University Hospitals Sussex NHS Foundation Trust

St Richard's Hospital

Inspection report

St Richards Hospital
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Ratings

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

Our findings

Overall summary of services at St Richard's Hospital

Requires Improvement 

St Richard’s Hospital is one of the hospitals of University Hospitals Sussex NHS Foundation Trust and provides clinical services to people living in and around Chichester.

At this inspection we inspected the surgery core service at St Richard’s Hospital. We found there was a deterioration in the quality and safety of the surgery service since the last inspection of surgery in 2016, resulting in a drop in their rating. The change in rating of the surgery services at St Richard's Hospital has affected the overall rating of the hospital which has dropped to requires improvement. More detail about the findings and required improvements can be found in the surgery core service section of this report.

Surgery

Requires Improvement  

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

- The service did not have enough staff to care for patients and keep them safe. The service did not control infection risk well. Staff did not always manage medicines well. The environment and its maintenance did not always support safe care and treatment. Organisational wide learning from incidents was not well implemented.
- The service did not always have enough staff to care for patients. Mandated training did not include training on how to interact with people with a learning disability and autistic people. Managers did not always ensure staff were competent or carry out staff appraisals in a timely way.
- The service did not effectively plan care to meet the needs of local people, with demand outstripping capacity. People could not always access the service when they needed it and had to wait too long for treatment.
- Staff could not describe the service's vision and values, and how to apply them in their work. Staff did not always feel respected, supported, and valued. Although staff were focused on the needs of patients receiving care, they were sometimes unclear about their roles and accountabilities.
- Emergency medical equipment was not always checked in line with guidance and oversight of equipment checking was not effective.

However:

- Staff understood how to protect patients from abuse, and managed safety well.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it.
- Staff treated patients with compassion and kindness, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- Staff assessed risks to patients, acted on them and kept good care records.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

Is the service safe?

Requires Improvement  

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

Mandatory training

The service provided mandatory training in some key skills to staff but this was not comprehensive. Managers monitored compliance, however not all staff were up to date and there was no plan to improve compliance.

Staff mostly received and kept up to date with their mandatory training. Overall mandatory training compliance target for staff in surgery was 90%. The service met the trust target, with an averaged compliance rate of 90%. However, this

was positively affected by administrative and healthcare scientists who had an overall compliance of 97% whereas specialist surgery staff were 87% compliant. The trust told us their compliance percentage had been affected by the junior doctor changeover which occurred nationally during the time the data was supplied, however when compliance was calculated without medical staff this still remained below target at 90%.

Data supplied by the trust following our inspection showed compliance with conflict management training was lower than the trust target. Only 80% of staff had completed this. Data also showed that 84% of staff had completed moving and handling training for clinical staff. In addition to this overall staff compliance for basic life support was below the trust target of 81%.

Managers told us they monitored mandatory training and alerted staff when they needed to update their training. The trust did not supply any additional information to evidence how they planned to address the shortfall in mandatory training compliance.

The mandatory training available was not comprehensive and only met the needs of some patients and staff. There was no dedicated training on recognising and responding to patients with mental health needs or dementia. The trust had also not fully implemented dedicated training on recognising and responding to patients with learning disabilities and autism. There was also no training available for all staff in sepsis recognition or management.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. There was training on how to recognise and report abuse but this was not always completed.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. For example, we heard an example of where a referral had been made for a patient who they were concerned was at risk of harm and this was followed up by the safeguarding team.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with could not identify the safeguarding lead but we saw information on how to contact them was easily found on the trust intranet.

All staff said they knew how to make a safeguarding referral and told us they would contact their line manager and refer to the intranet for additional guidance This meant staff knew how to contact them for support when required.

There was training for staff specific for their role on how to recognise and report abuse. The trust target for compliance was 90%. Data provided by the trust showed safeguarding training compliance was 98% for safeguarding adults level 1. Training compliance levels for children's safeguarding was 96% for level 1. Training compliance for safeguarding adults' level 2 was 94%.

Training compliance for safeguarding children level 2 was 87% which was below the trust target. The trust identified 1 member of staff in surgery who required level 3 safeguarding children training and this had been completed.

Staff had training in Prevent as part of safeguarding level 1 training, this government led training aimed to support staff to recognise people who may be susceptible to radicalisation. The compliance for this training was 94%. However, for staff who required level 2 training, the compliance percentage was only 56%.

Surgery

Cleanliness, infection control and hygiene

The service did not always control infection risk well. There was inconsistency in the use of audit to evidence infection prevention and control compliance. Staff did not always use control measures to protect patients, themselves, and others from infection. They did not always keep equipment and the premises visibly clean.

Ward and theatre areas were clean and had suitable furnishings which were clean and well-maintained.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed staff using 'I am clean' stickers on equipment and domestic staff followed daily work sheets to complete cleaning activities. We saw cleaning checklists were completed daily by staff and had been for the month prior to inspection. Staff in theatre recovery areas told us they completed cleaning at the start of the day but this was often delayed due to patients being in this area overnight due to not having a bed on a ward.

Following our inspection, we requested infection prevention and control (IPC) audit data for surgical wards and theatres at St Richard's Hospital. We identified a lack of consistency in the completion of these audits between surgical areas. The trust told us staff recorded all IPC audits on an electronic system and monthly reports could be generated to monitor compliance. The overview report generated for February to July 2023 showed theatres at St Richard's recording a compliance of 0%. The trust supplied data which showed inconsistent recording of weekly audit compliance for surgical wards including Bosham, Selsey and Wittering. Data we reviewed showed missing data for some weeks. For example, Wittering ward had 6 out of 17 weeks without a recorded score, and Bosham ward showed only 15 boxes without a score.

Despite the inconsistent completion of recorded scores, some areas, including Aldwick and Pagham were recorded as having 100% compliance. This seemed to be based on only completed audits and not those that had not been completed, so it was unclear how this score was generated. When we spoke with senior leaders they told us these audits were completed so it was not clear how they were recorded or monitored at local or provider level.

We requested hand hygiene audit scores for the period between February and August 2023. The trust provided hand hygiene audits; however these were incomplete. Wittering ward was recorded as not having completed an audit for 6 out of 7 months. A score of 100% for May 2023 was given. Despite these audits being incomplete, the areas were recorded as having 100% compliance, this seemed to be based solely on the completed audits and not those that had not been recorded so it was unclear how this score was generated. There were no compliance scores supplied for a further 7 wards, including Ashling and Chilgrove. Therefore it was unclear how IPC practices for any of these areas was monitored for compliance and improvement at ward or a higher governance level.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE was available in all areas. We saw the correct use of PPE such as disposable gloves and aprons. PPE was available in all clinical areas. Hand sanitiser was located across ward areas and staff and visitors were encouraged to use it.

Within theatres we saw how staff wore designated scrubs to ensure sterility of this area was maintained. Scrubs single session clothing items are worn by medical professionals involved in patient care. There were visual reminders to not enter non-surgical areas in these uniforms. However, we saw that surgical scrubs were not always readily available for staff. We spoke with staff who told us they frequently arrived for work in theatres and were unable to change. This led to delays on starting surgical procedures. Staff told us this was frustrating as these items were essential and necessary to maintain the sterility of theatres. We spoke with leaders who told us these shortages were regularly escalated but not resolved.

