time.
- As of October 2016 the trust reported 40% of patients waited over 30 minutes to see a clinician.
- Between October and December 2016, an audit of overrunning clinics in outpatient areas was completed. This indicated, by speciality, that rheumatology and haematology clinics were frequently overrunning. As a result of this, reception staff now consistently recorded arrival time of patients as well as time they were called into the consultant. This meant the trust could monitor frequently overrunning clinics and assess where any issues were occurring.
- We saw posters advertising the Patient Advice and Liaison Service (PALS) and leaflets that patients could take away. We also saw that comment boxes were available to allow patients to raise concerns and to give feedback on the service.
- We observed bariatric chairs were available within the main outpatient's waiting room.
- There was a whiteboard in each waiting area with the names of staff on duty and the current wait time or delays for appointments.
- A ticketing system was in place for phlebotomy services to manage patient waits.
- Staff highlighted there had been a challenge to meet two week referral times for neurosciences particularly however, dedicated appointments were now reserved to ensure this time frame is met.
- We saw data that indicated that between January and March 2017, 55% of all clinic letters from outpatients were completed within seven days, 24% were completed within 14 days, and 22% took longer than 14 days to be completed. This meant not all letters were sent within the target time of seven days.
- As of October 2016, the trust reported that less than 1% of patients seen in outpatients without their full medical record being available. This was an improvement since 2016 where 8% of patients were seen without their full medical record. We were told that in the event of a medical record not being available, a temporary set would be created by medical records staff, which would include the patient's details and a printed copy of the referral letter sent by the referrer and any related test results.

Meeting people's individual needs

- The Patient Led Assessment of the Care Environment (PLACE) for 2016 showed the hospital scored 44% across five outpatient areas for dementia, which was worse than the England Average of 80%.
- The PLACE assessment for the period of 2016 showed the hospital scored 40% for disability across five outpatient areas, which was lower than the England average of 81%. The place assessment for disability was included for the first time in 2016, and focuses on key issues of access including wheelchair, mobility (e.g. handrails), signage and provision of such things as visual/ audible appointment alert systems, hearing loops, which can prove helpful to people living with disability.
- We saw patient leaflets available in waiting areas covering a number of topics such as stop smoking, arthritis research and Macmillan cancer support.

Outpatients and diagnostic imaging

- We saw several clinics had access to a 'quiet room' such as in the colposcopy and early pregnancy clinics where patients could be taken if they had received bad news.
- The trust could access both face to face and audio translation and interpretation services for patients who did not speak English fluently. The trust website advised patients to contact the department they were visiting as detailed in the clinic letter they received prior to their appointment.

Learning from complaints and concerns

- Between January 2016 and February 2017 there were 344 complaints about outpatients trustwide. The trust took an average of 18 days to investigate and close complaints, which was in line with their complaints policy, which stated that 90% of complaints should be investigated and closed within 40 days. A large proportion of complaints received were in relation to treatment pathways, staff attitude, treatment and procedure and cancelled appointments.
- We saw in various waiting rooms and areas of outpatients and diagnostics imaging, leaflets explaining how to complain and signposting to PALS.
- The CQC received ten enquiries relating to outpatients between April 2016 and March 2017. All of these were negative feedback relating to cancelled or delayed appointments.

Are outpatient and diagnostic imaging services well-led?

Requires improvement



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

- There was no formal strategy or vision in place in the outpatient department.
- Not all staff felt they could approach their managers for support.
- Senior managers and the executive team were not always visible to staff in the department.

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

- There was no formal strategy or vision in place in the outpatient department.
- Not all staff we spoke with knew what directorate they belonged to.
- The 2016 staff survey results indicated that staff engagement had worsened since the 2015 survey results.

However:

- We saw that the culture in the service was good.
- Staff felt supported by both their immediate line managers and their directorate lead nurse.
- There was staff engagement at department level with team meetings and forums for staff to attend.

