

# 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



Accident and emergency

Requires improvement



Medical care

Good



Surgery

Good



Critical care

Good



Maternity and family planning

Requires improvement



Services for children and young people

Good



End of life care

Good



Outpatients

Requires improvement



# Summary of findings

## Letter from the Chief Inspector of Hospitals

Princess Royal Hospital is an acute hospital in the Brighton and Sussex University Hospitals NHS Trust, which provides acute services to the population of people across the Haywards Heath area. The hospital provides maternity, a special care baby unit, outpatient services, medical care and it is the trust's centre for elective surgical services. The campus also houses the Hurstwood Park Neurosciences Centre and The Sussex Orthopaedic Treatment Centre.

We carried out this comprehensive inspection because the Brighton and Sussex University Hospitals NHS Trust was an aspirant foundation trust. The inspection of Princess Royal Hospital took place between 21 and 23 May 2014.

Overall, this hospital requires improvement. We rated it 'good' for being caring and effective, but it required improvement in providing safe care, being responsive to patients' needs and being well-led.

Our key findings were as follows:

- Staffing levels in medicine and surgery and the high use of bank or agency staff placed pressure on staff and meant there was a risk that patients' care needs may not be appropriately met.
- There was a lack of consultant cover at weekends and out of hours.
- Staff were not always able to attend training as required.
- Lack of beds in some services had an impact on poor flow and patients were cared for in wards which were not for their required speciality.
- The outpatient Hub was not operating efficiently and effectively to ensure patients had access to outpatient review and follow-up as required.

We saw several areas of good practice including:

- Support for the provision of care for stroke pathway.
- Team working and commitment in the critical care units.

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

Importantly, the trust must:

- Ensure that there are sufficient numbers of staff for critical care and medical wards.
- Review the provision and skills mix of staff to ensure they are suitably trained to meet the needs of children who use the service.
- Ensure that patient flow does not impact on access to services and treatment.
- Ensure that equipment allocated to manage sick children or newborn babies is routinely checked to ensure it is safe for use.
- Ensure that planning and delivery of care on the obstetrics and gynaecology units meets patients' individual needs.
- Address the culture between staff groups to prevent potential harm to patients.
- Review and monitor all aspects of the Hub, in particular for high-risk patients who are unable to access urgent referrals for treatment through the Hub.

In addition the hospital should

- Ensure that the Princess Royal Hospital emergency department is fully integrated into the governance structure within the medicine directorate.
- Ensure that learning from incidents, accidents and complaints is disseminated among staff to ensure changes to practice are fully embedded.
- Ensure that consultants are available to support members of the medical team at all times when on call.

# Summary of findings

- Continue the work to introduce more midwife-led pathways to help normalise birth and reduce the rates of caesarean sections.
- Ensure equipment in all of the departments is checked, as required, and the outcomes recorded.
- Ensure IT connectivity across all clinical bases is at a level where all community midwives can review essential information.
- Ensure cover is in place for specialist services as part of the workforce planning.
- Ensure that senior staff for outpatient services receive the necessary performance data for referral to treatment targets and non-attendances (DNAs) to enable them to more effectively manage the outpatient services at the Princess Royal Hospital.
- Maintain the security of patient records at all times.
- Ensure that the senior staff for outpatient services are part of a wider clinical governance framework for outpatient services, across the trust.
- Ensure that staff are able to access mandatory training.
- Ensure the secure storage of medicines in critical care.
- Develop and use care plans for patients for whom restraint has been necessary.
- Maintain the privacy and dignity of patients on the neurological unit.
- Ensure the trust-wide profile for end of life care is reviewed in line with the recommendations of the End of Life Care Strategy (2008).
- Communicate changes to service configuration in a timely manner to relevant staff.

## **Professor Sir Mike Richards**

Chief Inspector of Hospitals

# Summary of findings

## Our judgements about each of the main services

### Service

#### Accident and emergency

Requires improvement

### Rating



### Why have we given this rating?

The emergency department (ED) was challenged with capacity issues both within the department and trust-wide. There was poor patient flow across the trust which impacted on the ability of the ED at the Royal Sussex County Hospital to perform to its actual ability. During times of high demand, the Royal Sussex County Hospital ED placed internal diverts of ambulances to the Princess Royal Hospital, which resulted in patients experiencing delays in receiving treatment. However, the ED consistently managed the extra demand that was placed on them and there was evidence that they consistently met the four hour national target. The cleaning contractor was not able to fully meet the needs of the service to ensure patients were cared for in a clean and hygienic environment. Staff were seen to be caring and attentive to people's needs. Patients and their relatives and carers told us that they felt well informed and involved in the decision and plans of care. However, there were concerns that children receiving treatment in the ED did not always receive care from staff who were trained to care for children. Furthermore, the department did not have a suitably robust system in place to ensure vulnerable children were identified and referred in a timely manner. Staff at all grades were proud of working for the service. However, there was a general consensus amongst staff that the department lacked a strong and cohesive leadership team. Staff told us that the senior management team responsible for emergency services at Brighton and Sussex University Hospitals NHS Trust were mainly focused on the Major Trauma Centre at the Royal Sussex County Hospital. The staff that we spoke with were aware of the chief executive's values and behaviours. The staff had a clear understanding of what these involved and were optimistic that if successful, the initiative would help address some of the wider cultural issues within the trust.

# Summary of findings

## Medical care

Good



Medical care services were delivered by caring and compassionate staff. The lower than agreed staffing levels on some wards placed staff under pressure. The staffing complement was made up by agency or bank staff or staff moved from other wards. This inconsistency of staffing levels and skills mix placed further pressure on staff and placed patients at risk of their care needs not being appropriately met. A consultant was not always available on some wards and this included out-of-hours and weekend cover. Junior staff relied on on-call cover to access support, when needed. Some areas of care were being supported to provide a developing and improved service. These areas included stroke pathways and dementia care provision. Staff reported concerns and incidents. However, very limited feedback was given to staff to make positive changes. Generally, staff felt supported and well-led at ward-level.

## Surgery

Good



The surgical care teams were highly motivated, committed and compassionate about the services they provided to patients. Staff were caring and supported to deliver high standards of care with strong and effective leadership. Patients and their relatives reported a high level of satisfaction with the quality of care and their experience of using the hospital. We spoke with patients who told us staff treated them with dignity and respect. Patients described staff as “good” and “attentive”. Patients told us they were “happy” and that things were “well organised”. Pain was said to be managed well and patients said they were given enough information to help them make decisions about their treatment and care. Feedback we heard and read about the care and treatment from all staff, was positive. Nursing staff levels were improving, but there was a high use of bank to cover vacancies and staff unplanned absence. Mandatory training was provided to staff, however, attendance rates were low in some areas, including staff attendance at safeguarding vulnerable adults and infection prevention and control. The trust should ensure that staff have the opportunity to update their skills and knowledge in order to ensure safe practice.

# Summary of findings

Surgery was consultant-led and there were medical staffing arrangements in place to support the surgical services 24/7. Patient treatment and care needs were assessed, monitored and acted upon at each stage of their pathway, with involvement from the multidisciplinary team.

Staff and patients were supported to access specialist expertise such as the palliative care team, learning disability and safeguarding leads. Patients had access to interpretation services and could also raise concerns or make a complaint through the Patient Advice and Liaison Service, although response to such complaints were sometimes delayed.

Patient referral access and follow-up arrangements were in some cases impacted on negatively, as a result of the inadequacies of the booking Hub. Bed occupancy was not always maximised for elective procedures. The trust must ensure that patient referrals are acted upon promptly and that patients who need to be seen postoperatively, have access to the correct consultant at the correct time.

Staff understood their responsibilities to ensure that patient care was delivered safely and effectively. There were arrangements in place for staff to report adverse events and to learn from these. Clinical effectiveness was continuously monitored and governance was taken seriously, with monitored patient outcomes at ward and department-level.

## Critical care

Good



Care and treatment delivered in critical care was safe and effective. The teams leading the units were dedicated and committed to patients, their families and their staff. Patients spoke highly of their care and feedback was overwhelmingly positive. There were shortages of nursing staff in the units, a situation that was improving, but remained insufficient to avoiding the use of temporary staff. Poor patient flow meant that some patients were not being discharged when they were ready, as there were no available beds elsewhere. Some patients were discharged earlier than was optimal to free up bed space. Some patients were transferred to other hospitals and some patients were being discharged at suboptimal times, such as after 10pm. The neurological unit at this hospital did not currently contribute to the Intensive Care National

# Summary of findings

## Maternity and family planning

### Requires improvement



Audit & Research Centre (ICNARC) data. Although it measured its own data, it was not able to show readily how outcomes compared with other similar units in England. The general unit did contribute to the data and results showed good outcomes for patients.

This department has serious on going cultural issues which has affected patient safety and staff sickness. There was a lack of leadership amongst a small group of consultant staff, for example consultants not willing to hold a pager and not attending key meetings. There was a high level of grievances. Senior managers have struggled to address these issues but the trust now has the services of an external agency to help address this.

Difficult working relationships amongst and between medical, nursing and midwifery staff were cited during the inspection. Some staff reported that there was an increased potential risk to patients, due to the fear of reporting incidents and poor working relationships.

Instrumental and caesarean section rates were higher than expected. The trust recognised this and had strategies in place to help reduce the rate. Midwifery staffing levels were sufficient to provide a safe service throughout the obstetrics and gynaecology (O&G) departments.

We spent time observing and talking to staff on all of the units. We also joined a doctors round on the labour ward. We found that care and support offered to women and their families was compassionate, kind and informative.

Nursing and midwifery staff were committed to improving the services they offered and promoting continued professional development.

## Services for children and young people

### Good



We found the special care baby unit (SCBU) to be safe. There were adequate procedures to follow in the event of any incidents or accidents. The unit was clean and staff followed the trust's policies on the prevention and control of infection.

Medicines were managed appropriately and baby's records were comprehensive and included appropriate risk assessments.

# Summary of findings

Nursing and medical, including advanced neonatal nurse practitioners (ANNPs) staffing levels were adequate and there were enough appropriately skilled and experienced staff on duty at all times. The services for babies on the SCBU were effective. The unit used evidence-based care and treatment and had a clinical audit programme in place. There was evidence of effective multidisciplinary working and the service operated safely over the seven-day week.

There were procedures in place to ensure competent staff. However, half of the ANNPs had not received an appraisal within the past 12 months. The matron told us that there were plans in place to address this. Staff were compassionate and provided effective emotional support to parents. Parents were positive about their experience. One person said, "I am 100% satisfied with the care we have received."

Parents were involved in decisions about their baby's care and treatment.

We found services responsive. Service planning and delivery to meet the needs of local people and flow arrangements were in place.

People's individual needs were met and there were effective systems in place to receive and act on feedback from parents.

The service was well-led. All of the staff we spoke with told us that there was a positive culture within the unit and effective leadership.

There were regular safety and governance meetings, as well as effective processes for measuring and ensuring quality standards.

Innovation and sustainability was evident within the unit.

## End of life care

Good



Training relating to end of life care was extensively offered across the trust, with study days arranged twice per month. A monthly end of life newsletter, annual conference and intranet site was found to be very informative and comprehensive and could be accessed by all staff at any time of the day. The trust was actively engaged in the NHS Improving Quality's Transforming End of Life Care in Acute Hospitals (2012) that aims to improve the quality of end of life care within acute hospitals. Streams of work being undertaken included the development of amber care bundles and advance care planning.



# Summary of findings

The Liverpool Care Pathway (LCP) was the pathway patients were placed on in the last few days of life, but across the trust we found that not all areas were using the LCP and individualised care plans were in use. The trust is developing their 'Recognising and caring for a dying person and their carers' policy that will be released for consultation at the next end of life steering group on the 2 July 2014 to replace the LCP on the 15 July 2014.

Multidisciplinary team working was good and the specialist palliative care (SPC) team and end of life facilitator engaged well with all staff across the trust to improve services and raise end of life issues across the trust.

We saw evidence, during the inspection, of multidisciplinary team working between the SPC clinical nurse specialist, the lung cancer and the head injury clinical nurse specialist's to ensure continuity of care. Patients will be reviewed together to provide a holistic approach to care. The SPC clinical nurse specialist would be able to give advice on areas such as complex symptom management, psychological and spiritual needs.

Staff said end of life care was sensitive and caring. We observed the SPC nurse reviewing end of life patients. The patients were reviewed in professional, caring, compassionate manner.

We spoke to one family whose relative was receiving end of life care. We were told that, "Care was very good, it is excellent and staff are very caring to patients and their families."

A multidisciplinary team approach was in place to facilitate the rapid discharge of patients to their preferred place of care. Out of the 100 patients discharged, only seven patients were readmitted to hospital to die. This means that 93 patients achieved their preferred place of care and death.

There were regular SPC team meetings where performance data, complaints and incidents were discussed.

The end of life care facilitator was able to demonstrate examples of practice that the team were proud of, which included providing a holistic approach to patients receiving palliative or end of life care and an educational series where the SPC team were involved in developing policy documents, along with other professionals.

# Summary of findings

We found that end of life care was not a regular agenda item at board meetings and the trust had no strategy to implement the recommendations of the end of life care strategy (2008).

## Outpatients

### Requires improvement



We spoke to patients using the service and they told us they felt safe while attending the unit and undergoing their treatment.

Attendance at children's safeguarding training was mandatory for all staff in outpatient services. All outpatient staff had attended training in adult and children's safeguarding and attendance rates were at 100%.

Staff told us about the centralised booking system (the Hub) for all outpatient services that had been put in place across the trust in October 2013. They reported that outpatient clinic bookings through the Hub had caused significant difficulties for patients attending outpatient services at the Princess Royal Hospital. One area of concern raised by staff from outpatient services was their lack of involvement in the planning meetings with the Hub delivery unit. The consultant for the medical digestives clinic, which was due to start at 1.30pm (and had been double-booked for the surgical medical digestives clinic) found that there were no patients booked until 3pm, which incurred wasted clinic time. No one was able to clarify why these incidents had occurred and what would be done to address the failing in services.

Staff were not engaged in the implementation of the Hub and had become frustrated about the process.

# Princess Royal Hospital

## Detailed findings

### Services we looked at

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

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# Detailed findings

## Background to Princess Royal Hospital

We inspected Princess Royal Hospital as part of the comprehensive inspection of Brighton and Sussex University Hospitals NHS Trust.

The trust employs a diverse workforce of around 7,136 with 896 beds and provides district general hospital services to the local population of some 460,000 across Brighton, Hove and Mid Sussex. It also provides a range of specialist services to a population of approximately 1,000,000, including: cancer services, neurosciences, cardiac surgery, renal services and intensive care for adults, children and new-born babies. There are approximately 856 beds in the trust, with 293 of these provided at Princess Royal Hospital.

The inspection team inspected the following eight core services at the Princess Royal Hospital:

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

## Our inspection team

Our inspection team was led by:

**Chair:** Dr Sean O'Kelly, Medical Director, University Hospitals Bristol NHS Foundation Trust

**Head of Hospital Inspections:** Mary Cridge, Care Quality Commission

The team of 35 included CQC inspectors and a variety of specialists. These included: a consultant cardiologist, a consultant obstetrician, a consultant paediatrician, a consultant orthopaedic surgeon, a consultant in emergency medicine, a junior doctor, a matron, senior nurses, a student nurse, a non-executive director and an expert by experience.

## How we carried out this inspection

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

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

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

We held a listening event in Haywards Heath on 20 May 2014, where 10 people shared their views and experiences of the Princess Royal Hospital. As some people were unable to attend the listening events, they shared their experiences via email or telephone.

We carried out the announced inspection visit between 21 and 22 May 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses and midwives, junior doctors, consultants, physiotherapists and occupational therapists. We also spoke with staff individually as requested.

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

# Detailed findings

## Facts and data about Princess Royal Hospital

The trust reported three Never Events between December 2012 and January 2014. A serious incident known as a Never Event is classified as such because they are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.

Between March 2013 and March 2014, the number of patients experiencing new pressure ulcers was below the England average for all 12 months of the year. However, the data reflected that the instances of pressure ulcers reached their highest point (at 0.4%) in May, September, October and December 2013.

For new venous thromboembolism (VTEs), the trust performed above the England average for all 12 months of the year. In April 2013 and July 2013 the trust performed at their highest by 1.9% and 1.8% respectively. The trust have continued to perform above the England average.

The number of patients suffering a new urinary tract infection (UTI) was above the England average for all patients over five months of the year. By 0.3% in June 2013 and March 2014. For patients over 70 years old suffering a new UTI, the trust was above the England average for over half of the year. With double the England average suffering a new UTI in March 2013 and 0.9% more in June 2013.

For falls with harm, the trust performed well below the England average for all 12 months of the year.

The trust bed occupancy average of 85.1% for October to December 2013 was lower than the England average. Bed occupancy for two of the three critical care areas were higher than the England average. Adult intensive care unit bed occupancy was 84.8%, paediatric intensive care unit bed occupancy was 100% and neonatal critical care bed occupancy was 96.3%.

The trust reported five cases of MRSA and 48 cases of C. difficile against a target of 34 for 2013/14.

The trust performed worse than expected for all six data items in the 2013 staff survey. 48% of staff witnessed potentially harmful errors or near misses in the last month, while 76% of staff felt satisfied with the quality of work and patient care they delivered.

The trust inpatient NHS Friends and Family Test showed that the trust performed below the England average from November to February, with November scoring the lowest with 64. The trust received a good volume of responses with the exception of January, which was the lowest at 394. The ED NHS Friends and Family Test highlighted that the trust was performing below the England average from November to February, with December scoring the lowest at 10. It also showed that the most responses were received in January with 905 responses.


Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and family planning	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

# Detailed findings

Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

# Accident and emergency

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

## Information about the service

The Princess Royal Hospital provides accident and emergency services through the main emergency department (ED) to patients who require medical care. The department does not receive surgical cases via ambulance; these cases are transferred directly to the Royal Sussex County Hospital. The department saw 32,430 in 2013/14.

The adult emergency department has a three bay resuscitation area and six spaces for treating minor cases. Two side rooms and a plaster room are also available. The department is able to treat children who are brought to the department by their parents or carers. Children are taken directly to the Royal Alexandra Children's Hospital if they are conveyed by ambulance. Children are treated in a dedicated room, which has a small waiting area so as to keep children separate from the main adult waiting area.

During our inspection, we spoke with nine members of staff and one family. We also spoke with seven patients who were present in the main adult ED.

## Summary of findings

The ED was seen to actively manage the circa 80 patients that it treated each day. A recent increased capacity initiative has resulted in 6 clinical decision bed spaces being created, enhancing patient experience and lessening delays. During times of high demand, the Royal Sussex County Hospital ED placed internal diverts of ambulances to the Princess Royal Hospital, which resulted in patients experiencing less delays in receiving treatment at RSCH as patients can be transferred and assessed treated within 4 hours. However there is a 40 minute journey for this to happen but still an improvement in patient experience in times of extremeness. Despite the internal diverts which occasionally placed additional pressure on the Princess Royal ED, there was evidence that they consistently met the four hour national target.

The cleaning contractor was not able to fully meet the needs of the service to ensure patients were cared for in a clean and hygienic environment.

Staff were seen to be caring and attentive to people's needs. Patients and their relatives and carers told us that they felt well informed and involved in decisions and plans of care. However, there were concerns that children receiving treatment in the ED may not always receive care from staff who were trained to care for children. Furthermore, the department did not have a suitably robust system in place to ensure vulnerable children were identified and referred in a timely manner.

# Accident and emergency

Staff at all grades were proud of working for the service. However, there was a general consensus amongst staff that the department lacked a strong and cohesive leadership team and that this was in part due to the senior management team for both EDs being based at the Royal Sussex County Hospital.

The staff that we spoke with were aware of the chief executive's values and behaviours. The staff had a clear understanding of what these involved and were optimistic that, if successful, the initiative would help address some of the wider cultural issues within the trust.

## Are accident and emergency services safe?

Requires improvement



There was a good mix of nursing and medical staff available across the 24-hour period to meet the needs of adults. However, there were insufficient numbers of staff with relevant experience of managing children who presented to the department. There had been an increase in the nursing establishment and so recruitment was ongoing.

Staff did not always get feedback after reporting incidents.

The cleaning contractor was not able to fully meet the needs of the service to ensure that patients were cared for in a clean and hygienic environment.

Equipment was available. However, some equipment, such as the paediatric and neonatal emergency trolleys, were not routinely being checked to ensure the contents were suitable for use.

There were concerns that staff were not routinely receiving updates in safeguarding vulnerable children. This was an additional area of concern because we found that the systems in place for ED staff to raise concerns in a timely manner regarding the reporting of children who may have been subject to abuse were not sufficiently robust.

### Incidents

- There were no Never Events in the ED between December 2012 and January 2014.
- The trust reported seven serious incidents (SI) to the Strategic Executive Information System (STEIS) relating to the main ED between December 2012 and January 2014. One report was directly attributed to the Princess Royal Hospital ED and referred to the death of a patient.
- In addition, the trust provided us with the ED incident listing reports from September 2013 to February 2014, which were logged on the hospital incident reporting system, Datix. In total, 48 incidents were reported. One report was linked to the death of a patient and four reports were categorised as 'moderate', as there had been harm caused to a patient.
- We were provided with the root cause analysis (RCA) for one serious incident, which involved the ED, in 2013. We reviewed the serious incident investigation into this event. One outcome from this investigation was that all



# Accident and emergency

patients who required a referral to the mental health liaison team would undergo a mental health risk assessment by a member of the ED. This action was further reiterated in a clinical governance meeting, which took place on 18 September 2013. The ED at Royal Sussex County Hospital carried out an audit of notes for patients, who were referred for psychiatric input between 17 February 2014 and 3 March 2014. 114 case notes were reviewed, of which only 39 patients had a completed a mental health risk assessment form.

- As a result of this audit, the mental health risk assessment form was reviewed and simplified in April 2014 to help improve completion. The form was trialled at the Princess Royal Hospital to ensure that the form was appropriate and fit for purpose. A random review of 15 ED Central Alerting System (CAS) cards demonstrated that the revised risk assessment was being used appropriately.
- We asked staff directly if they reported incidents. We received a varied response, depending on the grade and profession of staff we spoke with. Some senior nursing staff said that the number of incidents reported within the ED were lower than they would have expected, although they were not able to corroborate this statement. More junior staff said that they reported incidents, but did not always receive feedback to the incidents they reported.
- The trust provided us with a range of data which encapsulated both the Princess Royal and Royal Sussex County Hospitals.
- The number of clinical incidents reported per 100 admissions (or in the instance of the ED, the number of visits), ranged from 1.9 reports per 100 in June 2013, to as high as 8.8 reports per 100 visits in January 2013.
- Between July 2013 and January 2014, the number of clinical incidents reported per 100 visits averaged 5.8 reported clinical incidents with July seeing 5.1 reports at the lowest end and August 2013 at the higher end with 6.4 reports per 100 visits. The average number of clinical incidents reported across the trust over a 12 month period dating from February 2013 to January 2014 was 7.7 incidents per 100 admissions/visits. This demonstrated that, although staff told us that they had not always reported incidents, the average number of reports had remained reasonably consistent during a seven month period, although the overall number of clinical incidents reported within the ED was below the trust average.

- Minutes from an ED staff meeting held on 28 March 2014 at Royal Sussex County Hospital, which was attended by 14 members of staff, including the head of nursing and the ED clinical lead, reported that the head of nursing was developing a 'newsletter' as a means of providing feedback on Datix incidents and safety incidents. The matron and nursing staff, who were based at the Princess Royal Hospital, did not attend the meeting.

## Cleanliness, infection control and hygiene

- The department had a range of equipment which was, for the most part, seen to be clean and well maintained. Labels were in use to indicate when items of equipment had been cleaned. A range of equipment was stored in an electrical store room. We noted that the tops of two trolleys, namely the paediatric and neonatal resuscitation trolleys, were both covered with dust.
- The ED was identified as an area of high risk regarding infection control, and as such, compliance with environmental audits was required to be 98% or above. An audit carried out in November 2013 resulted in an audit compliance score of 90% for the ED at Princess Royal Hospital.
- We observed staff complying with the trust policies for infection prevention and control. This included wearing the correct personal protective equipment, such as gloves and aprons.
- We observed staff appropriately decontaminate patients' skin, in line with the trust policy, prior to the insertion of venous and/or arterial catheters.
- Staff washed their hands between each patient and we noted good usage of the hand sanitising gel.
- 'Bare below the elbow' policies were seen to be observed by all staff.
- The ED scorecard provided to us demonstrated that there was, overall, good compliance with ED staff in relation to the 'Clean your hands' audit. The overall rating for this area of audit was green, with 95% compliance being achieved on a regular basis. Compliance was reported as being as 66% during the October 2013 audit.

## Environment

- Overall, the ED environment was found to be of sufficient size for the number of patients seen on a daily basis. However, staff reported that the resuscitation area was too small and required additional work to extend

# Accident and emergency

the area to five-bed spaces. We were told that a revised design of the resuscitation area had taken place and a business case was now being finalised for the works to go ahead.

- The clinical decision unit had been separated into single-sex areas, so as to provide privacy and dignity to patients who were admitted to those areas. However, we noted that, due to the design of the unit, there was only one unisex toilet available. This may have encroached on the privacy and dignity of patients when mobilising to use the toilet. However, the patients we spoke with at the time of the inspection were not concerned about the configuration of the area and told us that they did not feel their privacy or dignity had been affected.
- Two side rooms were available to patients who presented with a possible cross-infection risk.
- There was a small waiting area for children. This area was situated within the main ED, but was separated by a door. Staff reported that the room became “hot and stuffy” during the summer months, because the unit was located in the middle of the department and had no access to any outside windows or doors.

## Equipment

- There was adequate resuscitation and medical equipment to treat adults. This was clean, regularly checked and ready for use.
- Each bed space within the resuscitation area was configured in a similar way, so as to allow staff to be familiar with the environment. We were told that the League of Friends Charity had purchased new resuscitation trolleys, which were similar to those used at the Royal Sussex County Hospital. This would allow the staff to fully configure the resuscitation room, so that it mirrored the Royal Sussex County Hospital resuscitation room.
- There were separate trolleys which contained equipment for the management of children and neonates. These trolleys were stored in a room set away from the main resuscitation area so staff were required to retrieve the trolley during emergency situations. We noted that the paediatric trolley was not routinely checked. The trolley had been checked on 10, 14 and 16 May 2014. While the trolley was sealed, there was no

audit trail to record the serial number of the tag, so it was not possible for staff to determine whether the trolley had been used or whether equipment had been removed and the trolley then resealed.

- The neonatal trolley was last recorded as being checked on 4 January 2014. We reviewed the contents of the trolley and found that two sachets of antimicrobial skin preparation solution, one enteral syringe and one umbilical catheter had expired. This was reported to the matron of the ED at the time of inspection.

## Medicines

- Medicines in all areas were stored correctly, including in locked cabinets or fridges, where necessary. Fridge temperatures were checked regularly and were within range.
- Staff were observed carrying out the checks of controlled drugs between shift handovers.
- On reviewing ten patient care records, medication had been prescribed and administered appropriately. Patients' current medications were listed on the patient care record as part of their initial assessment.
- Nursing staff were able to administer certain medications, which were subject to patient group directions (PGD). These medications included simple analgesics, topical anaesthetics for children for use prior to venepuncture (blood tests) and local anaesthetics for use prior to the suturing of skin wounds.
- There was a process in place for auditing the use of PGD's to ensure that the practice was safe and the use of specific PGD's remained relevant to the department.
- The department reported two medication incidents between January and April 2014.

## Records

- We looked at 20 sets of notes during our inspection (some were current, others were provided by the trust from the previous week).
- An audit of records was carried out by the matron on a monthly basis. The content of the audit included whether the following information had been recorded: a full patient history, social history, previous medical history, a record of current medications the patient was taking, any allergies the patient suffered from and a list of property the patient arrived into the department with. Furthermore, a review was carried out by the matron to determine whether appropriate risk assessments were routinely carried out, including: patient vital sign observations, Waterlow assessments (for monitoring

# Accident and emergency

possible skin pressure damage), a falls risk assessment, pain assessments, urinary catheter care bundles, intravenous line care bundles and nutrition screening tools.

- 100% compliance was attained for ensuring that appropriate observations were carried out on 16 patients during March 2014. This included a full set of observations being recorded within 15 minutes of admission to the department, and an appropriate national early warning score was recorded and correctly calculated.
- There was good compliance with the completion of intravenous catheter insertion care bundles being used, with 100% of all applicable cases having a recorded IV insertion care bundle being completed.
- There was poor compliance with staff recording reassessed pain scores after analgesia had been administered to patients, with only 40% of audited patients being reassessed in March 2014.
- The department had a computer system that showed how long people had been waiting for and what investigations they had received. The system was seen to be updated regularly.

## **Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards**

- Consent forms were available for people with parental responsibility to consent on behalf of children who are not Gillick competent. Gillick competency is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.
- We observed that consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent.
- The staff we spoke with had sound knowledge about consent and mental capacity.
- Training records demonstrated that 70% of clinical staff working within the ED had received training on the Mental Capacity Act 2005.
- Where people lacked the capacity to make decisions for themselves, such as those patients who had arrived into the resuscitation department unconscious, we observed staff making decisions that were considered to be in the best interest of the patient. We found that any decisions made were appropriately recorded within the patient's care notes.

## **Safeguarding**

- There were ineffective systems in place for the reporting of safeguarding children's incidents so they could be appropriately investigated by the multiagency safeguarding team. The department employed one qualified children's nurse who worked three days per week. In addition to their clinical responsibilities, the children's nurse was required to review each of the care records of children who presented to the emergency department to determine whether there was a requirement to refer the child to their local health visitor, school nurse or social services. The department treated approximately 110 children each week. We were told that there could be a backlog of case notes to be reviewed if the children's nurse was on leave.
- According to the data provided to us by the trust, only one nurse had attended level 3 safeguarding training in the previous year. From the records provided, no staff had received level 1 or 2 training in safeguarding vulnerable children during the previous three years.
- There was a named consultant and nurse for safeguarding children within the trust. The consultant told us that there were weekly peer reviews of all non-accidental injuries. This took place at the Royal Alexandra Children's Hospital.

## **Mandatory training**

- Overall, compliance with mandatory training was found to be acceptable, with the exception of safeguarding vulnerable children training. According to the data provided to us by the trust, only one nurse had attended level 3 safeguard training in the previous year. From the records provided, no staff had received level 1 or 2 training in safeguarding vulnerable children during the previous three years.
- 100% of staff had attended fire safety training in the previous 12 months.
- 60% of staff had undertaken annual adult basic life support training.
- Between 2010 and 2014 the trust had trained 268 staff in advanced life support, 80 staff in the use of the European Paediatric Life Support, 96 staff in the use of Advanced Paediatric Life Support and 159 staff in neonatal life support. These courses are recognised as advanced resuscitation courses and are provided by nationally-accredited training teams.

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## Initial assessment and management of patients

- Patients arriving by ambulance as a priority (blue light) call are transferred immediately to the resuscitation area or to an allocated cubicle space. Such calls are phoned through in advance so that an appropriate team are alerted and prepared for their arrival.
- Patients arriving in an ambulance, car or on foot between 11pm and 7:30am were initially triaged and booked into the hospital system by a senior nurse. Patients were assessed by an assessment nurse who carried out baseline observations from which a national early warning score was generated. In addition, the nurse took an initial patient history and pain score and then graded the patient in line with the Manchester triage system to determine the acuity of the patient. If, during the initial assessment stage, the patient was identified as needing urgent and more intensive intervention, they were transferred though to the resuscitation area or to another, more appropriate, area, depending on the availability of bed spaces.
- Between 7:30am and 11pm, patients who walked into the department were seen in the first instance by a receptionist, who would then direct the patient to a triage area. Patients were then reviewed by a senior nurse, before being placed into a specific patient care pathway depending on the urgency of their condition. Patients requiring an urgent review (such as those with chest pain) would undergo an electrocardiogram (ECG) immediately. We were told that, during peak times, patients could expect to wait up to 45 minutes before being initially assessed by the triage nurse. We requested information from the trust regarding this, but at the time of writing this report, we had not received this information and so were unable to corroborate this statement.

## Management of deteriorating patients

- The national early warning score (NEWS) was used throughout the department. A clear escalation procedure was available to staff. We found good utilisation of the NEWS during our inspection.
- The paediatric early warning score (PEWS) was used in the children's area of the emergency department. This helped to determine if a patient's condition was worsening.
- The emergency department used the Manchester triage guidelines. This helped to determine the severity of the patient's injury or illness.

## Nursing staffing

- The nursing establishment for the ED at Princess Royal Hospital was 40.6 whole time equivalent (WTE) posts.
- The total number of vacancies as of April 2014 was 7.5 WTE (18.4%). 5.5 WTE posts had been newly created following a review of the department establishment in April 2014.
- The average sickness rate amongst the ED nursing cohort between May 2013 and March 2014 was 6.3%.
- The average staff turnover rate amongst the ED nursing cohort between May 2013 and March 2014 was 19.2%.
- The department employed 11.4 WTE emergency nurse practitioners, which was 0.4 WTE over the budgeted establishment. Emergency nurse practitioner's rotated between Royal Sussex County Hospital and Princess Royal Hospital.
- The trust-wide emergency care service was supported by one full time practice educator, whose role it was to support staff and to facilitate learning within the department. However, staff told us that they rarely had any input or engagement from the practice educator as they spent the majority of their time at the Royal Sussex County Hospital.
- The average sickness rate amongst the emergency nurse practitioners' between May 2013 and March 2014 was 8.9%; there was a 0% turnover of emergency nurse practitioners' during that same period.
- Bank and agency receive a local induction prior to starting their shift. Evidence of this was seen at the time of our inspection.
- Shifts in the ED were staffed with a mix of band 7 sister/charge nurse grades, with band 6 and band 5 nurses, health care assistants and student nurses completing the team. We saw that the head of nursing and matron were actively recruiting new nursing staff in to the ED.
- We were told by staff that the emergency service had seen a regular turnover of senior nursing management in recent years. The current head of nursing had been in post for approximately ten months, having been seconded from the critical care unit. The secondment was due to finish in June 2014 and there was noticeable anxiety amongst the nursing and medical team that, due to internal restructuring, the head of nursing post may have been at risk. We were advised by the chief executive that the organisational restructuring was currently in the pre-consultation stage, and it was noted

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that the chief executive had been clear that each division would have the opportunity to design their management structure in whatever way they thought would best suit each department.

- During each day shift, the department was supported by seven registered nurses, as well as an emergency nurse practitioner service, which was provided between 8:30pm and 9pm each day.
- Between January and April 2014 there was one Datix incident report in which it was reported that the ED was not likely to be fully staffed by substantive staff and therefore there may have been a requirement for the department to be partially staffed by agency staff.
- There was not an adequate skill mix to ensure the safety of children who were visiting the department for treatment. The department employed one substantive children's nurse who worked three days per week. Outside of the days when the children's nurse was not working, a band 6 adult nurse was allocated to care for children. Two band 6 nurses were seconded to the Royal Alexandra's Children's Hospital ED, in order that they could gain more experience. The matron told us that they were in the process of developing a business case to enable additional band 6 nurses to rotate through the RACH in order that they could be up-skilled to appropriately care for children who visited the department.