Surgery

Staff worked to prevent, identify, and treat surgical site infections (SSI). Staff used records to identify how well the service prevented infections. The theatre ventilation systems were recorded on the service risk register as being old and requiring replacement. The service had investigated if the ventilation system was a contributory factor in the increased number of SSIs, however this proved inconclusive. There were concerns with the plant room of the theatres and its age. A plant room, sometimes referred to as a mechanical room or boiler room, is a dedicated space containing the equipment required to provide or supply building services such as ventilation, electrical distribution, and water. The ageing plant had an impact when temperatures were either extremely low or very high. Operating lists had been cancelled because of this issue.

Environment and equipment

The design, and use of facilities and premises did not always keep people safe. maintenance and safety checks on equipment were not always completed. However, Staff were trained to use equipment and managed clinical waste well.

In main theatres and the treatment centre we saw equipment stored in corridors as there were no secure areas for these to be stored in. In one area this equipment was blocking an entrance into a theatre so an alternative entrance was used. This meant equipment and corridors were difficult to access for cleaning. Staff told us equipment in corridors also made it challenging to move patients and equipment around.

In main theatres and in the Chichester Treatment Centre we saw that hazardous chemicals were not stored in line with guidance. We saw chlorine tablets stored on both areas on shelves in unlocked store rooms. This was not in line with Control of Substances Hazardous to Health (COSHH) guidance which stipulates that hazardous substances must be stored in a way that minimises exposure and risk. These areas were also cluttered with large amounts of equipment being stored on the floor,this meant effective cleaning was a challenge and posed a risk to staff of trips or boxes being insecurely stored and falling. There was also sink in the Chichester Treatment centre storage area with a broken mirror taped to the wall. We asked staff about this and they were unsure if the mirror has been reported but said it had been like this for more than a year.

Although access to the wider theatres area was secure via staff pass cards, we saw that doors to storage areas were unlocked or propped open. We also saw a fire extinguisher was stored in a corridor, next to the theatres exit and the tamper pin had been removed, this posed a hazard. We brought this to the attention of a staff member who removed it.

Senior leaders told us environmental spot checks were undertaken to monitor compliance with guidance such as cleaning of equipment and access to hazardous chemicals. The compliance for Bosham ward was, on average for the last 12 months, below target at 87%. The audit for June 2023 showed compliance was 97% for the month but in July 2023 this reduced to 85%.

We reviewed data from Middleton and Aldwick wards which showed average compliance with environmental guidance was below target at 74% and 85% respectively from the 4 months prior to July 2023. There were no environmental audit records for theatres or Pagham wards, therefore, we saw no evidence of trust oversight of compliance with environmental guidance.

On Pagham ward, we found an unlocked door to a storage cupboard in the recovery area. The door, identified as a fire door, was held open by a length of cable that had been attached by staff. The cupboard was used to store general items of equipment. Within the cupboard there was an unlocked cabinet containing medicines to be provided to patients upon their discharge. We saw fluids being stored in this cupboard. We highlighted this to staff during the inspection and they immediately ensured the door was closed.

Surgery

The service had enough suitable equipment to help them to safely care for patients. However, staff did not always carry out daily safety checks of specialist equipment. In theatres we saw daily checking for emergency equipment had not been completed in line with policy. For example, we saw a trolley containing emergency equipment had not been checked on 8 occasions in May, June, and July 2023. In February there were 12 occasions where it had not been checked, on two occasions this was not done for 3 consecutive days.

In addition to this, a trolley containing equipment for emergencies involving a patient with difficulty breathing had not been checked on 13 days in July and 9 days in June 2023. There were also incomplete checks on paediatric emergency equipment. Records showed that no safety checking has been completed for a period of 7 days between June to July 2023. There were 30 days in the period between April to August where no safety checking of this equipment had been completed. We were not provided with evidence of any internal monitoring processes to oversee compliance of emergency equipment checks. This meant that resuscitation equipment may not be available and fit for purpose and was not checked in line with professional guidance.

We saw anaesthetic machine safety checks had not been recorded in log books on multiple occasions where there had been surgery within theatres. This was not in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) recommendations. The trust told us that anaesthetic machines were checked daily and this was recorded electronically on the equipment. However, all clinical staff we spoke with told us this should always be recorded in the log book as the AAGBI guidelines were widely regarded as best practice. This was also not in line with MHRA guidelines which state accurate and complete copies of records in paper or electronic form are required to be made available for future inspection, review and copying e.g. for CQC, internal audits, traceability, and investigations. This meant that anaesthetic equipment may not be available and fit for purpose and was not checked in line with professional guidance.

Staff disposed of clinical waste safely. Appropriate facilities were available for storage and disposal of household and clinical waste. A sharps bin is a container that can be filled with used medical needles and all categories of ‘sharps’ waste, before being disposed of safely. Most ‘sharps’ bins we observed were appropriately labelled, stored correctly and not overfilled. However, we saw one sharps bin in a supplies store of the treatment centre being used to store confidential documents. This posed a risk of these documents being viewed by staff who did not have access or a legitimate reason for doing so e.g. they were not the intended recipient.

In main theatres and the treatment centre we saw fridges used to store medicines that had April 2023 service dates which evidenced they were overdue for servicing. We were told by managers that servicing was monitored by an internal spreadsheet, we requested this from the trust following the inspection but this was not provided.

The design of most environments followed national guidance. However, staff told us the preparation rooms in day surgery did not meet national guidance, this did not adversely affect patients and changes to process had been risk assessed. Theatres were located in an older area of the hospital and had limited space. We saw equipment being stored in corridors. There were also issues with the plant equipment that supported the theatre area. We heard how this was unreliable and would break down. This would lead to surgery cancellations due to the temperature in theatres becoming too high to safely continue.

We saw some wards were cluttered and did not have enough room for all equipment.

Patients could reach call bells and patients we spoke with told us that staff were responsive when they called for support.

Surgery

The service did not always have suitable facilities to meet the needs of patients and their families. For example, day rooms on wards were being used as escalation areas for additional beds spaces. On Middleton ward staff told us a treatment room was used as an additional bed space. Staff showed us the room, which had no window, no call-bell, piped oxygen, or suction. At the time of the inspection the room was being used as an office with a desk and computer, as well as a general storage area. Staff told us when a bed was placed in the room all the general items needed to be moved into the ward corridor, which cluttered the corridor. The desk was unable to be moved due to its size. This posed a risk to patient safety should these items be required and also a fire hazard when these items were in the corridor and posed a risk that premises may not always keep people safe.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, the service was not compliant with safer surgery guidance and best practice.

Risk within theatres should be recorded as part of the World Health Organisation (WHO) surgical safety checklist. Staff told us that these checklists were regularly audited. We reviewed the completion of surgical safety checklists in all of the theatres we visited. These showed that between May and July 2023 the compliance with WHO checklists was 96%. Completion of the WHO checklist is mandatory and compliance should always be completed, it is monitored in all services where surgery is performed.