Leadership of service

- The head and neck directorate were responsible for delivering outpatient services at the trust, with the clinical activity monitored by the relevant directorate. Each clinical directorate had a leadership team which included a Clinical Director, Lead Nurse and Directorate Manager.
- Diagnostic imaging services and the pathology teams sat under the central clinical services directorate. Administration teams and the booking hub were managed by central administration services.
- The lead directorate nurse had set up the outpatient nurse forum to look at practice across all clinics and we spoke to outpatient nurse managers who said how valuable and useful this forum was. Outpatient nurse managers managed their own areas within different buildings across the site, and the forum was an opportunity for staff to improve joint-working and discuss any issues. They told us this meeting was valuable, and helped facilitate consistency in the department.
- Staff felt that the culture of the outpatients department had improved under the current manager. The staff we talked with told us that the manager was 'visible, caring and helpful and escalates problems on behalf of staff'.

Outpatients and diagnostic imaging

- All members of staff we spoke to were able to tell us who they reported to, but the majority of staff we spoke to were unaware what directorate they sat in. Staff told us that the directorates changed so often that it was difficult to keep up indicating that communication from senior leadership was not always effective. A further change to the structure of directorates was planned for 2017 but not all staff were aware of this.
- In diagnostic imaging, all staff we spoke with told us that the managers were supportive and visible. Radiography staff told us the new manager has empowered the superintendent radiographer and worked well with the team.

Vision and strategy for this service

- There was no strategy or vision for outpatients or diagnostic imaging. We spoke to the lead directorate nurse for outpatients who told us whilst there was no formal vision in place, the aspirational vision was to celebrate outpatients and empower staff.
- We spoke to staff managed by the lead directorate nurse who told us that they had felt empowered by the directorate lead nurse.
- Senior staff in diagnostic imaging informed us that whilst there was no current updated strategy, one was being refreshed in line with the new trust-wide clinical strategy.
- We spoke to staff about the trust visions and values and whilst not able to articulate the hospital values of communication, kindness, working together and excellence, staff spoke of the importance of quality patient care, which fitted with the trust vision of providing safe, high quality services.
- There was an outpatient improvement project which focussed on administrative processes, patient experience of waiting times & technology projects. This included process improvement milestones such as processing referrals within 24 hours, two week wait appointments booked within 30 minutes of receipt and auditing of overrunning clinics. Each stage was red, amber, green (RAG) rated to indicate what stage the process was at. This enabled staff to visualise the improvement of administrative services within outpatients. We saw the terms of reference for the

outpatient improvement group meetings, and membership included members of the central administrative service and the lead nurse for outpatients.

Governance, risk management and quality measurement

- The majority of data we reviewed was not site specific, such as mandatory training data. This meant that whilst they were recording important information about the performance of the service, it was not clear whether a problem or poor compliance was a trust-wide issue or site specific.
- The lead directorate nurse had initiated a Patient Quality and Safety Measurement tool. This was a matrix that was completed bi-monthly by either the directorate lead nurse or their deputy. We saw a completed matrix for the main outpatients from November 2016 to April 2017. This measured against four standards: risk management, incidents, medicines management and infection control. The assessor would check against the various performance indicators such as if gel dispensers were present, whether there was a daily huddle and if appropriate risk assessments had been completed. We observed most of the checks had been completed on the sheet we saw, however there were some gaps where it was not clear whether a check had been undertaken or not. There was also a column for 'agreed person to action' which had been left blank on all entries we viewed so it was not clear who was responsible should one of the checks be found missing.
- The Quality and Performance Committee (QPC) was an executive level meeting that met monthly. We reviewed the minutes from February and March 2017 which demonstrated that compliance with the 18 week, diagnostics waits and national cancer targets was discussed at board level, demonstrating that the board had an understanding of these issues. Also discussed at the QPC was the clinical review of patients waiting longer than 52 weeks for review by a clinician, indicating that the board had an awareness not only of the breach of standards, but the potential of patients coming to harm as a result of this.
- The six outpatient nurse managers met monthly for the outpatient nurse manager meetings. We saw minutes

Outpatients and diagnostic imaging

from two sets of these meetings, and saw topics such as complaints and infection control issues were discussed, however quality issues such as incidents and risks were not discussed at these meetings.