## Medical staffing

- The trust employed 17 emergency medicine consultants.
- A consultant was available Monday to Sunday from 9am to 5pm, with an additional consultant working 1pm to 11pm on Mondays to meet the needs of the department.
- Registrar cover was provided from 1pm to 11pm during the day and then from 11pm to 9am each night.
- Junior doctors could seek support and advice from a consultant emergency physician 24 hours per day.
- The department was supported by six WTE middle grade doctors.
- To ensure the quality of care provided to patients by the middle grade doctors out-of-hours, all notes associated with patients who received treatment during the night were reviewed by the consultant the following day.
- Overall, junior doctors spoke positively about working in ED. They told us that the consultants were supportive and always accessible.

- The consultant team met weekly to discuss any operational issues, including any foreseeable medical staffing problems that required resolving so as to ensure the department was suitably covered with medical staff.

## Major incident awareness and training

- The hospital had a major incident plan (MIP) which had last been reviewed in January 2014. The MIP provided clinical guidance and support to staff on treating patients of all age groups and included information on the triaging and management of patients suffering from a range of injuries, including those caused by burns or blasts.
- We were told that a 'desktop' major incident exercise was next scheduled to take place on 20 June 2014.

## Security

- Staff working in the department told us they felt safe and supported and both reported that the relationship between the ED and security team was good.
- Security staff had undertaken control and restraint training.
- We observed members of the security team regularly being present in ED.

## Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate



The main ED service had an ongoing programme of auditing, which encompassed local audits. However, we noted that the Princess Royal ED service did not participate in national audits, which were attributed to the College of Emergency Medicine.

Policies and procedures were developed in conjunction with national guidance and best practice evidence from professional bodies such as the College of Emergency Medicine, National Institute for Health and Care Excellence (NICE) and the Resuscitation Council UK.

There was evidence of strong multidisciplinary working, with good working relations noted between the ED and the Rapid Access Medical Unit, which operated each day from 8:30am to 8:30am.



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## Evidence-based care and treatment

- Departmental policies were easily accessible on the trust's intranet, which staff were aware of and reported that they used. In addition, the ED introduced 'emergency prompt cards' into the department in March 2014. Prompt cards were observed to be readily accessible throughout the department and staff were observed to be using them during our visit.
- The emergency prompt cards contained approximately 29 separate protocols and/or guidance to help support staff. For example, prompt cards 12 to 17 referred to advanced resuscitation algorithms, which had been endorsed and published by the Resuscitation Council UK in 2010.
- Other departmental guidelines and policies had been written in conjunction with guidance and evidence provided by the National Institute for Health and Care Excellence (NICE) and the College of Emergency Medicine.
- A protocol was in place to support staff undertaking rapid sequence inductions (RSI). This is a medical procedure involving a prompt induction of general anaesthesia and subsequent intubation of the trachea. The use of the RSI protocol had been audited by the emergency care department. The audit demonstrated an increase in the use of the RSI checklist between 2012 and 2013. During 2012, the RSI checklist was used on 15 out of a possible 70 occasions (compliance rate of 21%), as compared with it being used on 30 occasions out of a possible 80 in 2013 (compliance rate of 45%). It was noted that a requirement to record the use of the RSI checklist was discontinued in October 2013 and so it was considered by the ED team that the use of the RSI checklist was likely to be higher than could be evidenced. The lead nurse for resuscitation had made the decision to source a stamp which could be used by staff to record the use of the RSI in the future.
- In addition to the RSI checklist, the department also utilised a procedural sedation checklist. During 2012 the checklist was reported to have been used on 89 patients out of a possible 154 (compliance rate of 58%). During 2013, the use of the procedural sedation checklist had increased to 142 out of a possible 162 cases (compliance rate of 88%). The use of the various checklists and emergency prompt cards were considered to reduce the overall number of incidents directly attributed to human factor errors, and ultimately improve patient safety.
- The emergency medicine division participated in a number of national audits, including those carried out on behalf of the College of Emergency Medicine. Results from the 2013 College of Emergency Medicine clinical audit relating to 'consultant sign-off' was compared with the same audit in 2011 to determine whether the ED had made any improvements. The College of Emergency Medicine consultant sign-off audit measures a number of outcomes, including whether a patient has been seen by an ED consultant or senior trainee in emergency medicine, prior to being discharged from ED when they have presented with non-traumatic chest pain (17 years of age or older), children under one years of age presenting with a high temperature and patients who present back to ED within 72 hours of previously being discharged.
- During 2011, the number of patients seen by a consultant was 4% versus a national average of 12%. This had increased in 2013 to 22% of patients being seen by a consultant – the national average was 14%.
- During 2011, the number of patients who were discussed with an ED consultant prior to discharge was 16%, versus a national average of 12%. In 2013, this had increased to 25% of patients being discussed with a consultant, versus the national average of 13%. The number of patients discussed with a senior trainee emergency medicine doctor was 72% in 2013, versus the national average of 36%.
- The number of ED notes reviewed by an ED consultant following discharge was reported as 0% in 2011, versus a national average of 7%. This had improved significantly in 2013, with 22% of ED notes being reviewed, versus the national average of 7%.

## Pain relief

- Pain scoring tools, relevant to a child's age, were used in the children's emergency department.
- We saw evidence that pain was appropriately assessed and managed within paediatrics. This included the further assessment of pain following pain relief.
- We noted that there were distraction therapies for children. These included sensory equipment, bubbles and music.
- During March 2014, compliance with staff carrying out and recording a pain assessment on patients within 15 minutes of their arrival, was 26.3%.

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- Only 40% of patients had their pain score reassessed after 30 minutes of analgesia being administered during March 2014.

## Nutrition and hydration

- We observed staff providing drinks and snacks to patients during our inspection.
- Nutritional risk assessments were undertaken as required. Where food or drink had been offered, we found that this had been recorded in the patient's emergency department care record.
- A review of the March 2014 nursing metric for ED indicated that, of the six case notes reviewed, five out of six patients did not have documented evidence that food or drink had been offered. In addition, where patients were nil by mouth, this had not been recorded within their notes.

## Patient outcomes

- The College of Emergency Medicine recommends that the unplanned re-attendance rate for ED's should be between 1 and 5%. The national average is around 7%, which the trust has exceeded since March 2013. Their rate in December 2013 was 7.8% and had been RAG-rated as red. The trust had set a benchmark that less than 5% of patients would re-attend the ED within seven days. However, the figures provided by the trust combined both the Royal Sussex County Hospital and the Princess Royal Hospital, so it was not possible to fully determine the actual performance of the Princess Royal Hospital emergency department.
- The ED at Princess Royal Hospital was not participating in any national audit attributed to the College of Emergency Medicine. National audit activity was noted as predominantly taking place in the Royal Sussex County Hospital ED.
- Data provided by the trust in the form of the 'A&E November 2013 scorecard', which indicated that the overall mortality rate for the emergency department was 0.4%, as compared to the set benchmark of less than 5.3%. This meant the department was RAG-rated as green for overall mortality within the department.

## Competent staff

- Appraisals of both medical and nursing middle grades and consultants was being undertaken and staff spoke positively about the process. The overall trust appraisal compliance rate for medical staff was 97%, with a caveat that 16% of doctors were considered to be compliant

due to being on maternity leave, study leave, or having recently started with the trust. A further 15% of doctors had received an appraisal within the 12 months of the end of the appraisal window. These 15% of doctors were scheduled to have their next appraisal in June 2014.

- At the time of writing this report, the trust reported that 74% of doctors had been booked into an appraisal meeting during the 2014/2015 appraisal year.
- There were conflicting figures for the number of nursing staff that had received an appraisal during the past 12 months. Departmental figures showed that the majority of staff had received their appraisal in time, whereas the human resource department figures showed that only 34.5% of staff had received their appraisal. We spoke about this with the departmental manager. They told us that they thought the discrepancy was due to a delay in updating the system in the human resource department.
- We spoke with junior doctors who told us that they received regular supervision from the emergency department consultants, as well as weekly teaching.
- We saw evidence that staff were supported in maintaining their competence and had training and education in the use of patient group directives (PGDs) for the transcribing of medicines, intravenous fluids and cannulas, venepuncture, plastering, triage, mentorship and Ionising radiation medical exposure IRMER regulations.
- The matron for ED explained that the department had a two-year plan to up-skill the current emergency nurse practitioners to help enable them to undertake additional clinical tasks. We saw that this programme was supported and facilitated by a named consultant.

## Multidisciplinary working

- There was effective multidisciplinary working within the ED. This included effective working relations with speciality doctors, nurses and physiotherapists.
- We observed close working relationships between the nursing and medical staff within ED. The stroke team were seen to integrate well with the resuscitation team.
- There appeared to be a good working relationship between the ED team and members of cardiology and acute medicine.

## Seven-day services

- The department had access to radiology support 24 hours each day, with full access to computerised tomography (CT) scanning.

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- Consultant ED physicians covered the major trauma centre at Royal Sussex County Hospital in Brighton and so offered telephone support and advice to junior doctors at the Princess Royal Hospital 24 hours per day, seven days per week.

## Are accident and emergency services caring?

Good



Overall, the ED provided a caring and compassionate service.

We observed staff treating patients with respect. Patients and their relatives and carers told us that they felt well informed and involved in decisions and plans of care. We saw that staff respected patients' choices and preferences and were supportive of their culture, faith and background.

### Compassionate care

- In 2012, CQC carried out a survey of patients who used A&E services. We asked 850 people to rate their experiences of ED services provided by Brighton and Sussex University Hospitals NHS Trust. We received 326 completed surveys.
- The trust scored an 'average' rating for 33 out of 35 questions. Two questions, specifically 'not being told one thing by a member of staff and something quite different by another' and 'for not feeling threatened by other patients or visitors' both scored a below average rating when compared to other trusts nationally.
- The trust performed below the England average for the NHS Friends and Family Test. In April 2014, ED scored 27, as compared with the England average of 55. In March 2014, ED scored 48, as compared to the national average of 54.
- The ED management team acknowledged the return rate for the NHS Friends and Family Test to be poor and were trying to address this. In April 2014, the return rate of NHS Friends and Family Test results for ED was 7.8% as compared to 18.6% nationally.
- We witnessed multiple episodes of patient and staff interaction, during which staff demonstrated caring attitudes towards patients.

- Between April 2013 and December 2013, the ED division received 16 complaints which were attributed to poor staff attitudes.
- A search of NHS choices on 5 June 2014 returned 10 comments from patients or family representatives who had used the Princess Royal Hospital ED between February 2013 and May 2014. Seven patients rated the service they received as 5 out of 5 with comments such as, "The medical care I received was thorough and quick, and the staff team were warm, friendly and reassuring," and, "We were impressed with the care and kindness of all concerned [staff]," and, "I was extremely satisfied with all the staff I came into contact with and cannot praise them highly enough."
- One patient, who rated the service as 1 out of 5, stated that they experienced delays in receiving treatment and considered the overall treatment they received as unsatisfactory.
- Another patient rated the department as 2 out of 5, citing poor staff attitude as the reason for their poor overall rating of the service.
- One patient did not rate the service, but considered that the treatment their relative received was unsatisfactory.

### Patient understanding and involvement

- The children and parents we spoke with said that they had been involved in the planning of their care and had understood what had been said to them.
- Patients and relatives told us that they had been consulted about their treatment and felt involved in their care.

### Emotional support

- We observed staff giving emotional support to both children and their parents.
- The ED had access to a room that functioned as a family room. This area allowed staff to have conversations with relatives, which may have been of a sensitive or emotional nature.
- We were told, and saw evidence that, staff could access a support service called HELP (Health, Employee Learning and Psychotherapy services). The HELP service was created to provide staff with confidential support, counselling and psychotherapy for an assortment of issues, ranging from work-related matters, such as staff being involved in traumatic incidents, through to advice regarding finances or personal relationships. We were



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provided with data from the trust which indicated that eight members of staff from across the Princess Royal Hospital had been referred to receive support from the HELP team in April 2014.

- ED and the wider hospital were supported by a bereavement team, who routinely worked Monday to Friday. Relatives of patients who had passed away could be referred to the bereavement team who could provide additional information on counselling services, as well as providing information to people such as how to record a death with the local registrar, through to making funeral arrangements.

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

Good



The ED at Princess Royal Hospital consistently treated and discharged patients within four hours. However, there were occasions when patients who were conveyed to ED by ambulance experienced delays in their care when being handed over from the ambulance service to ED. Such delays were seen to occur more frequently when the Royal Sussex County Hospital was at full capacity and had placed an internal divert of ambulances to the Princess Royal Hospital.

There was limited evidence to demonstrate that the staff working within the ED learnt from complaints.

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

- Between January and March 2013 the ED at Royal Sussex County Hospital experienced a high number of patients who breached the 12 hour national target, which are that once a decision had been made to admit a patient, that patient would be moved to an inpatient bed within 12 hours. In response to the high number of breaches, the trust invited the emergency care intensive support team (ECIST) to review the ED's emergency care pathways. This review included a review of the Princess Royal Hospital to determine how the Princess Royal Hospital interacted with the ED at the Royal Sussex County Hospital.

- In response to the ECIST recommendations, a new project was endorsed by the trust: 'Emergency and Unscheduled Care – Right Care, Right Place, First Time – Implementation Plan'. We saw that the plan had five work streams, each of which had a number of action plans to which key individuals had been assigned as having responsibility. A review of capital investment within ED at the Princess Royal Hospital was identified as an action within the trust's ECIST action plan.
- The trust had a 'patient flow and escalation policy', which was reviewed in March 2014. The purpose of the policy was to ensure that "all patients are admitted to the right place at the right time, first time".
- In order to help manage the significant capacity issues at Royal Sussex County Hospital, the trust requested the local ambulance service to divert appropriate (non-surgical) adult patients to Princess Royal Hospital on eight occasions between 1 February and 30 March 2014. Staff told us that when the Royal Sussex County Hospital was on divert, the overall length of time patients may have expected to wait to receive treatment at Princess Royal Hospital was likely to increase, but that the department generally always managed to see, treat, admit, transfer or discharge patients within four hours of arrival.

## Access and flow

- In 2013/14 there were 32,430 ED attendances.
- The department treat approximately 115 children each week.
- According to data provided to us by the trust by way of the 'A&E November 2013 scorecard', the ED at Princess Royal Hospital was consistently seeing, treating and admitting/transferring or discharging over 95% of patients within four hours.
- Between September 2013 and February 2014, there were no reported incidents relating to capacity concerns within ED.
- During our inspection on 22 May 2014, ED was observed to be calm. The average length of time for patients to see a clinician was one hour and 12 minutes.
- The department were also able to refer primary care patients to an on-site GP service, which was provided by a third party. This service was provided out-of-hours and commenced at 7pm each day. Referrals to this service from the ED were routinely audited by the clinical lead for the department to ensure appropriate referrals were being made.

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## Meeting people's individual needs

- We saw that ED had an equality and diversity 'red box' that contained information and tools to help staff to communicate with people who may have been hard of hearing, who may have had poor eye sight, or for those people with learning disabilities.
- There was a range of patient information leaflets available for different conditions, including head injuries and burns. However, we did not see any evidence that these leaflets were available in any language other than English. Staff that we spoke with did not consider this to be an issue, as they reported the majority of patients who accessed the service spoke English.
- Staff had access to translation services by way of a telephone interpreter system. Staff reported that this system worked well whenever they were required to use it.
- Staff raised concerns that access to mental health provision remained poor, despite a serious incident taking place in 2013, which resulted in the death of a patient. Staff reported that the mental health service was provided by an external organisation. At times, staff had reported that they experienced delays in accessing timely support from the mental health provider. There were no reported Datix incident reports regarding delays in patients being reviewed by the mental health service. Furthermore, this issue was not identified as a risk on ED's risk register.

## Learning from complaints

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint, then they would speak to the shift coordinator. If the concern was not able to be resolved locally, patients were referred to the Patient Advice and Liaison Service, who would formally log their complaint and would attempt to resolve their issue within a set period of time. Patient Advice and Liaison Service information was available within the main ED.
- The matron and head of nursing told us that all complaints were logged onto the trust's incident reporting system and we saw evidence of this. Complaints were investigated by the matron or other senior staff within the department such as the clinical lead when the complaint related to a member of the medical team.
- The trust had a number of ways in which learning from complaints was shared including monthly newsletters

called Patients First and through feedback from the Family and Friends which were fed back monthly to wards and departments. However some staff we spoke with felt that learning from complaints in the ED was not good.

- We were told that, since the consultants had moved to a 24/7 staffing rota at Royal Sussex County Hospital, the overall number of complaints received by the Patient Advice and Liaison Service team, directly attributed to ED, had reduced significantly.

## Are accident and emergency services well-led?

Requires improvement

Staff at all grades were proud of working for the service. However, there was a general consensus amongst staff that the department lacked a strong and cohesive leadership team. Staff told us that the senior management team responsible for ED services at Brighton and Sussex University Hospitals NHS Trust were mainly focused on the Major Trauma Centre at the Royal Sussex County Hospital.

The staff that we spoke with were aware of the chief executive's values and behaviours. The staff had a clear understanding of what these involved and were optimistic that, if successful, the initiative would help address some of the wider cultural issues within the trust.

## Vision and strategy for this service

- The ED and wider hospital had undertaken a plethora of changes to enhance the overall quality offered by the emergency care pathway.
- There was further anxiety amongst staff, because they were concerned for the future of ED at Princess Royal Hospital. Although in response to this the trust management confirmed that retaining an ED at PRH was part of the clinical strategy
- There was further anxiety amongst staff, because they were concerned for the future of ED at Princess Royal Hospital. The matron had developed a two year service improvement plan, which included the up-skilling of staff. The clinical lead for the department told us that these concerns had been discussed with the chief executive, who had reported that their vision was that the provision of ED services at Princess Royal Hospital would continue in the future.