However, staff told us that due to a new IT system, in theatres they were unable to complete the checklists for surgical 'briefs' and 'debriefs' effectively. The brief/debrief is not mandatory. Briefing facilitates delivery of clear messages and ensures all staff are aware of their roles and the surgical list. Debriefing is carried out at the end of the surgical list. All the members of the surgical team discuss the work of the day stating the positive and potential negative issues. These parts of the checklists are sometimes overlooked during a list due to time constraints, interruptions, and other distractions. However, when training is limited due to staffing it ensures learning and training is structured and positive. When we reviewed compliance for these it showed that average compliance for surgical briefs between May and July 2023 was 59%. For the same period compliance for debrief was 20%. This meant that the hospital was not ensuring compliance with the 5 steps to safer surgery guidelines set out by the National Institute of Health this is also advocated as good practice by the National Patient Safety Agency (NPSA) for all patients in England and Wales undergoing surgical procedures.

There had been investment in the pre-operative assessment team to ensure patients were fit for surgery at the hospital and for any issues to be identified and resolved. This included a stand-alone pre-operative assessment unit at the hospital with increased anaesthetic consultant input. All patients attended a nurse-led, face-to-face surgical pre-assessment clinic appropriate to the surgery or procedure they were having. Where required, patients would also attend a dedicated anaesthetic clinic to determine their suitability for surgery.

Staff completed an initial assessment for each patient upon admission and prior to their surgery, using a series of questions to determine the frequency of subsequent assessments. The individual assessments then flagged as a colour, with red indicating patients who were at particularly high risk. For example, being at risk of falls. Staff told us they completed these assessments for each patient and they included pressure ulcer risk assessments and venous thromboembolism assessments, where appropriate. Senior ward staff told us they had oversight of these assessments and demonstrated the ward overview screens on the electronic recording systems. This meant the hospital ensured risk based pre-operative assessments were carried out.

Surgery

Staffing

The service did not have enough nursing, allied health professionals and support staff keep patients safe from avoidable harm and to provide the right care and treatment. Bank and agency staff were not always given a full induction.

The service did not have enough nursing and support staff to keep patients safe. On all wards we visited, we saw actual nurse staffing was consistently below planned establishment. The trust were also unable to provide us with information that gave assurance that they were compliant on ward staffing levels.

Not all wards displayed the planned and actual staffing numbers for each day. Staff told us this was because staff were moved around constantly to meet the needs of the busiest wards and departments. This often meant staff on wards with a full complement of staff were moved to other areas. Staff told us this was frustrating for these areas as it felt that their staffing numbers were reduced and that affected staff morale and the ability to care for their patients.

The trust provided information that stated that on night shifts the nurse to patient ratio across a 24 hour period was usually less or equal to 1 Registered Nurse (RN) to 8 patients. However, there were instances where this was not met and data showed that on average Wittering ward had a ratio of 1 RN to 13 patients overnight in the last 4 months of 2021.

The trust wide vacancy rate for band 5 nursing staff had increased from 8% in January 2022 to 19% in May 2023. The vacancy rate for band 2 staff was 11% in May 2023. The trust was aware of these issues and a workforce steering group had been implemented to reduce these to 8%. Leaders and ward staff told us recruitment was ongoing and there had been several allied health professional and nursing appointments, which they had found encouraging. None of the wards we visited had a full complement of staff, at the time of inspection. This meant staffing levels and skill mix were not always planned and reviewed so that people received safe care and treatment at all times. This also meant there was no assurance that ward staff do not work excessive hours.

Managers limited their use of agency staff and requested staff familiar with the service. We heard how in theatres surgical staff were requested who had worked with the service.

Medical staffing

The service generally had enough medical staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service generally had enough medical staff to keep patients safe. Medical staff rotas were organised and planned to keep patients safe. The medical staff matched on duty the planned number. The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service had low vacancy rates, low turnover rates and low rates of bank and locum use for medical staff.

However, in particular the breast service was challenged as 2 out of 3 breast surgeons working across Worthing and St Richard's had recently left the trust. This had impacted the ability of the service to provide timely surgery, and also impacted the workload of the remaining staff. The trust advised they were actively recruiting to fill the vacant posts.

The service always had a surgical registrar on call during evenings and weekends. This member of staff was identified and named on the staff rota for the theatres. The trust did not provide any specific information on consultant availability over a seven day period.

Surgery

Records

Staff kept records of patients' care and treatment. However, paper records were not always clear or stored securely.

We reviewed 5 inpatient records and found them difficult to review. People's individual care records, including clinical data, were not consistently written, and managed in a way that kept people safe. We found there was no set order for the paper-based notes which meant information could not be easily located.

Patient notes were a mixture of electronic and paper records. Staff told us of their frustration of working with different systems and the combination of paper and electronic records. We heard how the hospital admission system often caused delays on weekends or overnight, as some patients were admitted but no electronic records created. This delayed the ability to provide post-surgical care as staff struggled to contact administration staff to resolve these issues.

Paper records within surgery wards were stored in trolleys that could be locked. On inspection we saw three instances where paper records were not always stored appropriately and were sometimes left unattended.

Within theatre pre assessment we saw surgical lists were stored in a dedicated area with allocated sections for each theatre, this ensured that access to these was restricted to only authorised persons. It also ensured that lists were not unnecessarily pre-printed as staff knew where to find them.

During our inspection we saw computers that were unlocked and unattended which meant electronic records may be able to be accessed inappropriately. We also observed confidential waste bins were not secure. Although these were kept in staff areas this meant records could be easily removed by anyone working in the area and the safe disposal of these by the intended recipient was not assured. Staff told us these bins often fell apart as they were cardboard and we saw bins which had been taped together in several areas. This posed a risk of these records being viewed by staff who did not have access or a legitimate reason for doing so e.g. they were not the intended recipient.

Staff said when patients transferred to a new team, there were no delays in staff accessing their records.

Medicines

Ward staff used systems and processes to safely prescribe, administer, and record medicines. However, within theatres not all medicines and prescribing documents were stored or managed safely.

Staff followed some systems and processes when safely prescribing, administering, recording, and storing medicines. The trust had an electronic prescribing and administration (EPMA) system for medicines which had inbuilt safeguards and reports were run routinely to ensure safe prescribing. They were some issues that had been identified were addressed via the previous upgrade and were being implemented via the current round of clinician training. Some of the guidance documents that were in use by staff were out of date, for example the day Surgery unit the perioperative guidance was dated 2018 and had been superseded in 2021. On Bosham ward a document used to decide on medicines to be stopped on the date of operation was undated and there was no assurance this was the most current version.

In theatres, staff stored and managed all medicines safely. However, we saw 10 instances where log books used to record administration of controlled drugs (CDs) were not completed in line with guidance. For example, the amounts of medicine given to a patient was not always recorded. Instead the only amount recorded was that drawn up by staff, so there was no record of what was given to patients. This meant there was no assurance as to the amount that were

disposed of or who did this. This was not in line with National Institute for Clinical Excellence (NICE) guidance regarding CDs which states that a separate CDs register must be kept for each of the premises of an organisation where CDs are stored, in line with Regulation 27 of the Misuse of Drugs Regulations 2001. The member of staff disposing of medicines should also document this and NICE best practice is to have a witness to this procedure.