- We also noted from the minutes of the meetings, two nurse managers brought the 'safety huddle' idea back from a visit to a nearby NHS trust. This was a system of discussion of key safety issues before clinics started and was in use at the trust's other site, but we were told by staff that these do not regularly take place at this hospital.
- The highest rated risk for the diagnostic imaging department was the lack of paediatric radiology cover outside of hours. There were controls in place for this which involved an external company providing advice over the telephone if required, although this did not resolve the issue if a paediatric radiologist was required on site out of hours. Other high rated risks included the age of the CT scanner at the hospital, and pest control risks within the interventional radiology suite.
- The imaging department did not hold its own governance meetings, instead holding imaging discrepancy meetings and quality and safety updates. Whilst we did not see minutes from these meetings, we saw that they were a standing agenda in the diagnostic imaging department. We also saw minutes from the Ionising Radiation Safety Committee meetings, where incidents reported in the previous month were discussed.
- The outpatient improvement project (OIP) and outpatient nurse forum (ONF) both fed in to the Quality and Performance Committee (QPC). The ONF focussed on clinical processes, environment & patient experience.
- The patient led assessments of the care environments (PLACE) audits were significantly worse than the national average for both disability and dementia, however there was no action plan to address this.

Culture within the service

- Staff we spoke with in diagnostic imaging felt motivated and enthusiastic about their job.
- We spoke to senior members of staff regarding the management of poor performance and behaviours not in line with the trust values. There was a policy in place for managing performance and poor behaviour and we

were told that the human resources department had been supportive of managers who were dealing with these types of processes. Furthermore, the lead directorate nurse for head and neck had set up a weekly meeting with HR to discuss any outstanding issues regarding performance, recruitment or other workforce concerns.

- We spoke to members of staff who felt that their work was not recognised by the trust and they felt that this affected morale and motivation.

Public engagement

- The hospital participated in patient led assessments of the care environments (PLACE) audits. These assessments invite local people go into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance.
- There was a patient experience panel that had been set up in a revised format from April 2017. We saw the terms of reference for this panel which stated that a minimum of two patient representatives must be present at this meeting in order for it to be quorate. We saw minutes from the May meeting which demonstrated that two patient representatives sat on this meeting and were able to share their views and experience at this meeting.
- Patients and relatives could use the NHS Choices website to leave feedback regarding their experience. We reviewed the feedback left for the last 12 months; however the feedback could not be broken down to outpatients services or diagnostic imaging.
- The trust had a public website that patients could access to find out more information about their outpatient appointment or to feedback their experience. Patients could click on the 'your outpatient appointment' section to find out useful contact numbers, how to access transport and could cancel or re-schedule their appointment by a form should they need to.

Staff engagement

- The diagnostic imaging team had regular team briefs and staff told us they could discuss issues such as image quality, problems with referral forms and that openness was encouraged in this forum.

Outpatients and diagnostic imaging

- Staff received a leaflet along with their payslip regarding the freedom to speak up guardian – an impartial person that staff could approach regarding any work related concerns or issues. Staff told us this was highlighted and discussed in the team briefs.
- In the diagnostic imaging department we saw a designated notice board for students in the department, and this had the names of students' clinical assessors and contact details, attendance sheets and prompts for jobs during quiet spells.
- The trust participated in the NHS staff survey. This data could not be broken down by hospital site. This survey assessed staff engagement by asking a range of questions about working lives, assigning a score

between one (indicating poor engagement) and five (good engagement) and then comparing these scores against other similar trusts. The 2016 staff survey showed a decrease in overall staff engagement compared to the 2015 staff survey. The trust's score of 3.62 was in the worst 20% when compared with trusts of a similar type.

Innovation, improvement and sustainability

- The photodynamic therapy service was nurse led and we spoke to one of the nurses who had helped implement the service. This was not a service that is routinely offered across the country and we saw multiple plaudits received for this service.