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- The trust had a vision, titled '3T's: Teaching, Trauma and Tertiary Care'. One stage of this initiative was to relocate the neurosurgical service, which was located on the campus at Princess Royal Hospital, to Royal Sussex County Hospital. In order that this relocation could take place, a number of services were scheduled to be moved to Princess Royal Hospital. One such service to be relocated to the Princess Royal Hospital was the service allocated to the treatment and management of patients who had suffered from a fractured neck of femur. This was due to take place in August 2014. We asked the ED matron whether any training had been commenced with staff in light of this development, we were advised that no such training had taken place as yet, but had been identified as an area that needed to be addressed in the very near future.
- The staff that we spoke with were aware of the chief executive's values and behaviours. The staff had a clear understanding of what these involved and were optimistic that, if successful, the initiative would help address some of the wider cultural issues within the trust.

## Governance, risk management and quality measurement

- Quarterly departmental governance meetings were held, during which clinical incidents and complaints were reviewed. These meetings were held at the Royal Sussex County Hospital. We were provided with the minutes from the two most recent ED clinical governance meetings. It was not clear from the minutes we were provided with whether matters such as those areas of risk recorded on the department risk register were discussed. It was, therefore, not possible for us to determine how the department were managing those risks. Furthermore, there was no representation from the matron who was responsible for the day-to-day nursing leadership within the Princess Royal Hospital emergency department. When we spoke with the matron regarding this, they told us that they were not routinely invited to attend the governance meeting although they did attend meetings for the division of medicine.
- Senior clinicians were seen to attend divisional mortality and morbidity meetings.

## Leadership and culture within the service

- Oversight for the department was in the form of a triumvirate, including a clinical lead (an ED consultant), a nursing lead (an interim senior head of nursing) and a general manager.
- It was apparent that the department operated on a medical model, with the clinical lead assuming overall responsibility for the department. The clinical lead spoke positively about the nursing lead and believed that the department's leadership team were united in improving the overall quality of the service. However, staff told us that ED leadership was heavily focused on the provision of emergency services from the Royal Sussex County Hospital and there was little or no engagement with senior management at Princess Royal Hospital. We were told the Associate director of nursing for medicine and the Head of Nursing for ED visit weekly.
- Staff routinely made comments that indicated that they considered they were treated as "second-rate" when compared to Royal Sussex County Hospital, because Princess Royal Hospital was not allocated as a major trauma centre.
- Despite this perception, staff spoke positively about working at the Princess Royal Hospital. Staff said, "I am proud to work here" and, "I love working here," and, "We have very good clinical leadership from the consultant lead; it is nice to work here." Some staff, who worked between the Royal Sussex County Hospital and Princess Royal Hospital, said they liked to self-roster shifts at the Princess Royal Hospital because the atmosphere was more relaxed when compared to the ED at Royal Sussex County Hospital.
- Staff repeatedly spoke of a 'flattened hierarchy' within the department. We observed staff of all grades engaging with the clinical lead, who was present in ED on the day of our inspection.
- We saw that when the department was under control, there was a high level of decorum and calmness within the department. Staff were observed to be relaxed and were able to spend time with patients and relatives, providing care and support in a friendly and compassionate manner.
- There were concerns within ED about nursing leadership. Staff felt that this level of leadership was weak.

# Accident and emergency







## Public and staff engagement

- There was evidence displayed on a notice board in the main ED reception area that encouraged patients to submit their comments and views on the service they had received.
- There were no posters or signs in the department of changes made as a result of patient feedback (for example: 'You Said, We Did').
- The staff that we spoke with were not aware of any public engagement groups or other formal initiatives other than the patient feedback comment cards, whereby input from patients was sought to help improve the overall ED experience.

## Innovation, improvement and sustainability

- The introduction of the emergency prompt cards was seen as an area of good practice within the department. This initiative was being coordinated by a national lead in patient safety.
- Staff told us that the impact of poor patient flow and congestion within ED at Royal Sussex County Hospital was noticeable at the Princess Royal Hospital, especially when ambulances were placed on internal divert because of the increase in ambulances attending the Princess Royal Hospital. Further engagement with the local clinical commissioning groups and organisations in the wider health economy to address the issues experienced by the Royal Sussex County Hospital ED and the trust overall were ongoing.

# Medical care (including older people's care)

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

## Information about the service

The medical division of the Princess Royal Hospital included an acute medical unit (AMU) and eight wards. These wards included a stroke unit and dementia care unit.

We visited all of those areas which deliver medical or specialist care.

We talked with 15 patients, four relatives and 27 members of staff. These included consultants, doctors, junior doctors, all grades of nursing staff, healthcare assistants and Allied Healthcare professionals. We also spoke with pharmacy staff, administrative staff, cleaning staff and volunteers.

We observed care and treatment, and looked at four sets of patient records, including medical and nursing notes, and drug charts. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from and about the trust.

## Summary of findings

Medical care services were delivered by caring and compassionate staff. The lower than agreed staffing levels on some wards placed staff under pressure. Staffing complement was made up by agency or bank staff or staff moved from other wards. This inconsistency of staffing levels and skills mix placed further pressure on staff and placed patients at risk of their care needs not being appropriately met.

Where there were gaps in consultant establishment, this at times led to decisions about treatment and discharges being delayed and patients could be on the ward longer than needed. Junior staff relied on on-call cover to access support, when needed.

Some areas of care were being supported to provide a developing and improved service. These areas included stroke pathways and dementia care provision.

Staff reported concerns and incidents but felt learning from these was not always evident with only limited feedback provided to help staff to make positive changes. Generally, staff felt supported and well-led at ward-level.

# Medical care (including older people's care)

## Are medical care services safe?

Requires improvement



We found that improvements were required to medical services to ensure the safety of patients at all times.

Learning from incidents was not evident and staff told us that, while reporting was encouraged, no changes or evident learning were seen as a result of incidents reported.

Some equipment, including resuscitation equipment was not serviced regularly to ensure it was suitable for use.

Nurse staffing levels were not sufficient on some wards. Skills mix of nursing staff was compromised as staff moved from ward to ward to cover staff shortages. These shortfalls placed patients at risk and caused delays in care.

During out-of-hours and at the weekends, there was reduced access to senior staff. Consultant cover was not available every day and this caused delays in patients being discharged.

### Incidents

- There were systems for reporting incidents across the medical directorate of Princess Royal Hospital. Staff told us that they were supported by senior staff to report incidents, but the system for reporting was time-consuming. Between March 2013 and March 2014 the trust submitted 128 incidents to the National Reporting and Learning System (NRLS) across the trust sites. Medical specialities had the highest number of patient incidents, with 37.5% moderate harm incidents that accounted for the majority of the total.
- Staff told us that they received little or no feedback from incidents and alerts they made via the electronic system in place. No members of staff we spoke with were able to tell us of any changes that had taken place as a result of incident reporting. Within a focus group, we identified that staff reported incidents and other staff responded, but those responses were never received at ward-level.
- Pharmacy staff confirmed that they also did not receive feedback from incident reporting and so any information relating to medicines was not used to ensure changes in practice to promote safety.

### Safety thermometer

- Safety thermometer information was clearly displayed at the entrance to each ward. This included information about falls, new venous thromboembolism (VTE), catheter use with urinary tract infections, and new pressure ulcers.
- Between March 2013 and March 2014, the number of patients experiencing new pressure ulcers was below the England average for all 12 months of the year. For new VTE's, the trust reported fewer cases when compared to the England average for all 12 months of the year. The number of patients suffering a new urinary tract infection was higher than the England average for all patients over five months of the year. For falls, the trust had less falls than the England average for all 12 months of the year, with the exception of April 2013.

### Cleanliness, infection control and hygiene

- The areas of the hospital we visited appeared clean, although equipment was stored in corridors and this made some cleaning less practical, as we observed cleaning staff cleaning around equipment.
- We observed staff following good hand hygiene practice and 'bare below the elbow' guidance. Staff were able to describe, and demonstrated, a good knowledge of current infection prevention and control guidelines. We saw doctors and nurses washing their hands between patients and using the hand sanitising gel provided.
- The trust's infection rates for *Clostridium difficile* (C. difficile) lay within a statistically acceptable range, taking into account the trust's size and the national level of infections.
- The MRSA infection rates lay above the statistical range, with a total of five cases.

### Environment and equipment

- There were poor storage arrangements on some wards, including Ardingly Ward, with equipment being stored in corridors and in bathrooms. We observed that this created a falls hazard for patients and visitors, with large pieces of equipment obstructing some corridor areas of the ward.
- The Princess Royal Hospital had access to equipment; however, not all equipment was serviced to ensure its safety. On Clayton Ward, we saw eight infusion pumps used for the delivery of fluids and medicines. According to the service labels on each piece of equipment, four pumps had been serviced within the last year and four pumps had not been serviced. This meant that the trust



# Medical care (including older people's care)

could not be assured that the infusion pumps were safe for use. On Pyecombe Ward, five out of six pumps available had out-of-date service labels. The electrocardiography (ECG) machine on Pyecombe Ward was last serviced in 2009 and so was out of date for safe use.

- Resuscitation equipment, including the portable drug bag on Clayton Ward, did not display a record that confirmed the drugs had been replaced within the last 12 months. This bag had been checked on 31 March 2014 and noted as out of date, but was only replaced on 14 April 2014. The staff check reported the bag as out of date on 3 April 2014, but was noted as in date on 5 April 2014, for one day only. The ward sister told us this delay was in delivery in replacing the bag (this was noted across the hospital). There was no explanation for the signature for 5 April 2014, which deemed the equipment fit for use.
- On Ardingly Ward, the emergency portable suction machine had not been serviced since 2011 and on Ardingly and Pyecombe Wards, the daily record checks of resuscitation equipment had gaps when the checks had not been completed.

## Records

- During our inspection, we reviewed four sets of patient records over the eight areas we visited. Documentation seen was signed and dated, providing an audit trail of the patient's care and treatment. The records relating to the stroke pathways were seen to be comprehensive and fully completed by doctors, nurses and therapy staff to provide an audit trail of ongoing care. Records noted when care was given and when care was refused, to demonstrate when patients had voiced choices and preferences.
- We looked at do not attempt cardio-pulmonary resuscitation (DNA CPR) orders on most of the wards and units we inspected, these had not all been completed in line with guidance on the reverse of the document. We saw that, for two patients, the date of birth recorded on the DNA CPR was not the person's date of birth.

## Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- We spoke with staff about their knowledge of the Mental Capacity Act 2005 and how this was used to protect

patient's rights. Staff were clear about their responsibilities under the Mental Capacity Act 2005 and that decisions would be made in the patients' best interest.

- The Princess Royal Hospital included within their policy for transfers between hospital ward areas that consent by the patient was needed and any wishes regarding transfer should be considered before the patient was moved.

## Safeguarding

- All of the staff we spoke with about safeguarding had undertaken safeguarding training and felt able to raise an alert when needed. Staff spoke positively about raising an alert should they have any concerns.

## Mandatory training

- Staff told us they had annual appraisals and could tell us when their last appraisal had been. This identified when training was needed, the areas for personal development and learning goals and plans for when this would be undertaken.
- Staff told us that they had received training in safe moving and handling and infection control. A new staff member told us that the induction was condensed but they had felt supported in the role once on the wards, to ensure they were safe to provide care.

## Management of deteriorating patients

- The trust used an early warning score tool (NEWS) which was designed to identify patients whose condition was deteriorating. Staff could then identify and call for appropriate support, should a change or deterioration be noted. The chart being used incorporated a clear escalation policy. We found that this tool was in use and staff understood how to use it. We are not aware of whether or not the charts were being audited to identify if staff were using the escalation process correctly. The critical outreach staff were available from the high dependency unit to assess deteriorating patients and support ward staff.

## Nursing staffing

- We found nurse staffing levels were calculated using a dependency tool and the ratio of staff member to patient was displayed on the wards.
- We visited Ardingly Ward, and found that 50% of the staffing complement was not available on a daily basis.

# Medical care (including older people's care)

Recruitment to cover those vacancies was ongoing. As an interim measure, staff from the bank or agency were used, or staff were 'borrowed' from other wards. Staff told us that, mostly, they worked short of staff.

- On Pyecombe Ward, there were nine whole time equivalent (WTE) staffing vacancies. The ward had 27 beds plus two side rooms for overnight use. The ward covered specialist services, including respiratory medicine, gastroenterology, diabetes and endocrinology and so provided a range of services. Staff told us staffing levels were low. For example, the night before our inspection the ratio of patient to nurse was 13.5 patients to one nurse on a ward of 29 patients.
- On Hurstpierpoint Ward, there were five trained nurse vacancies and two healthcare assistant vacancies. Vacancies were covered by bank staff.
- The trust is recruiting to the new templates (so the agreed staffing levels have risen significantly in April this year) the new template is not always filled due to B&A fill rates being approx. 60 – 70% of shifts requested

## Medical staffing

- The rapid access medical unit was staffed by a registrar with an on-call consultant. Patients were initially seen by a junior doctor, then a registrar and then a consultant. This unit also undertook blood transfusions and haematology services.
- Consultant cover for medical care was available Monday to Thursday and consultants undertook a ward round of their patients daily. A registrar covered Friday and the weekend. Junior medical staff told us that, sometimes, a consultant was only available by telephone. However, there was unlimited access to a registrar, unless they were not on-site.
- We were told that weekend day shifts could be difficult to manage because of the workload. These shifts were covered by one registrar, one senior house officer and one F1 doctor. They covered all medical patients and included a list of jobs needed that day. This list could be extensive. They also covered ED and acute medical unit clerking in of new patients and covering all medical wards.
- Consultant cover on the stroke unit was provided by two consultants. However, only one was currently available. Five days cover was being provided by a locum consultant. A registrar was available but also covered clinics. This delay in consultant availability meant that

decisions about treatment and discharges were delayed and patients could be on the ward longer than needed. Junior doctor cover was provided by two F1 doctors and three senior house officers, who worked one day each.

- Consultant cover for coronary care was supported by the on-call medical team.
- Patients told us that doctors were approachable, visible on the wards, kind and explained clearly what was happening to them. Patients and relatives told us that they felt involved in decisions about their care.

## Are medical care services effective?

Good



Medical care was effective. Patients achieved good outcomes; however, some delays in decision-making resulted from limited medical, nursing and therapy cover.

## Evidence-based care and treatment

- There were no outliers for mortality associated with medical conditions. According to the Dr Foster Intelligence 2012 Hospital Guide, there were no tier 1 mortality indicators flagged as a 'risk' or 'elevated risk' for medical areas inspected.
- The stroke pathway had been developed to support patients to have door-to-needle times that were monitored and developed to promote improvements in patient care. Staff on the stroke ward carried an emergency pager, which was used to alert them that a stroke patient suitable for thrombolysis treatment was in ED. This enabled the process to start in ED and the staff member would transfer the patient to the stroke unit. This reduced the waiting time for treatment. All staff on the stroke ward were trained in the stroke pathway and a rolling program of thrombolysis training was underway.
- While the trust was developing 'Diabetes Direct', this service was not yet available at the Princess Royal Hospital. Specialist diabetes nurses were available as an on-call service on the wards.

## Nutrition and hydration

- Patients we spoke with were complimentary about the meals served at the trust. A member of the inspection team sampled the lunch being served and found it to be served hot and had good flavour and texture. Patients had a choice of suitable food and drink and we



# Medical care (including older people's care)

observed that hot and cold drinks were available throughout the day. A system of red trays was in place to identify if patients needed assistance to eat and drink. Staff were available to help serve food and assistance was given to those patients who needed help.

- For patients who had suffered a stroke, they would be treated as 'nil by mouth' and this would trigger a referral to the speech and language therapist to undertake an assessment to ensure food and drink could be taken safely.
- Patients on the dementia unit had recently been served a cooked breakfast on a three-day rota and this had now become a permanent arrangement due to its success.

## Patient outcomes

- There were no outliers for mortality associated with medical conditions.
- The Sentinel Stroke National Audit Programme (SSNAP) data showed that areas related to therapy and discharge were below the national data. These areas included access to speech and language therapists, occupational therapists and physiotherapists.
- We spoke with a therapist, who confirmed that, for the Princess Royal Hospital, 2.4 WTE occupational therapists were employed whose remit is to provide a service to Ardingly stroke beds, Hurstwood Park and Clayton ward and so reaching national targets of 45 minutes therapy for each patient was challenging and not always possible.
- An analysis of the National Diabetes Inpatient Audit 2013 showed that the trust was not performing well against some of the indicators analysed. These areas included: diabetic consultant availability, specialist diabetic nurse availability and dietician provision for the hospital, which were lower than the national average.
- Data seen relating to cardiac arrests for 2012 and 2013 showed falling cardiac arrest rates, with a good rate of survival that was better than the published national data.

## Competent staff

- Appraisals of both medical and nursing staff were being undertaken and staff told us that they had received a recent appraisal by a senior member of staff covering all areas of the hospital.

- Staff working on the elderly care ward told us "it's a privilege looking after the elderly" and "we only employ staff with a genuine interest in the elderly". This dedication to providing a specific service was seen throughout the hospital.