We also saw that when CDs were received from the hospital pharmacy there was not always a signature from a registered practitioner. We saw 4 instances where the signature of the witness or responsible person was not completed. We also saw controlled drug stock checks were not completed twice daily. This did not follow internal policy and was not in line with National Institute for Clinical Excellence (NICE) guidance regarding CDs.

Following our inspection, we requested controlled drug audits from the trust. We were told these had moved to a 6 monthly cycle. The last audit undertaken was for the period of July-December 2022. Four surgical wards passed the audit, 4 required improvement and 5 were identified as failing. The audit for the period January to June 2023 was overdue and had not been completed at the time of the inspection. The trust medicines monitoring policy approved in June 2023 also still stated audits were to be undertaken every 3 months.

In main theatres we saw 3 instances of medicines being left unattended by staff. The medicines were for several patients on the afternoon theatre list. This was not in line with best practice or trust policy. This posed a safety risk as no one was supervising or accountable for the medicines to ensure they were not accessed by people who were unauthorised to access them.

Staff in theatres did not always store and manage medicines in line with the provider's policy. Medicine fridges and storeroom temperatures were not always monitored in line with trust policy. There was an escalation process if the temperatures of fridges where medicines were stored were outside of a certain range. However, we saw there were gaps in monitoring these temperatures. For example, we saw 1 fridge where monitoring only occurred 7 times out of 30 days during June 2023. This meant staff could not be assured medicines would be effective.

Fluids stored inside intravenous fluid warming cabinets were not labelled when they were placed into the cabinet. This was not in line with guidance which states IV fluid should be marked with permanent marker to identify the date they were put in the warming cabinet, and the date they needed to be removed. This step also ensures fluids are not returned to the warming cabinet once removed. Records used for monitoring the temperature of warming cabinets were also unclear as this was the same document used for fridges, which meant that the values displayed were shown as 4°, when they should have been 40°. Although staff were aware this was incorrect no changes had been made to create a document with the correct temperature ranges.

Staff on the wards generally stored and managed medicines in line with the provider's policy. However, on Pagham ward we saw an unlocked cupboard in which medicines were stored for patients who were being discharged. Staff secured this immediately when this was raised during inspection.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines and prescribing documents. Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services.

Staff learned from safety alerts and incidents to improve practice. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. These were discussed at huddle meetings and these meetings were minuted and kept in a central file so staff could review these later.

Surgery

Incidents

At service level, leaders and staff managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers ensured that actions from patient safety alerts were implemented and monitored. Managers investigated local incidents but these were not always shared well. Organisational wide learning was not well implemented and staff felt they did not know about incident investigations.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We saw evidence of learning from some incidents. For example, following a serious incident where medical staff had been delayed in noting a high risk pressure ulcer, pressure ulcer stickers were implemented to alert staff if there were tissue viability concerns.

There was a process for incident investigations and these were discussed at weekly meetings. Information from these meetings was cascaded to junior staff along with actions from patient safety alerts. Information from these meetings was also given in theatre huddles and recorded in a handover book.

Staff knew what incidents to report and how to report them including serious incidents. Staff raised concerns and reported incidents and near misses in line with trust policy. However, staff told us they did not always receive feedback from investigations of incidents they had reported. Staff we spoke with were not always aware of outcomes and learning from investigations including serious incidents and never events. Staff we spoke with told us they had to look for updates into the incident investigations and this meant learning was not always shared as access to investigations varied depending on access requirements.

Managers debriefed and supported staff after any serious incident. We were told how a serious incident triggered an incident review huddle and staff spoke positively of these. However, they told us they could not always attend these due to operational pressures.

Organisational wide learning had not been well implemented and staff felt incidents from other sites was not always shared throughout the trust. Organisational wide learning is shown to reduce patient harm and improve safety by ensuring all staff across sites are aware of risks and learning from improvement is widely implemented. This reduces the risk of repeated incidents that may have been avoided had learning been shared.

We requested organisational wide learning following our inspection. However, this showed learning being shared in divisional meetings only. Therefore, it was not clear how this was shared with staff who told us they had little awareness of what incidents occurred at other trust sites. The trust told us they shared division wide learning through an online page referred to as a 'padlet', this was accessed by QR code. However, no staff we spoke with had accessed this system.

Is the service effective?

Requires Improvement ↓

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

Surgery

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The trust was in the process of standardising policies, guidance, and documents across the trust. However, the standardisation process was delayed due to the COVID-19 pandemic, meaning some guidance was past their review dates.

We spoke with leaders who told us the matron for the department was responsible for updating policies and guidance. When we spoke with the matron she explained how the process involved reviewing all current guidance and ensuring this was up to date. The policies were then reviewed and approved in divisional governance meetings. When policies were updated they were circulated to staff to note the changes. These were also highlighted in handover meetings. Staff signed to acknowledge they had read updates.

The service updated guidance and policies in line with the National Institute for Health and Care Excellence (NICE) guidance. For example, we saw pathways followed NG180 (perioperative care in adults). The service had national safety standards for invasive procedures guidance (NatSSIPs) and adapted these for local practice (LocSSIPs).

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Patients confirmed they had been given a choice and quality of the food had been particularly good.

We saw a patient being supported with eating and this was done promptly and with respect. The patient was asked what they would like on their plate and then given mouthfuls at their pace. Staff completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff assessed patient's nutrition and hydration needs using the MUST tool. All patient records we reviewed had nutritional statuses assessed within 24 hours of admission using the malnutrition universal screening tool (MUST).

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

If a patient required support with eating and drinking this was communicated at handover. Domestic staff were informed if there was anything they needed to know about the patients and there was also information above the bed if, for example, a patient was at risk of choking.

Patients waiting to have surgery were not left nil by mouth for long periods. Patients waiting for surgery were kept "nil by mouth" in accordance with national safety guidance to reduce the risks of aspiration during general anaesthesia. Staff followed guidance from the Royal College of Anaesthesia, raising the standards (2012), and offered specially formulated drinks to patients up to two hours before surgery to ensure optimisation of energy (calories) and fluid before surgery.

Surgery

Staff in the elective surgical pre-assessment clinic confirmed they gave patients clear instructions about fasting before admission. Information was given to patients both verbally and in writing. For example, patients were told not to eat for 6 to 8 hours before a general anaesthetic and were encouraged to drink sips of water up to 2 hours before a surgical procedure. Staff confirmed patients would be encouraged to drink after their procedure, providing it was safe to do so.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Patients received pain relief soon after requesting it. Patients told us they did not have to wait too long for staff to help them administer painkillers. In theatres we saw pain levels were monitored and if patients needed them there was no delay in administration. Records we reviewed for pain monitoring in recovery were also completed in full.

On wards and in theatre patient records staff prescribed, administered, and recorded pain relief accurately.

However, staff gave an example of a patient who had undergone surgery, which was logged on the original theatres system, but the patient was found to not have a main hospital record. This led to a long delay to move the patient from recovery and meant staff were unable to administer pain relief as this was recorded on the main system.