Outstanding practice and areas for improvement

Outstanding practice

- The new self-rostering approach to medical cover had a significant impact on Urgent Care service. Medical staff appreciated the autonomy and flexibility this promoted as well as the effective and safe cover for the department. Due to this initiative, the department was able to provide round the clock medical cover without the use of temporary staff.
- The introduction of the clinical fellow programme that had improved junior cover in the department and also the education and development opportunities for juniors.
- There were innovative approaches to supporting patients living with dementia on Pierpoint ward. There was a bus stop with bench in the ward corridor and was used as a focal point for patients to meet. Some patients wandered and this enabled them to rest and also provided a distinct reference if a patient could not

remember where they were going. Each bay was also painted a distinct colour to support patients to find their way back to their beds. A computer was available for patients to use in order that they could Skype family who could not visit every day. We also saw there was a quiet room available for patients and family to meet away from the ward area. This room contained life sized stuffed animals that were used as therapy due to the health and safety issues around bringing in a pet as therapy dog. The ward also had a reminiscence room that was decorated and set up like a living room from the 1950's. Staff advised us this area was used for therapy sessions as patients felt more at ease in the surroundings. Inside the room there was also a made up switchboard for patients with electronic and operator experience.

Areas for improvement

Action the hospital MUST take to improve

- In ED, the trust must ensure that medical gases are stored safely and securely.
- In ED, the trust must ensure the current paediatric service provision is reviewed and has a safe level of competent staff to meet children and young people's needs.
- In outpatients and diagnostic imaging, the trust must take action to ensure that patient records are kept securely.
- In surgery, the trust must ensure that safer sharps are used in all wards and department
- National Specification of Cleanliness (NCS) checklists and audits must be in place including a deep cleaning schedule for theatres.
- In critical care, the hospital must take action to ensure that information is easily available for those patients and visitors that do not speak English as a first language.
- In critical care, the trust must ensure there is adequate temperature monitoring of medicines fridges.
- In critical care the controlled drug register must comply with legislative requirements.

- In critical care, the trust must ensure that pharmacy support meets national guidance.
- In critical care, the trust must make arrangements to meet national guidance on dietetic provision.
- The trust must ensure that all staff within the medical directorate have attended mandatory training and that there are sufficient numbers of staff with the right competencies, knowledge and qualifications to meet the needs of patients.
- The trust must ensure all staff within the medicine directorate have an annual appraisal.
- The trust must ensure fire plans and risk assessments ensure patients, staff and visitors can evacuate safely.
- The trust must ensure all medical wards where medicines are stored have their ambient temperature monitored in order to ensure efficacy.

Action the hospital SHOULD take to improve

- In ED, the trust should consider how patients with impaired capacity have these risks identified and managed appropriately.

Outstanding practice and areas for improvement

- In ED, the trust should consider how mandatory training rates could be improved to meet the trust own compliance rates.
- In ED, the trust should consider how it manages continuity with incident, compliant and risk management processes across both sites.
- In ED, the trust should provide sufficient housekeeping cover in the department twenty-four hours a day.
- In ED, the trust should improve staff engagement at the PRH site.
- In outpatients and diagnostic imaging, the trust should improve that compliance with mandatory training completion.
- In outpatients and diagnostic imaging, the trust should consider how appraisal targets are met.
- In outpatients and diagnostic imaging, the trust should discuss incidents regularly with staff and share.
- In outpatients and diagnostic imaging, the trust should develop a strategy for the outpatients and diagnostic imaging department.
- In surgery, the trust should take steps to consider how the 18 week Referral to Treatment Time is achieved so patients are treated in a timely manner and their outcomes are improved.
- In surgery, the trust should continue to work on reducing the waiting list for specific colon surgery.
- In surgery, the trust should make arrangements so all staff have attended safeguarding and all other mandatory training.
- In surgery, the trust should ensure the plan to improve staff engagement is fully implemented.
- In critical care, the trust should take steps consider altering the record keeping system so it is the same as that at the RSCH.
- In critical care, the trust should not store items in corridors or use wooden pallets.
- In critical care, the trust should look to change the main door to the unit to one that is motorised.
- The trust should take steps to fully meet the national guidelines around the rehabilitation of adults with a critical illness.
- The critical care department should improve their performance in relation to the local critical care network measure of quality and innovation.
- The critical department should take steps to ensure that medical staff are given Mental Capacity Act and Deprivation of Liberty Safeguards.
- The critical care department should widely publish information collected from the friends and family test.
- The trust should take steps to address the delays that patients have when being discharged from critical care.
- The senior leadership team should develop an interim strategy and vision for the critical care department.
- The critical care management team should work the HR team to address the issue of staff working between the trust's two sites.
- The medicine directorate should review the provision of the pain service in order to provide a seven day service including the provision of the management of chronic pain services.
- The medicine directorate should review the provision of pharmacy services across the seven day week and improve pharmacy support.
- The medicine directorate should prioritise patient flow through the hospital as this impacted on length of stay, timely discharge and capacity.
- In maternity the trust should consider involving the directorate in Morbidity and Mortality meetings to ensure robust learning and review.
- The trust should consider representation from maternity on the board from the directorate to ensure feedback is received and heard.
- Targets for mandatory training in maternity and gynaecology should be reviewed so trust targets can be met, in particular with regards to safeguarding.