## Multidisciplinary working

- We saw that there was good communication on the wards to facilitate multidisciplinary working. We observed a member of the nursing staff questioning a drug dose with a doctor. A subsequent discussion was possible and the rationale for dosage explained. This level of communication promotes safer practice.
- We spoke with therapists working on specialist units and were told that working relationships were good and supported patient care. This was demonstrated by the inclusion of therapists in ward and board rounds and decision-making. Therapists told us that having a dedicated therapist for the stroke unit had been a positive development to focus attention on the patients on the ward by one therapist only and improve continuity. This had also enabled therapists to speak with relatives and this helped with discharge planning. Patient records showed patients were assessed and reviewed by physiotherapists, occupational therapists and dieticians. Records were kept updated to provide a clear audit trail of the care provided.
- Transfers between wards took place and patients and staff told us that all transfers were considered and discussed with the patient. Some transfers took place at night to facilitate urgent admissions and decisions relating to these transfers were carefully considered. Patients on the stroke unit were considered carefully before being moved, as this could negatively impact their recovery. There were three outlying patients from Ardingly Ward, none of whom were stroke patients.
- Transfers to the neighbouring Royal Sussex County Hospital took place when needed. Staff told us that the transfers took place during day-time and were well managed to provide the information and plans of care needed to support the patient's admission.

## Seven-day services

- There was seven-day access to consultant cover for the acute medical unit, via ED.
- Consultant cover was available for specific areas of the medical directorate between 8am and 6pm, with access

# Medical care (including older people's care)

to a medical consultant or registrar on-call and out-of-hours. Daily doctor's ward rounds usually took place in acute areas with mid-week ward rounds for specialist areas.

- Access to physiotherapist out of hours and at the weekends was available via the on call rota and provided a service for acute, critical care, respiratory, mobilisation and discharge needs of patients.

## Are medical care services caring?

Good



Medical and nursing care was provided by caring and dedicated staff. Patients and relatives told us staff at all times were kind and thoughtful.

Patients and their relatives and carers told us they felt well-informed and involved in decisions and plans of care. We saw staff respected patients choices and preferences and were supportive of their habits, culture, faith and background.

## Compassionate care

- We found that medical services were delivered by hardworking, caring and compassionate staff. We observed that, at all times, staff treated patients and their relatives with dignity and respect and included them in the care being provided.
- Patients and relatives told us, "I have received excellent care and have no complaints," and, "Can't fault it at all," and, "You wouldn't get better privately."
- In the CQC's Adult Inpatient Survey 2013, the trust had performed the same as other trusts for all ten areas of questioning in the survey. The trust has also seen an improvement in four of the questions in the survey compared to the 2012 CQC Adult Inpatient Survey. These were questions about the areas of information being provided and discharge planning. However, there was one question that showed a decline and this was around 'how would you rate the hospital food?'

## Patient understanding and involvement

- Patients and relatives told us that they felt involved in their plan of care and had the opportunity to speak with their consultant. They were provided with explanations of their treatment in a way they could understand and felt they were able to ask questions, if needed.

- We saw that patients had access to summon assistance. Each patient had a call bell and these were answered promptly. Patients told us that they never had to wait long for call bells to be answered. Curtains were pulled around each bed when care was being provided and patients' privacy was respected when they received personal care.
- We listened to staff speaking to patients and saw that they sought consent before undertaking care and treatment. Records reflected the discussions with patients and recorded agreed consent.

## Are medical care services responsive?

Good



Medical services were responsive to patients' needs.

We found that when patients could not be accommodated on the ward best suited to their needs, they were placed on other wards. The management of these outliers was organised to meet their needs.

A specialist dementia care unit has been developed on the Poynings Ward. Considerable work had been undertaken to develop the environment and ethos, which supported patients living with dementia to be comfortable and feel safe while receiving hospital treatment.

As there was not sufficient seven day consultant availability on some specialist wards – for example, the stroke unit – decisions were delayed and, as a result, delays in treatment and discharge took place.

Strong links were in place with community services to support the planning of emergency services.

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

- The trust's bed occupancy averages were higher than the England averages between April 2011 and September 2013. They peaked in January and March 2012 to 94.5%. Then bed occupancy fell from October 2013 to below the England average to 85.1%. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the Princess Royal Hospital.

# Medical care (including older people's care)

- The most recent CQC Adult Inpatient survey shows the trust is similar to expectations for giving notice of discharge and on the length of delays to discharging patients.
- A specialist dementia care unit has been developed on the Poynings Ward. This unit admitted patients with physical health problems and dementia and has access to two psychiatrists, consultant geriatricians and a mental health nurse to support the unit's specialist needs. Considerable work had been undertaken to develop the environment and ethos, which supported patients living with dementia to be comfortable and feel safe while receiving hospital treatment. The staff were dedicated to the development of good dementia care provision within the hospital and dementia care training has been provided to all staff on the unit.

## Access and flow

- We spoke with patients, who told us they had been moved only once or twice to get to the ward they should be on. They told us they had not had to wait very long. Some patients had been moved on the ward several times to ensure that shared areas were of single-sex occupancy only.
- The stroke ward had the capacity to take between 13 and 23 stroke patients and used the flexibility to suit the flow of patients through the Princess Royal Hospital. Should a bed be needed and there one was not available, a patient may have to become an outlier on another ward. The management of these outliers was organised to meet their needs. They were seen by the on-call doctor of the day and after that would be seen by their own consultant. A record on the ward they should be on was maintained to ensure all patients under the specific consultant were seen and included in ward rounds.

## Meeting people's individual needs

- Specialist link nurses were available to support vulnerable people to feel safe and supported during their admission. These included a link nurse for dementia care, end of life care and care for patients with a learning disability.
- For patients whose first language was not English, staff could access a language interpreter, if needed.
- Staff told us that access to spiritual support was available for many faiths and that the chaplain visited the ward.

## Learning from complaints and concerns

- Patients and relatives told us that they had received an explanation from staff about how to complain. Staff told us that they rarely had any feedback or learning from complaints. Doctors told us they would be approached directly by the complaints department, should any complaints be raised.
- Board reports from the Princess Royal Hospital up to February 2014 showed that patient experience scored below the national average, with 11% of complaints being reopened this year to date.

## Are medical care services well-led?

Good



At a local level, the wards/departments were well-led and staff spoke proudly of the service they provided.

Risks were regularly identified and flagged on risk registers at divisional level.

Staff told us that they did not feel as involved at trust-level as they could be, due mainly to the geographical position and the distance between Princess Royal Hospital and the Royal Sussex County Hospital.

## Vision and strategy for this service

- The trust had a set of values and behaviours as their vision. The staff had a clear understanding of what these involved and most staff had been afforded the opportunity to be involved in their development. Some staff expressed a wish to have been involved, but were limited because of staffing constraints.

## Governance, risk management and quality measurement

- Risks were regularly identified and flagged on risk registers at divisional level. Staff told us that, should they contact the trust board with questions, ideas or concerns, they did not receive a response so did not know if their comments or suggestions had been read or considered. Staff told us that they were not always made aware of changes, including changes in pay levels.
- Weekly ward managers' meetings took place, with an agenda that included incidents. These findings were not shared with other areas of the Princess Royal Hospital to afford general learning. Quarterly governance meetings took place to review data gathered and incidents

# Medical care (including older people's care)

reported. Safety audits were seen, of information relating to the medical directorate. These included complaints, a Patient Advice and Liaison Service report and details of serious incidents.

- Audits took place to make comparisons with national data including areas relating to medical care including SSNAP and the National Diabetes Inpatient Audit. Staff were aware of the data gathered and, in most cases, the outcomes and shortfalls.
- Education audits also took place and were reviewed at board-level to identify the areas needed for future training.

## Leadership of service

- The NHS staff survey showed that staff said the support from their managers was worse than expected (within the bottom 20% of acute trusts nationally). Some staff had experienced difficulties in progressing to a higher promotional level without understanding the reason for this.
- Junior doctors told us they felt well supported by more senior medical staff and consultants. They said consultants were accessible and approachable and provided learning opportunities for them.
- Some staff raised with us that the cleaning contractors were not always responsive when issues were raised by senior nursing staff. These were issues around standards of hygiene and staffing. Staff also raised concerns that ward staff were being used to clean wards with day and night staff cleaning mattresses.

## Culture within the service

- Staff were seen to be hardworking and dedicated to their roles. Despite the staff survey results, which indicated worse than expected for staff feeling of job satisfaction, staff spoke proudly of the service they provided.







## Public and staff engagement

- We saw that the trust used Patient's Voice surveys to ask patients their views of the care at the Princess Royal Hospital. The results, with an action plan, were displayed on each ward. On Ardingly Ward, the responses to the Patient's Voice survey included comments that the ward had been short-staffed, was cluttered and that patients experienced loneliness in a side-room.

## Innovation, improvement and sustainability

- We were told that a review of medical and emergency services at the Princess Royal Hospital was being planned. Staff had no clear vision of what that would involve for them.
- Some senior staff met with the board each week and a walk around took place. Staff told us that they knew who the chief executive of the trust was and described him as "available and approachable". The chief nurse visits the wards on a regular basis at PRH. Staff were unclear about the remaining members of the trust board.

# Surgery

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

## Information about the service

Princess Royal Hospital is located in Haywards Heath, West Sussex, and is the main centre for the trust for elective surgery. There are 149 surgical beds across five wards. Theatres are located in the day surgery unit, at the Sussex Orthopaedic Centre and on the main hospital site. There is provision of diagnostic services and pharmacy support on-site.

We visited the day surgical unit, including its operating theatre, main surgical theatres and the Sussex Orthopaedic Centre. We also visited the preadmission assessment, the post-anaesthetic recovery unit and discharge area. We visited the Cuckfield Ward, the male urology and endoscopic day care unit. We also visited the following surgical wards: Ansty Ward, used for day case admissions, plus eight beds used for male urology and surgical patients requiring an overnight stay, Albourne Ward, the elective orthopaedic ward, which included a four-bed extended dependency unit, Twineham Ward, the rehabilitation ward for patients who have had a fractured neck of femur, and Newick Ward, the elective orthopaedic ward. We reviewed six separate nursing and medical records and an additional number of patient safety-check records.

We spoke with six patients and three relatives. We spoke with 22 staff and also reviewed communications sent by two staff via email. We made observations of staff interactions from the start of the patient journey at pre-assessment, through to the operating theatre and

discharge. Equipment used for patient care and the environment was assessed, along with a range of information provided to us both prior to and during the inspection visit.

# Surgery

## Summary of findings

The surgical care teams were highly motivated, committed and compassionate about the services they provided to patients. Staff were caring and supported to deliver high standards of care with strong and effective leadership. Patients and their relatives reported a high level of satisfaction with the quality of care and their experience of using the Princess Royal Hospital. We spoke with patients who told us staff treated them with dignity and respect. Staff were described by patients as, “Good staff, attentive.” Patients told us they were “happy” and things were “well-organised.” Pain was said to be managed well and patients said they were given enough information to help them make decisions about their treatment and care. Feedback we heard and read was positive about the care and treatment from all staff.

Nursing staffing levels were improving with a high use of bank to cover vacancies and staff unplanned absence. Mandatory training was provided to staff, however, attendance rates were low in some areas, including staff attendance at safeguarding vulnerable adults and infection prevention and control. The trust should ensure that staff have the opportunity to update their skills and knowledge in order to ensure safe practice.

Surgery was consultant-led and there were medical staffing arrangements in place to support the surgical services 24/7. Patient treatment and care needs were assessed, monitored and acted upon at each stage of their pathway, with involvement from the multidisciplinary team.

Staff and patients were supported to access to specialist expertise, such as the palliative care team, learning disability and safeguarding leads. Patients had access to interpretation services and could also raise concerns or make a complaint through the Patient Advice and Liaison Service, although response to such complaints were sometimes delayed.

Bed occupancy was not always maximised for elective procedures.

Staff understood their responsibilities to ensure that patient care was delivered safely and effectively. There were arrangements in place for staff to report adverse

events and to learn from these. Clinical effectiveness was continuously monitored and governance was taken seriously, with monitored patient outcomes at ward and department-level.



# Surgery

## Are surgery services safe?

Requires improvement



Staff demonstrated they were supported to report adverse events and arrangements were in place to monitor and act on reported incidents. Risks to the safety and wellbeing of patients was assessed and monitored and measures were put in place to reduce such risks.

Arrangements were in place to ensure the provision of care in a clean environment and to minimise the risk of hospital-acquired infections.

Staff had access to equipment, but there were some storage issues that impacted on the environment and staff working in main theatres.

Staff did not always have the opportunity to attend mandatory training and be updated on changes in practice.

Patient care and treatment needs were assessed and systems were in place to ensure surgical procedures were only carried out with informed consent and subject to safety checks.

Although we were told the recruitment processes had improved, there were vacancies for staff in some areas, which impacted on the demands on staff and their ability to meet the needs of patients at all times.

### Incidents

- Staff could describe the mechanisms for reporting any adverse events, near misses or concerning matters via the internal electronic data system called Datix.
- Incidents included Never Events, which are situations that should not occur if safety measures are correctly employed. We were made aware of one such event that occurred at the Princess Royal site in 2013. The incident had been reviewed and lessons learnt from this communicated trust-wide.
- The surgical division undertook a review of all safety, quality and serious incidents in order to ensure that lessons related to safety of patients were implemented. Incidents were outlined and a designated person was identified for reviewing the matter and reporting on

progress within agreed time frames. Staff received information from incident reviews and via general communications. For example, staff were aware of the Never Event that occurred at the Sussex Eye Hospital.

- There were no identified risks related to patient deaths following surgical procedures.

### Safety thermometer

- The Princess Royal Hospital collected information as part of a Safety Thermometer, which included such areas as harm-free care, new pressure ulcers, falls with harm, catheters and urinary tract infections. The surgical wards were performing within expected levels for patient harms.
- Safety Thermometer outcomes recorded monthly figures for the wards and compared these with combined figures from across the trust. For transparency, Safety Thermometer information was displayed on wards for public viewing and contained a range of information such as falls and pressure sores.

### Cleanliness, infection control and hygiene

- Matrons had a direct responsibility for ensuring that cleaning standards were being delivered in clinical areas. Responsibilities were outlined in the trust's cleaning standards in the matrons' manual. During our inspection, we noted the areas where patients were receiving treatment and care were suitably clean. We saw that patients were encouraged to use the Patient's Voice survey to indicate their level of satisfaction with cleaning standards. Patients who spoke with us told us they were satisfied with the cleanliness of the Princess Royal Hospital. One person said, "The hospital is spotless, especially the toilets." This same person commented on the efficiency of staff in knowing that they were at risk of exposure to potential infection and because of this, they had been nursed in a side room.
- Domestic staff had guidance in place to support their cleaning responsibilities and had access to a range of cleaning equipment, which reflected the national recommended colour coding for use in different areas. Cleaning schedules were displayed on ward areas and cleaning audit results were displayed in public areas for the previous month. For example, on Newick Ward, a score of 92% had been achieved against a target of 95%.
- Clinical staff had access to a decontamination policy for guidance in relation to safe practice and cleaning of patient equipment. Equipment used for direct patient care was suitably clean and ready for use. The exception

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to this were commodes on Ansty Ward, one of which was found to be rusty, which meant there was a possibility it could not be cleaned effectively. A second commode on this ward had damage to the plastic fabric, which, again, could prevent thorough cleaning.

- Infection control updates were circulated to staff in the form of a newsletter, including the May 2014 Infection Prevention Update. This provided information to staff about infection results and reminders of standards in practice, such as hand washing.
- Staff could demonstrate they were aware of the staff members who had a designated link to the infection prevention and control lead person. There were link nurses on each surgical area and they had undertaken infection control audits of staff compliance with hand hygiene practices. We saw results that ranged from 75% compliance on the day care unit to 99% in the post-anaesthetic recovery unit for April 2014.
- We observed nursing and medical staff to wash hands between patient care, and use hand sanitising gel. Hand sanitising gels were in place at ward entrances, on bed ends and outside of rooms. All were well filled and ready for use. Staff were seen using personal protective equipment, such as aprons and gloves, all of which were readily available in all areas. Staff handled and disposed of waste, including sharp items and contaminated linen, in accordance with safe practice guidance.
- Staff complied with the policy of the trust to be 'bare below elbow' when working in clinical areas.
- Safe practices were observed within the theatre environment regarding preparing the environment, surgical equipment and surgical staff gowning up, as well as disposal of waste and cleaning of the theatre between cases.
- Infection rates were recorded by each ward area for *C. difficile*, as part of the Safety Thermometer. We saw from information provided to us that there had not been any *C. difficile* on Newick or Twineham Wards between May 2013 and April 2014.
- A review of safety data did not identify any concerns regarding patient safety from post-operative wound infections.

## Environment and equipment

- The environmental areas we visited were well-maintained overall and suitable for the activities being carried out.

- The day surgery unit and Sussex Orthopaedic Centre were newer buildings and as such were bright, spacious and suitably designed to facilitate treatment and care of people.
- The staff reported a number of design issues in the operating theatre within the day surgery unit, which meant electrical leads were a potential hazard, having to be trailed along the floor to facilitate equipment use. However, staff had measures in place to minimise risks and we were told that a new lead was on order to address this. In addition, staff reported the ceiling lights above the operating table were too low down, which was a problem for taller staff. Furthermore, the door from the theatre did not open automatically, which made it difficult to manoeuvre patients out of the area on the operating trolley.
- Areas where people were receiving care provided a suitable level of privacy, either in designated rooms, such as preadmission assessment, or in curtained bay areas.
- There were some issues regarding storage of equipment on this site, for example in the day surgery unit, which meant that one recovery area was being used for an equipment store. In the main hospital theatres, we saw equipment and boxes of intravenous fluids stored inappropriately on the corridor floor, which presented a hazard to staff and difficulties with cleaning.
- Staff reported having access to technical equipment, including surgical instruments, although for theatre cases, the planning of turnaround for day case procedures in the day surgery unit required careful coordination between the supplying decontamination unit and the department. This was because instrumentation came from the Royal Sussex County Hospital site. However, there had not been any reported cancellations as a result of equipment provision in the day surgery unit.
- Resuscitation equipment checked by us appeared to be in a good state of repair and ready for use. Most trolleys had automatic defibrillators, and checks had, in the main, been carried out.