Patient outcomes

Staff monitored the effectiveness of care and treatment, although it was unclear how they used the findings to make improvements and achieved good outcomes for patients.

Due to the COVID-19 pandemic there had been delays to the publication of some national audits. Data in the latest publications was at least two years old or data was not available at trust level. For example, The National Bowel Cancer Audit was last reported on in 2020 and had incomplete data for the trust.

We asked senior managers what plans there were to recommence data submission into these national audits. We were told the service conducted internal reviews with the data collected through their own internal governance processes. We did not see evidence this internal data was used to bench mark the trusts own performance against similar sized trusts nationally.

Managers and staff used the results to improve patients' outcomes and improvement was checked and monitored. For example, a review of the neck of femur fracture pathway identified the requirement to use pressure relieving mattresses and 'air boots' when patients were admitted. This reduced patient discomfort and improved patient experience.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There was an ongoing local audit programme with action plans. Although during the COVID-19 pandemic, some local audit programmes were suspended as staff were moved into clinical roles. At the time of the inspection senior leaders told us a local audit programme was in progress and we saw evidence of this. For example, a Venous Thromboembolism (VTE) audit showed only 64% of patients in the sample used were assessed for this. This was discussed at governance meetings and actions agreed to improve compliance.

Surgery

Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits. Audit results were shared via email and discussed at monthly surgery division quality and safety board meetings.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. Theatres at Worthing and St Richard's were currently not meeting the national standards for time to surgery for neck of femur patients. The reasons for this were identified as trauma capacity and availability of specialist surgeons. This was mediated by a daily review and prioritisation of these patients.

Competent staff

The service made sure staff were competent for their roles. However, managers did not always meet appraisal targets or hold regular supervision meetings with them to provide support and development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of some patients. We spoke with several staff working in newly appointed senior nursing roles. Many of whom had been in their current role for less than 12 months but were supported by matrons and colleagues working at a similar grade.

Staff working in pre-assessment clinics undertook specific training and completed pre-assessment competencies.

Managers gave all new staff a full induction tailored to their role before they started work. We saw induction booklets were tailored to the specific roles to ensure training was appropriate. In theatres staff said they were supernumerary while they worked through their inductions and were well supported by all staff. We saw student nurses working on wards. While they described good working environments, some told us they received limited training and initial support. Some described being left to 'get on with it' in their first few days of joining the ward.

Clinical educators supported the learning and development needs of staff. Senior ward staff told us newly qualified nurses were provided with ongoing support through their preceptorship period. All staff we spoke with told us the support received was invaluable.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us meeting notes were emailed to all staff by ward managers and we found printed copies were displayed on staff noticeboards.

However, Managers did not always support staff to develop through yearly, constructive appraisals of their work. The trust submitted divisional staff appraisal data. We saw that the overall appraisal figures for the surgery division was 82%, which was lower than the trust target of 90%. Medical staff appraisal rates were submitted separately and showed that only 67% of these staff had completed an appraisal with 19% of staff not having an appraisal booked. This data also showed that 28 staff required a medical appraisal and there were no staff allocated to complete this.

The trust had also not fully implemented training for staff on how to interact appropriately with people with a learning disability and autistic people, at a level appropriate to their role. This is a statutory requirement and must be completed by all staff. At the time of inspection only e-learning training was available for both clinical and non-clinical staff, this training had been implemented in June 2023. Only 18 staff across the trust had completed this training and no staff we spoke with had heard about the training. There was no face to face learning. This meant staff may not have the skills, knowledge, and experience to identify and manage issues arising from this vulnerable group of patients.

Surgery

Multidisciplinary working

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

Staff held regular and effective multidisciplinary team meetings to discuss patients and improve their care.

Meetings we observed were well attended and were focused on a multidisciplinary team approach to meeting patients' needs. They included input from physiotherapists, occupational therapists, and the discharge co-ordinator. Physiotherapists prioritised those patients who were immediately post-surgery and then those who were ready for discharge.

In theatres, the morning huddle covered key areas such as bed numbers, surgical lists, stock shortages and staffing. These meetings were held daily and run by the daily coordinator. Written meeting notes were recorded in a dedicated book so staff who had not been able to attend could review previous meetings.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Discussion during handover and ward rounds included patient requirements prior to discharge such as care packages, referrals to district nurses or other community services.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression.

Managers told us they made sure staff attended team meetings or had access to minutes when they could not attend. All managers we spoke with told us trying to bring staff together due to staffing shortages was challenging but tried to ensure meeting minutes were read by all staff where possible.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway, this included surgical outlier patients. Acute and emergency services were available seven days a week. The surgical service provided consultant cover on site seven days a week.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Input was available from pharmacy, physiotherapy, occupational therapy, specialist palliative care team as well as other specialities such as tissue viability or diabetes nurses. There was support from these services at weekends and on call out of hours.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. Health promotion information and materials were available on the wards. Examples included eating a healthy diet, moderating your alcohol intake, increasing your physical activity, and smoking cessation.

Surgery

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. The pre-assessment clinic provided patients with information on how they could promote their fitness before their procedure. Staff reminded patients of the importance of eating a balanced diet and quitting smoking.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were able to tell us what actions they would take to assess whether a patient had capacity.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff understood their responsibilities and the procedures in place to obtain consent from patients before undertaking surgical procedures. This was in line with the consent for examination and treatment policy which gave clear guidance for staff. We saw completed and signed forms for treatment and exploratory investigation during the inspection.

Staff made sure patients consented to treatment based on all the information available.

Staff recorded consent in the patients' records we reviewed. There had been a recent change to the consent forms used at this hospital to mirror those used elsewhere in the trust. Staff told us they had not received guidance regarding the correct completion of these forms. We noted this had led to confusion among staff when attempting to complete the forms. There had been no issues regarding patients not providing consent.

Staff told us they knew how to access the policy and get advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. Where Deprivation of Liberty Safeguards were applied to a patient, they were done so in conjunction with risk assessments to identify the impact of any measures to safeguard the patient such as bed rails or restraint.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers.

Is the service caring?

Good ↓

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. We saw staff take time to interact with patients and those close to them in a respectful and considerate way. We saw staff caring for patients, checking if they were comfortable

and if they wanted extra blankets, checking if they needed anything, and speaking with a caring tone. We saw them introducing themselves to patients and explaining the care they were going to be giving. We saw staff drawing privacy curtains and softly inquiring if they had finished with bedpans or urinal bottles. All staff we interacted with had a good knowledge of the patients in the ward and their needs.

Feedback from the trust wide Friends and Family Test (FFT) for January to July 2023 was positive. Aldwick ward had 92.5% positive response and in Day Surgery this was 97%, these were above the national average. Response rates for FFT were also above national average of 15%, for example Bosham ward was 20% and Pagham Suite 38%.

We saw staff going out of their way for patients, for example when a patient wanted a particular type of biscuit with their cup of tea, staff ensured these were always available despite not being a standard item. Staff told us they understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. We saw and heard nurses asking patients about their preferences.