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

Diagnostic and screening procedures
Maternity and midwifery services
Surgical procedures
Termination of pregnancies
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 (1) (2) (e) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and used in a safe way.

In theatres it was decided not to adopt safer sharps initiative. The Health and Safety (Sharp instruments in Healthcare) regulations 2013 state providers must use safer sharps.

Regulated activity

Diagnostic and screening procedures
Maternity and midwifery services
Surgical procedures
Termination of pregnancies
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 (1) (2) (h) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.

A deep cleaning of theatres has not been completed since September 2015.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Termination of pregnancies

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 12 (1) (2) (g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The proper and safe management of medicines

We identified two large cylinders (of air and oxygen) in the ED storeroom that were not stored in line with national guidance.

On all medical wards we visited, staff did not ensure that in areas where medicines are stored, ambient temperatures were taken daily.

In critical care, there was inadequate temperature monitoring of fridges where medicines were stored.

In critical care the controlled drug register did not comply with legislative requirements as errors in the controlled drug register had been crossed out.

In critical care, pharmacy support did not meet national guidance (Guidelines for the Provision of Intensive Care Services) which state that there must be a critical care pharmacist for every critical care unit.

Regulated activity

Regulation

Diagnostic and screening procedures

Surgical procedures

Termination of pregnancies

Treatment of disease, disorder or injury

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulation 9 (1) (2) (3) (c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Enabling and supporting relevant persons to understand the care or treatment choices available to the service user and to discuss, with a competent health care professional or other competent person, the balance or risks and benefits involved in any particular course of treatment.

In critical care, information was not easily available for those patients and visitors that did not speak English as a first language.

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Maternity and midwifery services

Surgical procedures

Termination of pregnancies

Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 (1) (2) (c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely

The hospital did not ensure all staff within the medicine directorate had received an appraisal. Therefore, there was no assurance that staff were receiving adequate development or that issues were being identified and reviewed.

Mandatory training rates within the medicine directorate were below trust targets. Therefore, there was no assurance staff knew up to date and best practice methods, or that staff would know correct procedures during an emergency.

Mandatory training rates within the maternity and gynaecology directorate were low. Therefore, there was no assurance staff knew up to date and best practice methods or that staff would know correct procedures during an emergency.

There was insufficient staff with the right skills (medical and nursing) to safely meet the needs of the children who attended the ED department.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Maternity and midwifery services

Surgical procedures

Termination of pregnancies

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 (1) (2) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Doing all that is reasonably practicable to mitigate any such risks.

This section is primarily information for the provider

Requirement notices

Fire risk assessments were incomplete and there was no over-arching governance of fire issues. Fire training rates were also below the trust target. Therefore, there was no assurance staff would know correct procedures in the event of a fire.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Termination of pregnancies
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 (1) (2) (c) HSCA (Regulated Activities) Regulations 2014

Systems or processes must be established and operated effectively to maintain securely an accurate, complete and comprehensive record in respect of each service user.

In the outpatient department we observed a room housing multiple patient records to be unlocked with the door wedged open and no staff were in the room. This meant that the notes were not secure.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Termination of pregnancies
Treatment of disease, disorder or injury

Regulation

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

Regulation 14 (1) (2) (3)(4)HSCA (Regulated Activities) Regulations 2014

Receipt by a service user of suitable and nutritious food and hydration which is adequate to sustain life and good health.

Dietetic in critical care did not meet national guidance which states there must be a dietitian as part of the critical care multidisciplinary team (Guidelines for the provision of intensive care services). Dietetic support was not provided to the number of hours recommended.