## Medicines

- Medicines were safely administered and records we reviewed on surgical wards and in theatres showed medicines had been given when they needed to be. Any gaps in administration shown on the charts were appropriately explained.



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- Arrangements were in place for the safe storage and management of medicines in all areas that we visited. Records had been completed for each patient within the care and treatment plans we checked. These included the details of each medicine prescribed, frequency and route of administration.
- Controlled drugs were stored correctly and records were completed each time such drugs were given to patients. Records were also made of stock levels and wastage.
- The Patient's Voice survey was used as a mechanism for collecting patient satisfaction with receiving medicines on time. Satisfaction scores were within acceptable ranges for the surgical wards we visited.
- There was said to be good pharmacist support to all ward areas and all prescriptions were screened by a pharmacist to ensure safe practices were in place.

## Records

- Patient treatment and nursing care records were found to be suitably completed and detailed in their content to enable nursing staff to provide the required level of care and support. Minor gaps were noted, such as religion not recorded in one out of the six notes reviewed and name preference not stated in three. Care needs had been continuously reviewed and required changes were identified and acted upon. Surgical pathways, such as short stay needs, as well as pathways for each part of the patient journey, were in place and these were completed by staff working in each area. For example, the pre-assessment staff, surgery team and post-operative staff.
- Multidisciplinary input was well documented and notes made by multidisciplinary team members, such as occupational therapists and physiotherapists, were clear. There was good use of relevant care bundles, including, for example, catheter care and intravenous cannulas.
- Risk assessments were noted in all records we reviewed and these included, for example: falls, manual handling needs, venous thromboembolism (VTE) and pressure areas. Where interventions were required to manage risks, these were in place, such as the prescribing and administration of blood thinning prophylaxis treatment and specialised compression stockings for minimising VTE arising.
- Repositioning charts were also used for patients who were at risk of developing damage to their skin over bony areas.

- We saw evidence that preoperative screening for MRSA had been carried out in order to minimise risks to the patient of acquiring a post-operative infection.
- Patient records contained evidence of intravenous (IV Cannula) placement and checks taking place to ensure that patients were not adversely affected by these medical devices.

## World Health Organisation Safety Checklist

- We noted, in the six surgical records reviewed, that staff had recorded evidence of the World Health Organisation's (WHO) five steps to safer surgery record. In addition to this, we observed and were included in the relevant checks within the theatre areas that we visited.
- All patients that were seen going into theatre were noted to have the side of the body and respective limb to be operated on marked as part of safe practice. Patients were included in verifying personal information, consent and the site to be operated on.

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

- Care records we reviewed contained evidence that each person having surgery had consented to the procedure. We observed the consent process taking place within the day surgery unit and patients who spoke with us confirmed they had been given sufficient information to enable them to consent to their planned surgery. One patient told us: "I had enough information to help inform my decision," adding that they recalled signing the consent form.
- We saw consent forms were designed to enable a copy to be given to each patient.
- Staff had access to the learning disability liaison team and a resource pack was available to support the delivery of care for those with a learning disability, taking into account mental capacity, consent and best interests.
- Information to guide staff concerning the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was in place.

## Safeguarding

- Staff we spoke with were aware of the safeguarding team and who to report any potential concerns to. The trust had a lead doctor, a named nurse and safeguarding nurse in place.

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- Staff confirmed that they had a safeguarding workbook to complete as part of their training in this area.
- For individuals with learning disabilities attending the Princess Royal Hospital for surgery, staff advised that they would be encouraged to bring a relative or carer with them. In addition, staff could also access the learning disability service within the trust and we saw contact details for arranging this.

## Mandatory training

- The trust had not met the training targets for mandatory training attendance. We were provided with information that indicated a range of mandatory training for various staff groups. This ranged from once only training regarding mental capacity, once a year for Advanced Basic Life Support, through to three yearly courses in, for example, infusion devices and venous thromboembolism (VTE).
- Annual safeguarding training formed part of mandatory skills for staff working directly with adults. The training was required to be updated every three years and required the completion of a workbook and e-learning. Trust-wide figures for training, concerning protecting adults at risk, indicated that in quarter four of 2013/14, only 50.3% of staff had been trained or updated. We looked at a sample of training records and found that, within operating theatres, 54 of the 77 (70%) clinical staff had no training dates recorded for safeguarding vulnerable adults. Of those trained, this had taken place in 2012/13, with only one staff member having attended training in for April 2014.
- Adult safeguarding training attendance was similarly low on wards. For example: of the 19 staff on Ansty Ward, only 5 (26%) had attended this training. Three in 2012, two in 2013 and one this year up to the time of our visit. Absence of training regarding safeguarding vulnerable adults could mean staff may not have sufficient knowledge and awareness to identify and report such matters.
- Infection control training, which clinical staff were required to attend on an annual basis, was also found to have gaps in attendance. For example, on Ansty Ward, of the 19 staff, 14 (73.4%) had not had a refresher or attended a formal session since 2011/12.
- Four out of five (80%) of staff listed under the Sussex Orthopaedic Treatment Centre had either not had any

infection control training or the update had expired. Where staff were not supported to attend training, they may not be updated or made fully aware of changes that could impact on patient safety outcomes.

- Staff working in theatres reported finding it difficult to be released for mandatory training, indicating this was mostly due to low staffing levels and training sessions being cancelled.

## Management of deteriorating patients

- Staff assessed and recorded people's general observations and wellbeing status using a nationally recognised early warning scoring system known as the new early warning score (NEWS). This enabled staff to identify changing needs and alert medical staff if any deterioration was seen. Pain assessment, respiratory rate and blood pressure were examples of the measurements that staff assessed using this tool. These were seen to have been recorded at regular intervals in the post-operative period in the patient notes we reviewed.
- Staff had access to a trust-wide policy regarding resuscitation. This policy included information on mental capacity and withholding resuscitation. Staff adherence with the policy was audited, although there was no formal report from this. However, an action plan was developed in April 2014 and this outlined the main areas of focus, such as correct form usage to record such events and staff training.

## Nursing and clinical staffing

- The trust informed us that, across the services, temporary nursing and medical staff were widely used, and the vacancy rate was 9.4%, as of April 2014.
- On the day of our inspection visit, we did not identify any shortages of nursing staff and saw that people were responded to in a timely manner.
- We reviewed feedback from patients who had completed the Patient's Voice responses placed on ward areas. Several of these commented on low staffing levels, particularly at night, and the pressures staff were under.
- Staffing level concerns were reported as part of the Princess Royal Hospital Safety Thermometer and we saw that during April 2014, on Twineham Ward, reports of low staffing levels were raised on seven occasions. For example, on 3 April 2014 there were said to be three

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trained nurses and two healthcare assistants for 34 patients. The impact of this was not clearly stated, making it difficult to identify if care needs had been compromised.

- Discussion with nursing staff on Twineham Ward demonstrated that the four band 5 nurse vacancies identified in September 2013 had not as yet all been filled. There remained 2.3 whole time equivalent (WTE) vacancies at this level and one healthcare support worker vacancy.
- Recruitment was said to be active, with quick publication of positions vacant, but delays in bringing staff on board. This was attributed to the checking processes, in that staff were not permitted to work with supervision until they had clearance from the Disclosure and Barring Service (DBS). Staff told us the impact of these delays had caused potential employees to be lost to other organisations.
- Occupational therapists (OTs) on Twineham Ward reported that, although staffing levels had improved, they felt that they could not meet the scope of their role. For example, they currently only undertook equipment checks for patients going home and felt that the role could be much more active in terms of rehabilitating people and improving the speed of patient discharge. The OTs worked the equivalent of half a WTE staff members on Monday and Tuesday and with two WTE staff on duty Wednesday, Thursday and Friday. There were 4.5 WTE physiotherapists to support the ward.
- We reviewed the staffing arrangements within the post-anaesthetic recovery unit and saw that advanced planning to cover shifts was in place up to six weeks ahead. Staff were allocated as a team to respective areas, such as two staff to preoperative assessment, four staff with variable start times in recovery level 1 and two staff working 9am to 7pm in second stage recovery. There was a designated person in charge on each shift. Staff on this unit who spoke with us, reported that staffing levels were good and that most permanent staff covered sickness absence within the internal 'bank nurse' system.
- We did not observe handovers. However, the teams we observed appeared to be clear about the care patients required, all observations and assessments undertaken, as appropriate, and patients appeared to be cared for.
- Grand rounds took place weekly on each ward, involving consultants and other medical staff.

- All areas we visited employed staff of a varied skills mix, including nursing staff at different bands and healthcare support workers. Within theatre areas, the team was made up of operating department practitioners, nursing staff, support workers, recovery trained staff and Allied Healthcare support staff.
- The trust business plan for 2014/15 included additional investment in nursing, such as the introduction of supervisory band 7s into all hospital wards, together with transparent safe staffing levels. We saw that a band 7 supervisor was in place on Newick Ward.
- The Princess Royal Hospital had an active internal 'bank' of clinical staff available. A recent change in the payment for bank work shifts was mentioned by some staff as a factor that may reduce their availability to cover gaps.

## Medical staffing

- We were provided with a copy of the medical staff on-call arrangements for the Princess Royal Hospital site. This demonstrated there was consultant-led care cover arranged for each day and specialist registrars covering specified time periods for each part of the week, day and night.
- Shift patterns allowed for handover of patient-related information to the oncoming doctor. On-call arrangements were also in place to support the service. Arrangements were in place that defined the roles and responsibilities of various medical grade staff covering the on-call duty rota. Shifts were designed to enable medical staff to work in accordance with the European working time directives.
- We noted initial sickness absence in the medical team was to be covered by a locum doctor from within the Princess Royal Hospital, before approaching the Royal Sussex County Hospital bank or external agencies.
- In our discussion with the chief of surgery and their colleagues, we were assured that all surgical cases were under the direction of consultant-led care. This arrangement did not mean that all operations would be carried out by the consultant, but that the relevant team, including registrars, would partake in treatment and care delivery, under the direction of responsible consultants.

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## Major incident awareness and training

- The trust had a major incident plan, which set out key responsibilities and actions to be taken by first responders and other staff. The policy included details of business continuity plans.
- Training on major incidents and business continuity was provided to all new staff as part of the induction, which was indicated to take place across the trust twice a month.
- A protocol was in place for deferring elective activity to prioritise emergency work, with clear responsibilities towards the provision of safe care.

## Are surgery services effective?

Good



There were effective arrangements in place for pre-assessing patients' health and wellbeing prior to surgery. The use of national guidelines to support the delivery of treatment and care were in place. The enhanced recovery programme was used, where relevant.

Staff had procedures to follow to ensure that care delivery was effective. There was evidence of comprehensive audit programme to monitor the quality of care and outcomes for surgical patients. There was a performance dashboard to monitor quality.

Multidisciplinary team working was in place with physiotherapy and occupational therapy support accessible.

Patients felt access to pain relief was effective and provided in a timely manner. There was a consultant-led seven-day on-call service and on-call pharmacy provision at all times.

## Evidenced –based care and treatment

- Patient care records indicated that pre-assessment was carried out in accordance with NICE clinical guidelines for preoperative tests.
- Patients who were to be admitted for elective surgery were said by staff to be pre-assessed prior to their admission as to their health status and suitability. The pre-assessment clinics were nurse-led and staff had access to anaesthetists four afternoons per week. Anaesthetists saw all patients who were to have a joint replacement. Anaesthetists would be asked to review any notes where the nurse identified a potential

concern, or where a patient would be having a spinal anaesthetic. This was in order to assess the need for additional investigations or treatment before their surgery.

## Use of National Guidelines

- The enhanced recovery programme was used in all specialities, where it was relevant.
- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations.
- Staff monitored the condition of patients in the post-operative phase of their recovery in accordance with the NICE clinical guideline number 50. This guidance is concerned with recognising and responding to the acutely ill person. Staff used a recognised assessment tool for this monitoring, referred to by staff as the NEWS (new early warning score) tool.
- Staff reported having access to local policies and procedures and we sampled a range of these, including: prevention and management of venous thromboembolism, safeguarding adults at risk policy, resuscitation policy and the administration of blood and blood components. These policies were up to date at the time of our visit.
- The nursing and medical staff following defined protocols in line with the NICE seven quality standards for VTE (venous thromboembolism) prevention. The protocol included patient groups who were excluded from having prophylaxis treatment. Clinical areas carried out audits in order to check that staff complied with required standards. The April 2014 audit for the post anaesthetic recovery unit (PACU) identified areas of low compliance with respect to the following: VTE risk assessment preoperatively and prescribed prophylaxis treatment respectively scoring only 30% compliance. For Twineham Ward, we saw 100% compliance with the VTE risk assessment carried out by medical staff in April 2014.
- Results from audits formed part of the compliance metrics and we saw that monthly figures were continuously measured at departmental level as well as across the trust. Examples of positive results for PACU across the period May 2013 to April 2014 included pain assessment, with 99.2% compliance rate, against the trust overall score of 92.7%. Compliance with care

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pathways was 94.2% in PACU and across the trust 84.1%. However, the inspection and recording of patient's pressure areas post-operatively, showed a compliance level of only 20% in PACU.

## Pain relief

- Patients who spoke with us confirmed they had their medicines on time and that when pain relief was required, staff provided this promptly. One patient stated that their pain was "well-managed". Another patient said with reference to nurses: "Quick with pain relief."
- Feedback from Newick Ward through the Patient's Voice survey indicated that out of 50 responses, 40 patients felt the staff always did everything they could to manage patients' pain, nine people said often and one sometimes.
- Nursing records indicated pain was assessed as part of the post-operative care pathway within the NEWS tool.
- As part of the review of patients' previous medical history, staff assessed individuals for existing measures in place for their pain relief, such as medication needs and frequency.
- Post-operative pain relief was considered by the anaesthetist as part of the procedural pathway.

## Nutrition and hydration

- We spoke with patients who were in the post-operative phase about the provision of food and drink. Patients said they were offered a choice and had enough to eat and drink. One person was happy with the food, however, the quality of the food was commented on negatively by others, such as: "The food is not good," and, "Food is poor, the type and way it is cooked." After further exploration with this patient, they said the food was "dry and processed".
- One patient who spoke with us reported there was nothing wrong with the food, although the menu was very similar each day. They said they were able to have Soya milk to manage their allergy to normal milk.
- Feedback from patients through the Patient's Voice survey indicated a level of satisfaction with food. For example on Newick Ward, in the April 2014 responses, 49 people out of 50 rated the food as acceptable, good or very good. The rating of food on Twineham Ward for the period May 2013 to April 2014 was averaged out as 3.6 against a maximum score of 6.
- Patient records that we reviewed demonstrated that staff carried out nutritional risk assessments using a

recognised tool known as the Malnutrition Universal Screening Tool (MUST). In addition to this assessment tool, staff also used food and nutrition charts for those more susceptible to weight loss or decreased nutritional intake.

- People were weighed according to their need and body mass index (BMI) records were completed, as required.
- We observed that patients who were able to eat and drink had access to fluids in their bed area.
- Where people required the support of intravenous fluids, care records were completed to indicate fluid intake and output. Prescription charts contained details of the required fluids and frequency of these. Staff made sure that patients ate and drank prior to discharge following day surgery.

## Patient outcomes

- The trust continuously reviewed information as part of the NHS Friends and Family Test or through the Patient's Voice survey.
- There was no evidence reported to the commission of any risks related to emergency readmissions after elective or non-elective surgical procedures. This included the monitoring of risks related to surgery when assessed as part of Patient Reported Outcome Measures (PROM) for hip and knee surgery undertaken at Princess Royal Hospital. A PROM is a series of questions or a questionnaire that seeks the views of the patient on their health or the impact that any received healthcare has on their health.
- The surgical directorate contributed to most of the national audits for which it was eligible.
- A performance dashboard was used to monitor patient outcomes and we did not identify any concerning areas. For example, data supplied to us by the trust indicated that up to February 2014 elective overnight stays was slightly elevated in February at 3.76% against a target of 3.45%. The year to date figure indicated a low-risk score of green, with a figure of 3.41%. Average length of stay for non-elective procedures indicated an amber risk rating for the year to date, with February's score of 7.20%, against a target of 6.74%. It was not known from the information how this related to specific hospital sites. Patient readmission rates recorded within 30 days of discharge from the Princess Royal Hospital were rated as an amber risk year to date, up to end of February 2014.



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## Competent staff

- Data supplied by the trust indicated that appraisals rates for all staff; excluding medical personnel, was 62.1% as of the end of February 2014. Appraisal rates were identified on the trust's board assurance framework as a risk, and measures were in place to improve compliance with this.
- Junior doctors reported having annual appraisals and supervisory meetings at the end of each placement.
- Supervision arrangements were in place for newly appointed staff, with competency checks related to their area of work.

## Multidisciplinary working

- Multidisciplinary working was in place and patients had access to physiotherapists, occupational therapists and dieticians. Ward rounds included consultants and a range of staff at different grades. The lead matron for operating theatres worked across both hospital sites, ensuring that collaborative working took place.

## Seven-day services

- Consultant-led service was in place at the Princess Royal Hospital, with arrangements in place for on-call of medical staff.
- Out-of-hours services from other departments were generally good. The pharmacy was available until midday on Saturday and then on-call over the weekend. Physiotherapy staff were available to support the service through regular shifts and on-call arrangements.

## Are surgery services caring?

Good



Patients and relatives who spoke with us commented very positively on the caring nature of staff, the admission process and care during and after surgery. Patients said they had been treated with dignity and respect and they had been fully involved in decisions about their treatment and care.

During our observations at the Princess Royal Hospital, we saw that staff treated people with respect. People's privacy and dignity was respected when personal care was being delivered. Staff were seen to be kind and supportive towards patients and their relatives.