Staff followed policy to keep patient care and treatment confidential whenever they could.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. We saw staff in a surgical recovery area providing care to a distressed patient to reassure them and reduce distress.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. Staff shared examples of how they had adapted their practice to accommodate individual needs and preferences. We heard how the family and carers of a patient with additional needs, had been involved in care planning to ensure their surgery did not cause them distress. Changes had been made to their admission so that they could attend directly to theatres and not wait in a busy area. They were also able to discharge directly from the recovery area and be collected by family so their time spent in hospital was minimised as this was an area of concern for them.

There was support available for the bereaved from the hospital palliative care team and bereavement team. Information on these services was displayed within leaflets with contact numbers.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We observed staff on wards communicating with patients in a clear verbal style ensuring they understood all the information regarding their care. In theatres we observed staff taking patients into surgery and taking time to ensure they felt reassured.

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary.

Surgery

Patients gave positive feedback about the service through friends and family feedback, however this did not provide detailed feedback and simply checked if they had a positive or negative experience.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced and informed decisions about their care.

Is the service responsive?

Inadequate 

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

Service delivery to meet the needs of local people

The service did not always plan or provide care in a way that met the needs of local people and the communities served.

The hospital provided a range of elective and unplanned surgical services for the communities it served. This included general surgery, gynaecology, trauma and orthopaedic, urology and ophthalmic surgery. Despite capacity sometimes outstripping demand, facilities and premises were generally appropriate for the services being delivered.

Managers didn't always plan or organise services to meet the needs of the local population. We reviewed the bed management process and saw patients who were safe to be transferred were moved regularly to accommodate elective surgical patients. The demands on beds and staffing levels however meant some operations were delayed or cancelled on the same day. There was a trust level standard operating policy in place for same day cancellations to ensure that the process of decision making was clearly defined. The trust monitored hospital and patient prompted cancellation rates at board level.

The service had systems to help care for patients in need of additional support or specialist intervention. Appropriate notification systems were used to highlight patients who had specific or complex needs and the service would be flexible with visiting times for patients who needed this.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. We asked several staff if their wards had any mixed sex breaches in the last 6 months and none told us they had. Day surgery however did not provide separate areas for male and female patients. This meant they should be reported as mixed sex breaches, however staff confirmed they did not report any such occurrences.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

Managers monitored and took action to minimise missed surgical appointments. We heard how all efforts were made to fill surgical spaces where surgeries were cancelled, this included doing shorter surgeries to ensure time was not lost.

Managers ensured that patients who did not attend appointments were contacted.

Surgery

The service relieved pressure on other departments when they could treat patients in a day. We were told where possible the service ensured that patients were admitted as day surgery cases.

Meeting people's individual needs

The service was inclusive and took account of most patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. However, adaptations to meet the needs of patients living with dementia had not been considered.

The service had information leaflets available in languages spoken by patients and the local community. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Staff made sure patients living with mental health problems, learning disabilities and dementia received the necessary care to meet all their needs. Staff could access emergency mental health support 24 hours a day seven days a week for patients living with mental health problems.

Staff could refer patients to the learning disability and autism service to help support them and their carers. Specialist learning disability nurses were available to help make reasonable adjustments and help co-ordinate care. For example, pre-admission planning, ward visits, communication advice and discharge planning.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff told us that they had various options to cater for different dietary requirements.

Wards were not always designed to meet the needs of patients living with dementia. We did not see any evidence of adaptation for patients with dementia such as appropriately coloured bays or specifically designed signage. Several senior ward staff told us they would include discussion around the needs of specific patients with dementia as part of the safety huddle, but we did not see records relating to specialist intervention or support.

On Pagham ward, day surgery patients were co-horted together both prior to surgery and in recovery. The recovery bay was large and staff told us steps were taken to care for women and men in separate areas where possible. However, we saw mixed sex care provided at the time of inspection and we were not assured that privacy and dignity was always maintained.

Access and flow

People could not always access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

It was nationally recognised at the time of inspection that the health and care system was under additional pressure. Each division had a waiting list and each patient on that waiting list was discussed weekly to identify what was needed to admit the patient for their planned procedure. The service reported waiting times and plans to reduce them to the trust board. Managers reported growing waiting lists which they said was worrying but they said this was in line with the national direction.

In theatres, we heard how operating lists had been cancelled due to staffing levels. This was frustrating for all involved and local leaders and staff told us this was always a last resort. The trust was also experiencing problems with access and flow because of delays in discharging a large population of patients with no criteria to reside (medically fit and well).

Surgery

Data provided by the trust gave details of cancellation reasons, both on the day of surgery and in the days leading up to surgery (split by hospital or patient cancellation). The data covered both St Richard's and Worthing hospitals and for the 3 months May to July 2023, the top 3 reasons given for hospital cancellation on the day of surgery were: Unfit due to existing condition (45 patients), Operation not required (34 patients), Requires further investigation (32 patients). On the list of cancellation reasons were theatre list over-run (22 patients), Administrative error (18 patients), Unfit due to acute illness (16 patients). The trust did not provide data specific to St Richard's theatre utilisation.

The service had developed a number of patient pathways to improve flow. This had been done by discharging patients directly from recovery and effectively making them 'day cases'. This meant that patients knew in advance how long they would be in hospital and avoided delayed discharge due to bed availability. There were a wide range of procedures that were treated as day cases, including mastectomies and hernias. Staff had a specific checklist of criteria to follow to enable discharge and we saw this was clear and well laid out. Staff told us that patients did not routinely stay in the main recovery area overnight however this did occur occasionally due to bed availability. Patients did not ever stay overnight in recovery in the Chichester treatment unit.

Managers monitored patient transfers and followed national standards. We observed patients transferred to other wards and escalation areas where it was deemed safe and appropriate to do so, to free up capacity for elective surgical patients or urgent admissions.

There was a process for monitoring patients awaiting surgical procedures and staff reviewed waiting lists regularly, monitored waiting times and reported these to the trust board. Each division had a waiting list and each patient on that waiting list was discussed weekly to identify what was needed to admit the patient for their planned procedure. The service reported waiting times and plans to reduce them to the trust board. We were told bed capacity, a decrease in theatre utilisation and workforce challenges greatly impacted on the services ability to meet demands.

Harm reviews were also completed for all patients within specific specialities, to ensure there was oversight of risk and harm. Patients identified as requiring urgent treatment were prioritised. The trust completed harm reviews for all patients waiting for procedures greater than 52 weeks.

Following our inspection we requested waiting time data from the trust. The trust was unable to supply information or data that focused on specific patient groups or lengths of stay. This limited the trusts ability to implement meaningful improvement by highlighting areas of concern.

We reviewed national data for the trust overall. The trust was starting First Definitive Treatment (FDT) for 17% more patients than before the COVID-19 pandemic. FDT is the first clinical intervention intended to manage their disease, condition or injury and avoid further treatment. The service performed second worst in of the South East England region for FDT within 31 days, 84.8% compared to 95% in the region. This was against a national target of 96%.

The trust performed second worst in the South East of England region for two week waits (2WW). The 2WW referral system allows a patient with symptoms that may indicate an underlying cancer to be seen as quickly as possible. The trust waiting time for 2WW for cancer showed only 66.14% of patients in July 2023 met this against a national target of 93%. This put the trust in the lowest 25% of NHS acute trusts in the South East. This was also much lower than the regional average of 81% and lower to the national average of 77%.