## Compassionate care

- In all surgical areas we visited at Princess Royal Hospital, we saw staff looking after patients with compassion, respect and in a dignified manner. Staff took time to explain procedures in a kind and respectful way.
- Staff in operating theatres gave a detailed explanation of what would be happening prior to, and at all stages of, the surgical procedure. Reassurance was continuously offered, as was checking of general comfort with the person who had not had a general anaesthetic.
- We spoke with patients about their experiences and received positive feedback. For example, one person said: "It was a smooth admission," adding, "Good staff, attentive," and then confirmed they were treated with dignity and respect. Other patients said staff treated them with respect and dignity. One person said they were "happy" and that things were "well organised".
- Patients said they had been kept informed and that they would recommend the service, although one person said: "Apart from the food."
- Two relatives, who had accompanied patients that were having day surgery, commented on the service positively. One described the pathway from referral to the attendance at the unit as, "A positive experience." They said: "Staff are caring."
- A second relative said: "I am impressed with the hospital. Everything is spotless and [my relative was] seen within two minutes of appointment time today." This relative said: "It is calmer at the Princess Royal," adding they "preferred the environment" at the Princess Royal Hospital.

## Patient feedback

- The Princess Royal Hospital collects feedback from patients through Patient's Voice surveys. We reviewed information supplied to us and found the following: feedback from 50 respondents on Newick Ward provided positive responses to most areas, with the exception of two people who felt that they rarely felt treated as an individual and that their particular needs were not recognised and catered for. 39 respondents reported that they were always treated with kindness and compassion.
- Patient's Voice survey responses from Twineham Ward scored, on average, above 4 out of 5 between May 2013 and April 2014 for all areas concerned with personal care and treatment. The exceptions being not always

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being seen by the same doctors, scoring an average of 3.9 and staff sometimes contradicted one another at an average score of 2.2. Trust-wide, this area of concern was also noted to be on average 2.1 for the same period. This suggests that there may be communication problems between staff impacting on the sharing of consistent information.

- Concerning recommending the Princess Royal Hospital a friend or family member, feedback on Newick Ward showed 39 respondents out of 50 were extremely likely to do so.

## Patient understanding and involvement

- Patients who spoke with us reported being involved in discussions about their treatment and care, as well as having enough information to make informed decisions. Of the six care records we reviewed, only one did not identify the name of the nurse responsible for the person's care. We did not consider this impacted on the care of this individual in any negative way.
- Patients had access to supplementary information to assist them in understanding procedures. Information leaflets were available in clinical areas and on the Princess Royal Hospital website. Leaflets covered areas such as discharge guidance following types of surgical procedures and post-anaesthetic instructions.
- Patients were supplied with contact details should they need to discuss anything following their return home and who to contact if there was a problem out-of-hours.

## Emotional support

- Staff could contact clinical nurse specialists for advice or direct input in patient care. There was access to a renal counselling service and palliative care team.
- Patient initial assessment and ongoing evaluation took into account their emotional needs, including any particular mental health matters.
- We observed staff providing a high level of emotional support, while patients were undergoing surgery under local anaesthetic. For example, a patient in the day surgery theatre was provided with direct support by a member of the theatre team. This person engaged the patient in conversation and generally ensured they were comfortable.

## Are surgery services responsive?

Good



The planning of elective surgery was arranged around the needs of people. Arrangements were in place to pre-assess individual needs prior to inpatient admission and on the day for day-case surgery.

Care delivery was responsive to the special needs of people, with access to translation services, learning disability and other specialty teams.

Discharge planning took into account the ongoing needs of people, including the provision of equipment.

Complaints were not always responded to within expected time frames.

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

- Elective surgery inpatient and day surgery facilities were provided to meet the needs of local people. Wards were identified by surgical specialty and single-sex accommodation was provided on inpatient areas.
- Staffing arrangements were designed around theatre activity, admissions and discharges, including weekend work.

## Access and flow

- The trust had a detailed access policy in place to guide staff concerning the referral and admission process, including emergency admissions. Non-emergency referrals were made through the Hub. Concerns were expressed in relation to the efficiency and effectiveness of the Hub, with examples of incorrect information being given to patients and incorrect booking of follow-up appointments, such as patients who needed to be followed up a week after surgery were given a follow-up appointment three weeks after their surgery. Some patients had been booked in for incorrect clinics and GP referrals had not always been acted on, causing delays for patients. This had resulted in one patient, who required a fractured wrist procedure, to have their procedure cancelled, as delays had resulted in the fracture fusing.
- Patients were pre-assessed prior to admission, where they were having elective surgery requiring inpatient stay. Day case patients were assessed prior to their procedure on the day of admission.



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- Bed occupancy figures were observed as part of the patient flow and bed capacity management. Staff expressed frustration, on Newick Ward, that they could not use the full bed availability. There were two bay areas and side rooms empty on the day and only 12 patients were being cared for out of a potential 31.

## Discharge planning

- As part of the care pathway, staff were noted to have assessed and planned for the patients' discharge home. For day cases, surgical patient staff followed a specific discharge criteria. This included physical observations, such as the person's blood pressure and temperature, as well as information provision and follow-up arrangements. Staff discussed progress and made arrangements for patients discharge home, involving the patient and their family or carers.
- Longer stay patients had their discharge process commenced as soon after admission as possible to ensure any support required was considered and put in place in a timely way. The provision of equipment to support the ongoing care needs at home was requested and arranged by occupational therapy.
- Nursing staff completed records in relation to the discharge process, which included any delays. The trust monitored figures regarding patients who were medically fit for discharge, but were delayed as a result of waiting for beds in care or nursing homes, as well as awaiting rehabilitation beds.
- Discharge summaries were sent to the patient's general practitioner and patient follow-up appointments were arranged via the booking Hub.
- An electronic patient tracking record known as the Online Applicant Status and Information System (OASIS) was used on surgical wards to record medical fitness for discharge appropriately.

## Cancellation of surgery

- Staff reported that there was a system in place to report cancellation of surgical procedures and explanations for cancellations was monitored by the trust. We did not have any hospital site-specific data to assess the level or frequency of cancellations for elective surgery. However, a patient on the high dependency orthopaedic ward had surgery cancelled the previous week due to lack of a high dependency bed. However, surgery had subsequently been rebooked and had taken place to their satisfaction.

## Meeting people's individual needs

- Nursing staff were supported to manage patients who had complex needs. Close observation and nursing on a one-to-one basis was used for patients who required additional support.
- The trust had a contract with an interpreting agency to provide interpreters to meet the language needs for all patients being treated across the hospital sites. There was a non-emergency and emergency contact number for the service, as well as an online booking form. There was also an additional service available to contact in the event the agency was not available. Staff had access to an agency that provided British sign language, lip speaking and deaf-blind interpretation.
- Portable induction hearing loops were available by direct request from staff.
- The trust has a learning disabilities liaison team, which staff could access in order to provide support, education and advice for the patient and their family and carers, as well as other staff.
- The trust had dementia care pathways in place, known as the Butterfly Scheme. This was underpinned by the trust's dementia strategy. Staff said they could access support from the specialist nurse or occupational therapist, as well as the mental health service. We saw evidence of Butterfly Scheme cards on Twineham Ward and an information board developed by the dementia champion. This provided information to people coming on to the ward.

## Learning from complaints and concerns

- The Princess Royal Hospital had information displayed in clinical areas and on wards that advised people using the service how to raise a concern or make a complaint through the Patient Advice and Liaison Service.
- The number of complaints were collected by ward and department as part of the hospital and trust-wide Safety Thermometer. For example, nine complaints had been made between the periods of May 2013 and April 2014 on Twineham Ward, and the Patient Advice and Liaison Service had been contacted 21 times across the period. Staff were made aware of complaints and discussed any required changes as part of their team meetings or general communication updates.
- An electronic copy of the complaints policy was available to staff, which included how the type of complaint would be acknowledged and investigated.

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The Quality and Safety Committee reviewed monthly complaints information, which included main concerns from both informal and formal complaints. The Quality and Safety Committee reported to the trust board.

- A representative of the patient participation group spoke with us at a listening event. They informed us that there were concerns about the complaints process, describing how, in response to a complaint, it was six months before the complainant received an apology letter. Within this letter they described five separate apologies being made concerning the referral process from Princess Royal Hospital and a local hospice.

## Are surgery services well-led?

Good



The majority of staff working at Princess Royal Hospital felt that they had good leadership and direction from their line managers. Information was communicated from director and chief executive level downwards and there was visibility of senior staff.

The surgical team benefitted from having a consultant-led service and medical staff felt supported and involved in promoting good patient outcomes. Junior medical staff felt the Princess Royal Hospital site provided opportunities for learning.

The trust board received information from the surgical directorate and were involved in considering and approving the trust's clinical strategy.

Arrangements were in place to review all aspects of the service within quality and governance structures, with contributions from surgical wards.

Patients and the public had a voice and were encouraged and supported to raise concerns or issues about the service.

## Vision and strategy for this service

- The trust provided a staff briefing which outlined the launch of a work stream called 'Foundation for Success' in October 2013. This was set out to develop the trust's core values and behaviours. The board minutes for February 2014 indicated a presentation would be made

to the board advising of progress in phase 1 and how the defined values and behaviours would be implemented as part of phase 2, from April 2014 onwards.

- The trust had a clinical strategy for immediate and longer-term visions, which had been submitted for approval to the board in March 2014. The strategy set out the provision of services across each site. It indicated that the Princess Royal Hospital would continue the main core of work around elderly care and elective surgery, while retaining the majority of its current service provision. Unscheduled care would be developed regarding the support of frail elderly people and people who had sustained a fractured hip. Ward and departmental staff who spoke with us, while they did not specifically describe the vision or strategy, were aware of changes taking place and the impact this would have. For example, the move of some surgical specialties to the site.

## Governance, risk management and quality measurement

- The surgical division carried out regular monthly meetings in which they reviewed service safety, quality and performance. We reviewed minutes that demonstrated that adverse incidents were discussed and agreed actions put in place with nominated lead for taking this forward. We saw that, for example, where a surgical pathway needed to be changed, this was discussed at the relevant governance meeting.
- The trust reviewed and implemented relevant NICE guidance within the trust.
- The implementation of NICE recommendations was measured through the trust's Safety and Quality Framework which provided assurance to the board. We looked at the trust's position concerning the implementation of the NICE quality standard in relation to surgical site infections, published October 2013. This was under review by the trust as of January 2014.
- Minutes of the board of directors' meetings demonstrated that these meetings were used as an opportunity to review an example of the patient's experience of the service, including outcomes and areas for improvement.
- We saw that the trust had a board assurance framework in place and reviewed the version for 2013/14. Risks

# Surgery

were identified by the trust and there were summarised actions to control the risk, the methods for monitoring, frequency, and a designated person responsible for overseeing this.

## Leadership of service

- Staff said there was effective leadership at departmental level, with good visibility and communication from matrons. The chief nurse was said to be visible and although less visible, staff reported receiving regular communications from the chief executive.
- Staff felt generally well informed and felt able to discuss issues or participate in discussions and decisions that impacted on them.

## Culture within the service

- We observed positive interactions and helpful teamwork amongst the staff we saw during our ward and departmental visits. Staff reported having a good working relationship with consultants and they were responsive to requests related to patient treatment or care.

## Public and staff engagement







- The public were encouraged to feedback through the 'Patient's Voice' comments procedure. In addition the public were encouraged to contribute to the NHS Friends and Family Test and 'You said. We did', (when comments or suggestions were made by people, the service posted the responses to these in ward and clinical areas so that they were visible).

- The Princess Royal Hospital internet had information about the Patient Experience Panel, including the frequency of meetings. This panel welcomed participation from patients, carers and local community groups.
- Nursing and Midwifery staff received regular communication from the director of nursing in the form of a newsletter titled 'Nursing and Midwifery Matter' (NMM). The NMM for April 2014 outlined the measures being taken regarding recruitment. It was noted too that a member of staff had been appointed to work with the provider of the cleaning services in order to address concerns about some of the standards.
- Staff also received communication from the chief executive and we saw for example in his message of 31 March 2014 a number of staff were mentioned as having been awarded 'Proud to Care awards'. One of the awards was to the manager of Albourne ward.

## Innovation, improvement and sustainability

- The trust's business plan outlined the priorities for 2014/15 with a focus on a range of areas that impacted on patient care outcomes. For example, strengthening their governance processes around quality and safety and learning from identified issues.
- At the time of our visit the trust was also in the process of developing an updated safety and quality strategy, which would provide an organisational vision to staff for achieving safe, high quality compassionate care for patients using the service. The vision was set out to reflect the World Health Organisation's six domains for safety, as well as the five domains assessed by the Care Quality Commission.

# Critical care

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

## Information about the service

Critical care services at the Princess Royal Hospital include a six bedded combined intensive care unit (ICU) and a high dependency unit (HDU) for general critical care. This unit is managed by a local nurse service manager and the team who also manage the general critical care unit at the Royal Sussex County Hospital in Brighton.

There is also a six-bedded critical care unit in the Hurstwood Park Neurosciences Centre (the neurological unit). This unit is run by a dedicated matron and the neurological team. There is shared consultant presence on both units.

On this inspection we visited the general critical care unit and the neurological unit on Thursday 22 May 2014. At both units we spoke with staff, including consultants and nurses from different grades. We met with patients and their relatives.

## Summary of findings

The critical care teams were strong, committed and compassionate. They were caring and well-led. Care they delivered was highly regarded by those who received it and their relatives. Feedback we heard and read was overwhelmingly positive about the care and treatment from all staff. A letter from the parent of a recent patient to the critical care team at the neurological unit said of staff: "Your professionalism, your compassion and your ability to work 'outside the box' has helped us all immeasurably..." Another letter from a patient to staff in the neurological unit said: "The level of care I received in ITU could not possibly have been higher...I was treated with respect and sensitivity, as was my wife..." We read many other letters with similar sentiments.

Although, overall, the critical care units were good, the poor flow of patients through the Princess Royal Hospital was affecting the ability of the general unit to respond effectively. The out-of-hours discharges, delayed discharges, high level of transfers into the general unit, and high bed occupancy were not within the control of the units, but patients or potential patients were affected by it. Elective surgery had been cancelled, on occasion, and care was compromised for patients who needed to be discharged when it was not optimal to do so. The general critical care unit was also

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not designed for some more complex intensive care, and these patients would be transferred to the Royal Sussex County Hospital in Brighton, thus increasing the pressure on that location.

## Are critical care services safe?

Good



Critical care services were safe. Incidents were being reported, investigated and learned from. Infection prevention control processes were done well and unit-acquired infection rates were low. Safety risks for patients were being monitored and tracked systematically. The environment in the general unit was acceptable, although, in many areas it did not meet the current building guidelines. The environment in the neurological unit was small, and did not allow of a good visibility of patients. There was very limited storage or staff working space. The privacy and dignity of patients was also compromised by entrance into the unit being directly off a public corridor. Equipment, overall, was well-maintained and there was adequate provision. Records were well documented and analysed for emerging risks and possible deterioration.

There were some issues to be resolved with the safe storage of medicines, but these were recognised by staff.

Nursing staffing levels were improving, but there was a high use of bank and agency staff to cover the level of vacancies and staff unplanned absence. Nursing staff levels were planned to meet the needs of patients and meet the guidelines of the Royal College of Nursing. Medical cover was good and consultants worked in blocks of days to provide consistency to patients and their relatives.

Staff ensured patients' rights were protected by appropriately using the provisions of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Consent was done well and the law was adhered to where valid, informed consent was not obtainable at the time of need. The outreach team worked effectively to support patients who were accommodated elsewhere in the Princess Royal Hospital and responded to deteriorating patients.

### Incidents

- The general critical care unit and the neurological unit had no cause to report a Never Event (a serious incident that should be avoided if systems work as required).
- The units had a good culture of incident reporting, analysing, sharing and learning. Staff said they used the incident reporting triggers to recognise what were

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reportable events. We reviewed the incidents for the general unit for the last year and there was a high level of reporting of various degrees of seriousness. This indicated an open culture of reporting incidents within the department. We looked at a sample of incidents reported by the general critical care unit in the last two years. Most reported incidents had been allocated to an investigator and had action plans, where required. The majority of incidents were reviewed by the lead nurse. The general critical care department had developed and produced a newsletter called 'Risky Business' to raise awareness of incidents and share learning and development. The newsletters we read included, notes from the safety and risk action meeting, highlighted actions not yet completed and listed themes in incident reports from the previous quarter. A recent incident in the general critical care unit had led to the decision to expand the outreach team to seven-day, 24-hour provision, from the current Monday to Friday day-time only (8am to 8pm) service. In the neurological unit, an error in counting of controlled drugs led to a change in procedures and no further incidents. Incidents elsewhere in the Princess Royal Hospital were shared with the local teams for learning and development.

- Mortality and morbidity (M&M) was reviewed at local level. The general critical care unit held monthly M&M meetings where a range of staff attended from different disciplines connected with the patients to be discussed. The neurological unit also had monthly M&M meetings and relevant staff attended to discuss individual cases.

## Safety thermometer

- The units were performing within expected levels for patient harms. This included hospital-acquired pressure ulcers (which were low), venous thromboembolism, falls with harm, and catheter use with urinary tract infections. The nurse in charge of the general unit, matron and one of the senior nurses in the neurological unit described how all patients admitted had risk assessments which included their fluid balance and nutrition levels (Waterlow and MUST scores). Turn charts were established to prevent pressure damage to skin.
- Results of safety checks relating to patients were displayed in the units in public areas. The general critical care service had a recently-introduced robust audit of safety observations and scores (referred to as 'nursing metrics'). The unit had been late to introduce audits of these standard, widely used and essential

safety measurements for patients, but this was being done. In April 2014, in the first collection of data, the audit had delivered some good but some less satisfactory results of compliance, but the majority were 100% compliant. The matron told us the results would be used at safety and risk meetings, handover, and leadership meetings. In areas where improvements were identified, the practice educator would arrange training and development sessions and look for identifiable improvements. The mixed results had reinforced the need to collect and monitor this data on an ongoing basis. The results for the neurological unit had been collected and monitored for some time, as part of the neurological surgery division. The division was above the trust average score for February 2013 to January 2014 for all measures, except observations and comfort rounds, which were just below the trust average.