The trust was the second lowest for the proportion of patients that were treated within 62 days of an urgent GP referral at 57%. It should be noted that there were no regions that were meeting the national target of 85%. The regional average was 67% and the national average was 62%.

Surgery

The service did not meet any of the national referral to treatment (RTT) standards for 18 week waits in May 2023. Data we reviewed showed that 47% of patients were seen within 18 weeks, this was against the national standard of 96%. This showed a total of 138,859 patients waited over this standard before they were treated.

Staff had worked together to develop a pathway for day case surgery for laparoscopic hysterectomy. This had been recognised nationally as a significant achievement for improving patient experience. Data showed that this procedure had resulted in no readmissions to hospital and a reduction in waiting times for this procedure.

Learning from complaints and concerns

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

Patients, relatives, and carers told us they knew how to complain or raise concerns but had no cause to do so. Patients and relatives we asked said they would feel confident asking ward staff how to raise a complaint or concern.

The service displayed information in patient areas about how to raise a concern. Wards had posters displayed to encourage patients and families to give feedback on the quality of care and treatment. This included information on the patient advice and liaison service.

Staff we spoke with understood the policy on complaints, knew how to handle them and could give examples of how they used patient feedback to improve daily practice.

Managers investigated complaints and identified themes and shared feedback from complaints with staff. Learning was used to improve the service. For example, a patient complaint on Middleton ward triggered a pressure area care review. This identified that 'skin tick' charts were not being used well, this prompted a move to place this sheet at every patient bed so it alerted staff to the need for increased and individualised pressure care for each patient. Visual prompt stickers were also added to patient notes so medical staff were aware of the measures being taken when they reviewed patients.

Is the service well-led?

Requires Improvement 

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

Leadership

Local leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Most staff spoke positively about the local leadership. They supported staff to develop their skills and take on more senior roles. However, most staff told us senior leaders were not visible, and engagement was limited.

The trust had an overarching executive leadership team. The trust managed its services through place-based care organisations or hospital site. The trust clinical operating model for each hospital site consisted of a full-time hospital site director and head of nursing, supported by a deputy chief medical officer.

Surgery

Services were managed in divisions, who were responsible for all staff and clinical performance. The division of surgery for St Richard's, Worthing and Southlands hospitals was split into the specialisms 4 of ophthalmology, specialist, general surgery, musculoskeletal and one single group which comprised of theatres, Central Sterile Supply department, pre-operative, and critical care.

Nursing leadership at ward level consisted of heads of nursing who managed a team of matrons who, in turn managed two or more wards. Matrons managed nurses in charge of wards. Each directorate had a head of nursing who reported to the divisional director of nursing.

All staff spoke positively about the local leadership and told us they had good working relationships and described it as "one big family". Staff in theatres told us they were actively encouraged to progress their career and we saw multiple examples of when this had been done and ongoing opportunities for staff. They told us managers supported them with educational training days when they could but this was not always possible due to staffing levels.

On the wards and units we visited during the inspection we saw strong clinical leadership from the ward managers and the lead nurses. However, staff did not speak positively about the senior leadership and organisation structure. Staff told us senior leadership were not visible and they found the leadership model confusing.

Most staff told us senior leaders were not visible, and engagement was limited. They told us they did not understand the leadership model or "who was in charge". They did not feel supported or listened to when raising concerns with executive members of staff. In theatres staff told us they did not see some executive leaders at all. Although we were told the Chief Executive had visited the department and staff had the opportunity to raise ongoing pay disputes where remuneration varied across sites. These concerns had not been resolved and staff were frustrated at what they felt were unequitable payments for the same role across sites.

Vision and Strategy

The service had a vision for what it wanted to achieve. The vision and strategy were focused on sustainability of services however there was no work within divisions to align these values to ensure they linked into specific core services.

During inspection senior leaders mentioned the trust strategy. However, there was no specific vision or values for the surgical division regarding how they were achieving this or to ensure they linked into the trust wide vision and strategy.

Staff could not describe the trust vision and strategy. They were therefore unable to articulate how surgical service fed into this. All staff described the motivation for their work as 'giving the best care for the patient'.

The trust had developed a vision and strategy for their values, this was underpinned by a strategy referred to as 'Patient First'. The strategy was based on the statement that they aimed to achieve 'excellent care every time'. The goals of this strategy were:

- The patient has to be at the heart of everything.
- Services must be sustainable.
- To attract and keep the best people.
- To strive for the very highest quality.
- To work with the wider health system and our partners.

- To invest in research to use innovation to drive improvement.

Staff expressed concerns that they could not look to develop or expand their service due to staffing shortages within theatres.

Culture

Staff did not always feel respected, supported, and valued. Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. Staff felt senior leaders were not always visible within their service or supportive of challenges.

Most staff told us morale was good and the culture in the division was positive. Some staff within theatres described low morale due to staff leaving the trust which impacted their workload. They said they did not always feel supported by their managers. Most nurses we spoke with told us they felt valued and fully supported by the ward managers but not always by senior leaders.

Staff were patient focused, and the culture was focused on the needs and experiences of people who used the services. Several members of staff told us they were proud of the care they gave to patients and told us they felt the service was patient centred. However, they were concerned low levels of staffing was impacting on patient care in some areas. All staff we spoke with said that staffing was the main issue that impacted on their work.

Staff told us there was good teamwork within the teams and we observed this during our inspection. Staff worked together to resolve issues and worked flexibly to accommodate service needs. They told us the whole team worked together to provide the best care for patients.

We heard how some process changes to the way patients were anesthetised had met with some resistance due to a culture issue between management and anaesthetists. The trust had previously worked with the national 'getting it right first time' team. This work had highlighted the need to improve patient experience and work flow by anaesthetising patients in the anaesthetics room. It was recognised this would reduce anxiety to patients and ultimately improve their experience. There had been resistance to the change and patients were being anesthetised in theatres at the time of the inspection.

In the weeks prior to the inspection, the trust had instigated and completed a series of ward reconfigurations. Whilst we were told this had been planned for some time, the actual moves took place at short notice. Feedback from ward staff was negative about the management of this process. Poor communication and lack of information regarding the moves were cited as the main contributory factors to how staff felt. We saw the service had completed a 'lessons learnt' exercise following feedback from staff, which highlighted the need to include staff in the process and with the number one learning point being 'communication, communication, communication'.

The trust told us how staff could access support from a freedom to speak up service, however, most staff we spoke with told us they did not know this service well or who to contact. They instead told us they would speak with local leaders.

Governance

Staff at all levels were clear about their roles and accountabilities. Staff had regular opportunities to meet, discuss and learn from the performance of the service.

Surgery

There were defined governance pathways within the trust which functioned well and interacted effectively with each other. The trust level governance committee was responsible for ensuring governance was embedded in the organisation and delivered safe, quality, and effective care. There was an on-going programme to develop the governance and risk management, which included training for staff to ensure a consistent approach across the trust.

Each subcommittee provided assurance to the board. For example, the minutes for the divisional quality and safety board showed they escalated risks to the board on a monthly basis.

We also reviewed subcommittee meeting papers which evidenced risk, issues and performance were effectively discussed and escalated to the board through the governance arrangements. These included the nursing and midwifery staffing group who monitored staff vacancy rates to improve staffing, retention, and recruitment. All meetings followed a standardised agenda which included topics such as: patient safety and experience, risk, duty of candour, incidents, learning and development, clinical effectiveness, and outcomes.

Some services were yet to be joined up in their approach, for example infection prevention control was still monitored differently at each site and leads were keen to align how this was delivered trust wide.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. However, systems to re-assess patients on waiting lists were limited in their effectiveness.

We reviewed the trust risk register and saw all identified risks had dates of entry, dates for review, mitigations and staff allocated to manage each risk. Senior staff escalated risks where necessary. The risk register reflected the picture of open risks across the surgical division.

The service had a quality assurance dashboard report which included the top risks by division. The senior management team were aware of the procedure to escalate any of the risk to the trust risk register so the trust board were aware of this and the mitigations they had.

The service had systems for monitoring and managing performance. The surgical service used a comprehensive quality assurance dashboard report to monitor performance information such as waiting time to referral, theatre utilisation, length of stay and unexpected returns to theatre.

There were processes to monitor patients waiting for surgery and performance against the post COVID-19 recovery plan. A patient tracking list was in place, and this was reviewed at weekly meetings. Clinical specialists initially reviewed referrals to ensure patients were prioritised in line with clinical need.

There were processes to give leaders oversight of patients waiting for appointments and referral to treatment performance. These were used to plan access for patients. However, there were limited systems to monitor and re-assess patients who were on the waiting list for extended periods. For example, patients whose condition may have deteriorated while waiting for surgery which meant their treatment plans altered.

Each surgical speciality held regular mortality and morbidity meetings to share outcomes of mortality reviews. We reviewed a selection of mortality and morbidity meeting records. The meeting records identified learning and actions to share across the service.

Surgery

Information Management

The service collected data and analysed it. Data or notifications were consistently submitted to external organisations as required. However, some leaders told us they could not always find the data they needed to understand performance, make decisions and improvements. The information systems were secure but not fully integrated.

Data was collected both at a national and local level, but we were not assured it was always utilised in a timely manner to make improvements. Data had been collected regarding ward infection prevention and control measures, but we saw no evidence of this data being monitored at a higher level or actions taken when compliance did not reach trust targets, this was particularly noted with ward-based hand hygiene compliance.

Some of the trust's systems and processes for recording and monitoring clinical information had recently changed so they were consistent across the trust. This had led to issues for staff who found they were having to use multiple systems to look up records. Staff told us there was no 'out of hours' support for systems if patient information was not in the system, which sometimes occurred with weekend or 'out of hours' trauma admissions. This could impact patient care as staff were unable to administer medicines and transfer patients to wards. There were also issues with duplication of patient identification as these had originally been local numbers and these matched others already in the new system that covered a larger geographical area.

Engagement

The service routinely engaged with patients to gain feedback to plan and manage services. However, opportunities to engage with the public, local organisations and equality groups was limited.

Patient feedback was captured but not effectively used. Data was recorded in systems with regard to patient feedback but local leaders told us they found this information difficult to access and therefore inhibited their ability to review themes and make improvement.

The division had a number of information sharing forums. For example, the divisional director of nursing held a twice weekly huddle with heads of nursing, matrons and theatre managers and the chief of service led a divisional huddle for the operational and clinical teams weekly. These huddles were not formally recorded.

The surgical division had a staff survey action plan with actions assigned to senior leaders. The division recognised staff engagement and communication across a wide area was challenging and as part of their engagement plan, following the staff survey, had committed to opening up the weekly huddle to the whole division monthly as well as joining smaller team meetings and holding coffee mornings and evening meetings for all staff.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They understood quality improvement methods and had the skills to use them. Leaders encouraged innovation and participation in research.

Senior leaders were able to articulate the need for continuous innovation and improvement as well as an understanding of quality improvement methods and had the skills to use them.

Surgery

Staff understood quality improvement methods and had the skills to use them to make changes. We were given examples of staff using quality improvement methods to make changes. For example, the service had developed a wide range of day case surgeries so that surgical patients could be rapidly discharged from recovery. This included laparoscopic hysterectomy as a day case procedure and at the time of inspection was the only NHS hospital offering this procedure.

The service participated in research which was communicated to staff, for example, during the morning huddles and through governance meetings.

Outstanding practice

We found the following outstanding practice:

- The service had developed a wide range of day case surgeries so surgical patients could be rapidly discharged from recovery. This included laparoscopic hysterectomy as a day case procedure and at the time of inspection was the only NHS hospital offering this procedure.

Areas for improvement

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

Action the trust MUST take to improve:

- The trust must ensure that medicines are used once opened in line with manufacturers guidance. Regulation 12.
- The trust must ensure that staff complete mandatory training in line with their role and that oversight of targets is effectively monitored. Regulation 12.
- The trust must ensure appropriate training, in line with guidance, is in place and completed by staff to support patients with learning disabilities, dementia and autism. Regulation 12.
- The trust must ensure there are enough nursing staff to keep patients safe. Regulation 12.
- The trust must ensure that all staff receive timely appraisals in line with provider policy. Regulation 12.
- The trust must ensure that controlled drug records and the oversight of these are in line with national guidance. Regulation 12.
- The trust must ensure the monitoring of anaesthetic machine checks is recorded and aligns with best practice guidance. Regulation 12.
- The trust must ensure that the systems used to monitor WHO checklist compliance, including brief and debrief, are effective in demonstrating compliance and able to show areas for improvement effectively in line with NPSA guidance. Regulation 12.
- The service must review its existing IPC audit monitoring systems to identify any shortfalls in infection prevention and control and so action can be taken to make improvements when needed. Regulation 12.

Surgery

- The trust must ensure equipment in ward and theatre environments is moved or stored in a suitable location and avoids emergency exits being blocked. Regulation 12.
- The trust must ensure action is taken to improve their compliance with national waiting list targets and that performance data for the trust can be separated to show site performance. Regulation 17.
- The trust must ensure that workforce data for the trust can be separated to show individual site performance. Regulation 17.
- The trust must ensure that patient record documents and systems are reviewed to ensure staff have access to patient information that is accessible, accurate and up to date across all electronic or paper-based records. Regulation 17.
- The trust must ensure organisational wide learning is shared within the trust to reduce the risk of repeated incidents. Regulation 17.
- The trust must ensure that guidance documents have been reviewed and are up to date. Regulation 17.

Our inspection team

The team that inspected the hospital included 2 CQC inspectors, 1 CQC operational manager and 3 specialist advisors who between them had expertise in medical and surgical services. The inspection was overseen by a CQC Deputy Director.

During the inspection we visited surgical wards, the day surgery unit, the preadmission unit, theatres, and recovery. We spoke with a range of patients, visitors and staff and conducted interviews with service managers and leaders remotely.

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

You can find information about how we carry out our inspection on our website: About us - Care Quality Commission (cqc.org.uk)