- Nursing care included the major themes in patient harms. Venous thromboembolism (VTE) risks were checked each day, as was skin integrity. Fluid balance was monitored throughout the day and charts were assessed to look for deterioration in key indicators. The neurological unit reported 100% harm-free care in January 2014 (the most recent data available) which was up from just below 80% in November 2013. The falls rate in the unit was zero in January 2014, which was a significant improvement from over 10 per 1000 bed days 12 months earlier. Pressure damage was also zero in January 2014.

## Cleanliness, infection control and hygiene

- The cleaning staff had clear responsibilities for their work and almost always worked only within the units. This meant they were used to the environment, equipment and specialist nature of their cleaning work.
- The units were clean and organised around infection prevention and control. There was good provision of hand-wash sinks and each we looked at had hot water, soap, and paper towels available. There was a good provision of hand gel in entrances, corridors, at the end of beds, and in staff areas. This was used, as expected by staff. All curtains on the general unit were disposable and showed the date they were hung. Staff were aware of when they needed to be changed. The curtains on the neurological unit were not the disposable type but they appeared clean and regularly laundered.



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- Staff observed infection control protocols. There was correct use of personal protective equipment, such as clean uniforms or scrubs, gloves, aprons and masks, if needed. Nurses caring for patients who were in isolation were following correct procedures.
- Hospital-acquired infection rates were low. For example, the Intensive Care National Audit & Research Centre data for the general unit showed there were no MRSA infections in the 12 months up to December 2013, and no C. difficile infections in the last nine months. There were two infections in January to March 2013. In the neurological unit, there had been no MRSA or C. difficile infections for the past two years. There had been two MRSA infections in the last year, which were related to suturing of lines. Both had been investigated with full support from the infection control team.

## Environment and equipment

- Security of the units was good. The units were locked and visitors were required to identify themselves upon arrival and be met by staff. Neither of the units had any reception or administration staff to meet visitors, as they did not have staff in these posts, and the units were not configured with any reception areas.
- There was enough equipment for services provided, although some units were required to share equipment if a piece was out of action for repair or maintenance. Each unit was funded and capable of supporting up to a certain number of patients requiring the highest level of support (level 3 patients). Units had sufficient numbers of ventilators for patients supported with their breathing. Each unit had spare equipment if a piece of kit failed. We checked the resuscitation trolleys and the required checks were done, but the list in the general unit was not itemised, so staff did not indicate what they had checked.
- The general critical care unit and neurological unit had good equipment, although the physical environments did not meet the latest Health Building Note 04-02 recommended guidance for critical care units. The general unit was relatively cramped in patient spaces, although staff had excellent visibility on all patients from their central staff area. The neurological unit, which will be relocated to the expanded HDU high dependency unit at Royal Sussex County Hospital later this year was small and made up of a number of small areas and narrow internal corridors. Despite this, staff were making the best use of the space. Storage space was very

limited. We were concerned with how visitors coming into the unit walked directly onto the unit where two patients were located. There was no reception area to protect the patients' privacy, apart from curtains around the bed, which needed to be generally open for safe visibility for staff. There was no general area for the clinical staff to work from, which provided acceptable visibility of patients. One of the bed spaces, where patients could be nursed in isolation, led onto an internal garden area, which is rare in intensive care settings. This was an area treasured by staff and patients. One family in particular who made use of it said, in a letter to staff, "Thank heaven for the garden and you letting [the patient] turn his face to the sun." Another patient wrote to say, "Your kindness, allowing me to go out into the sweet air and sunshine has nourished me beyond words..."

- The units had good flexibility for supporting the most unwell patients. The general unit had the facilities to admit up to five patients who required intensive care (level 3). The unit also had two dialysis machines, so it was able to admit and support patients who needed dialysing. The nurse in charge of the general unit said equipment could be rented, when needed, if more complex patients were admitted or additional equipment was needed. The neurological unit was able to admit up to six patients needing level 3 care (so all beds could be utilised). There was limited organ support on the neurological unit. For example, there was no access to dialysis. Patients who needed multiple organ support were transferred to the general unit.
- The pumps used to automatically administer medicines were regularly checked. This was done at nurse handover.

## Medicines

- Medicines were managed safely, although some storage arrangements needing to be improved. For example, there were medicines stored in the neurological unit, which were in unlocked drawers, alongside patients. The units had good support from the pharmacy team.
- Medicines were safely administered and records we reviewed in the general units showed medicines given when they needed to be. Any administration gaps shown on the charts were appropriately explained. Administration was signed by two members of the nursing staff. We had one concern with a patient's drug record on the general unit where there was no duration



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written for a dose of antibiotics. Some medicines were stored at the patient's bedside (including potassium in solution) to enable easy access for the nurse in charge of the patient. However, the cupboards were not lockable, and although they were not unattended, this did not meet good practice. The main medicines storage was locked with keys and number pads – this system was susceptible to keys being misplaced. Staff had recognised this and there were incident reports filed in April 2013. An action plan had been created and work to resolve the issues had been agreed, but nothing had been achieved a year later.

## Records

- Patient records were maintained safely. We reviewed a number of electronic patient records in the general units and found them to be well completed with all the relevant information and indicators. There were comprehensive, clear and monitored nursing notes. An audit of patient records in the general units in April 2014 had found some areas less well completed and staff said these areas had been highlighted and they would be measured each month. In one set of records on the general unit for a patient who was due for discharge shortly, paperwork was not fully completed. For example, there was no information regarding the patient's MRSA status to handover to the receiving ward.
- Consultants recorded their conversations with patients and relatives in recently introduced formal documentation. Those consultants' notes of conversations with patients and their relatives that we read were mostly clear and legible. The notes included conversations around resuscitation wishes or advanced directives, withdrawal, or escalations of care, and relatives' concerns.
- Multidisciplinary input was well documented. There were good notes made by multidisciplinary team members, such as speech and language therapists, physiotherapists and dieticians. There was good use of relevant care bundles, including, for example, catheter care, venous thromboembolism care and line care.
- Some patients in the units required restraint for many reasons, often including high agitation and delirium. Where restraint had been used, the general units were not actively using care plans to support patients or other patients affected by the use of restraint, neither had staff documented its frequency and duration for review and analysis.

## Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Patients were able to give their consent when they were mentally and physically able. Staff acted in accordance with the law when treating an unconscious patient or in an emergency. Staff said patients were told what decisions had been made, by whom and why, if and when the patient regained consciousness or when the emergency situation had been controlled.
- Staff acted in accordance with the Mental Capacity Act 2005 when patients were unable to make their own decisions. Patients were assessed by the medical staff to decide if they had the capacity to make their own decisions. This process was recorded in the patient's medical records. If a patient was assessed as not being able to make a decision about treatment when one was needed, the treatment would be given in their best interests. The decision about what was in the patient's best interest was made by the medical team, including doctors and nurses, and those who spoke for the patient, including close family or carers, and, if required, an independent mental capacity advocate (IMCA). The forms the Princess Royal Hospital used for assessment of capacity followed all best practice guidelines.
- Staff understood and acted in accordance with the Mental Capacity Act 2005 if it was decided to temporarily deprive a patient of their liberty.

## Safeguarding

- Vulnerable people were protected against abuse or potential abuse. Staff were aware of the signs of abuse or potential abuse for vulnerable adults in their care or children linked to patients or their relatives. Staff were clear about how to report abuse and their responsibilities to do so. Staff gave us examples of situations where this had arisen and the steps they took. This included robust reporting and follow-up by the responsible staff at both local and trust-level. Patients admitted with or acquiring pressure damage to their skin would be reported to safeguarding. The neurological staff said they had cause to raise safeguarding issues in the past, and had a lead for the department to assist with the process.

## Mandatory training

- Mandatory training was on track to meet trust targets. We reviewed the mandatory training records for the nursing staff on both units. Due to the nature of patients admitted to critical care, the majority of nursing staff

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were required to undertake almost the whole suite of mandatory training provided. Most of the standard courses completed were over the 75% completion target and most staff were booked on courses. This did not include staff who were on planned, unplanned or unavoidable absence. There were, however, problems at the trust with the e-learning software, which was criticised by staff in many departments. We were told this was being addressed by the IT department and system upgrades were taking place to resolve the issues. Staff workbooks for training had been considered as a great success by staff who found this format good for learning.

- The units had practice educators to manage and develop training and induction. New staff were supernumerary at induction for a month. They were given a mentor and worked through a Foundation in Critical Care induction programme, alongside the practice educators. New staff we met said they had been made welcome and were well supported when they joined the team. They said they were encouraged to ask questions and look for guidance at any time.

## Management of deteriorating patients

- The critical care unit and wards in the Princess Royal Hospital used recognised new early warning scores (NEWS) to manage deteriorating patients. The outreach team, who were part of the development and roll-out of NEWS in April 2013, reported NEWS was used well within the wards. They said staff knew when the scores indicated risks were at such a level as to require input from the outreach team. The outreach nurse told us staff on wards would sometimes act upon lower scores if other indicators were a risk factor. Critical care or ward medical staff would be asked for input if escalation or advice was required.

## Nursing staffing

- The critical care units used the Royal College of Nursing guidance to determine nursing staffing levels. Patients who were ventilated (level 3) were nursed by one nurse to one patient. Patients in high dependency beds (level 2) were nursed with one nurse for two patients.
- Each shift had structured handover sessions for the nursing team. Patients were then handed over individually, at the bedside, to the nurse taking over their care by the nurse finishing their shift.
- Substantive nursing staff levels for staff in post versus the establishment were not adequate, but the matron in

the neurological unit and nurse manager of the general unit said full staffing was usually achieved with the use of temporary staff. Levels of substantive nursing staff were improving following an ongoing recruitment programme and recent appointments. However, there were still vacancies in both the general and neurological unit. At the end of March 2014 in the general unit:

- There were two WTE (whole time equivalent) vacancies for healthcare assistants out of three posts.
- There were seven and a half WTE vacancies for nurses out of 36.5 posts.
- This was a total of nine and a half WTE vacancies out of 39.5 posts, or 23%. This rate had not fluctuated significantly over the 12 months from April 2013 and was around 22% on average. The data we were supplied with was basic, but bank and agency spend correlated to some extent with staff shortages, through sickness or vacancies.
- Sickness rates at the end of February 2014 were 3.9% or slightly below the 4% England average. On average for the 11 months to February 2014 they were 5.4% which was above the trust average of 3.8%.

In the neurological unit at the end of March 2014:

- There were five and a half WTE vacancies for nurses out of 40 posts. This was a rate of 13.7%.
- Over the previous 12 months the vacancy rate had increased from 2.2% in April 2013, to the current high. We were advised this was partially down to the move of the unit to the Royal Sussex County Hospital in Brighton and staff not wanting to relocate and securing jobs elsewhere. This was borne out by the staff turnover figures, which were high at an average of 17%.
- The sickness rate fluctuated throughout the 12 months from April 2013 and at the end of February 2014 was 6.9%, which was above the England average of 4%. At the peak in December 2013, sickness absence had been 10.5%.
- The data we were provided with was basic, but the spending on temporary staff (almost entirely bank and not agency staff) did not mirror the vacancy rates. There was some correlation with the sickness rates, but not with the vacancies in substantive posts.
- The units had, therefore, placed a high reliance upon bank staff and some agency staff. Nursing staff vacancies on the general unit were high, particularly

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around band 6 nurses. There were three agency nurses working in the general unit on longer-term contracts to provide continuity. Funding to support critical care had enabled band 5 nurses to access the intensive care unit course to allow them to gain promotion to the vacant level 6 posts.

## Medical staffing

- The general critical care unit was consultant-led. There were two ward rounds each day, led by the consultant with the morning round having input from all other relevant staff, including junior doctors, nurses, pharmacists and Allied Healthcare professionals.
- There was good consultant cover in both the critical care units. There were 13 consultants who were regularly on duty in the units. Both units were covered by consultants who worked in rotational blocks of three or four days. For example, one consultant may have worked Monday to Thursday one week and then Friday to Sunday the following week and covered both units. The consultant hours covered, as a minimum, 8am to 9pm on weekdays and 9am to 4pm on weekends. Consultants had an on-call rota to provide telephone consultations when not on-site and this extended to returns to hospital and late stays, as required.
- Consultant handovers took place at each rota change. This was, therefore, done each Monday morning and Friday morning. Some consultants would talk with their colleague coming onto the rota on the evening before, if there were particularly difficult cases or if longer explanations were required. An hour was allowed on-site for the full rota handover.
- There was a good consultant to patient ratio. There was one consultant on duty covering both units and 14 beds (which was slightly below the recommended maximum ratio of 1:15). The consultants were fully committed to the critical care units when they were on-call or on duty and did not have other responsibilities within the hospital to attend to.
- Locum use at the Princess Royal Hospital was limited. There were no consultant locum's used at the time of our visit, and the 13 consultants working in the critical care unit would change their rotas among themselves to cover colleagues. There was some locum use among junior doctors with more night-time activity occurring at the Princess Royal Hospital.

- There was a good range of teaching for junior doctors. Teaching was delivered by the supervising consultant each Tuesday from 4pm, which was 'pager free' so as to not be interrupted unless there was an emergency.
- The units had support from qualified medical staff elsewhere in the hospital. The general unit was located adjacent to the operating theatres and if staff needed help with, for example, difficult airways, support was available from the anaesthetists working in theatre. Medical staff could also reach the neurological unit from the main building in under a minute.

## Major incident awareness and training

- The trust had a major incident escalation plan for business continuity that included actions for critical care. The critical care facilities at the Princess Royal Hospital were, however, not able to fully double their capacity in 48 hours to follow national pandemic emergency protocols. The unit did not undertake emergency surgery and there was no provision for critically ill patients to be cared for in the post-anaesthetic recovery unit.

## Are critical care services effective?

Good



Critical care services were safe. Incidents were being reported, investigated and learned from. Infection prevention control processes were done well and unit-acquired infection rates were low. Safety risks for patients were being monitored and tracked systematically. The environment in the general unit was acceptable, although, in many areas it did not meet the current building guidelines. The environment in the neurological unit was small, and did not allow of a good visibility of patients. There was very limited storage or staff working space. The privacy and dignity of patients was also compromised by entrance into the unit being directly off a public corridor. Equipment, overall, was well-maintained and there was adequate provision. Records were well documented and analysed for emerging risks and possible deterioration.

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## Incidents

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- The units had a good culture of incident reporting, analysing, sharing and learning. Staff said they used the incident reporting triggers to recognise what were reportable events. We reviewed the incidents for the general unit for the last year and there was a high level of reporting of various degrees of seriousness. This indicated an open culture of reporting incidents within the department. We looked at a sample of incidents reported by the general critical care unit in the last two years. Most reported incidents had been allocated to an investigator and had action plans, where required. The majority of incidents were reviewed by the lead nurse. The general critical care department had developed and produced a newsletter called 'Risky Business' to raise awareness of incidents and share learning and development. The newsletters we read included, notes from the safety and risk action meeting, highlighted actions not yet completed and listed themes in incident reports from the previous quarter. A recent incident in the general critical care unit had led to the decision to expand the outreach team to seven-day, 24-hour provision, from the current Monday to Friday day-time only (8am to 8pm) service. In the neurological unit, an error in counting of controlled drugs led to a change in procedures and no further incidents. Incidents elsewhere in the Princess Royal Hospital were shared with the local teams for learning and development.

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- Results of safety checks relating to patients were displayed in the units in public areas. The general critical care service had a recently-introduced robust audit of safety observations and scores (referred to as 'nursing metrics'). The unit had been late to introduce audits of these standard, widely used and essential safety measurements for patients, but this was being done. In April 2014, in the first collection of data, the audit had delivered some good but some less satisfactory results of compliance, but the majority were 100% compliant. The matron told us the results would be used at safety and risk meetings, handover, and leadership meetings. In areas where improvements were identified, the practice educator would arrange training and development sessions and look for identifiable improvements. The mixed results had reinforced the need to collect and monitor this data on an ongoing basis. The results for the neurological unit had been collected and monitored for some time, as part of the neurological surgery division. The division was above the trust average score for February 2013 to January 2014 for all measures, except observations and comfort rounds, which were just below the trust average.
- Nursing care included the major themes in patient harms. Venous thromboembolism (VTE) risks were checked each day, as was skin integrity. Fluid balance was monitored throughout the day and charts were assessed to look for deterioration in key indicators. The neurological unit reported 100% harm-free care in

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January 2014 (the most recent data available) which was up from just below 80% in November 2013. The falls rate in the unit was zero in January 2014, which was a significant improvement from over 10 per 1000 bed days 12 months earlier. Pressure damage was also zero in January 2014.

## Cleanliness, infection control and hygiene

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- The units were clean and organised around infection prevention and control. There was good provision of hand-wash sinks and each we looked at had hot water, soap, and paper towels available. There was a good provision of hand gel in entrances, corridors, at the end of beds, and in staff areas. This was used, as expected by staff. All curtains on the general unit were disposable and showed the date they were hung. Staff were aware of when they needed to be changed. The curtains on the neurological unit were not the disposable type but they appeared clean and regularly laundered.
- Staff observed infection control protocols. There was correct use of personal protective equipment, such as clean uniforms or scrubs, gloves, aprons and masks, if needed. Nurses caring for patients who were in isolation were following correct procedures.
- Hospital-acquired infection rates were low. For example, the Intensive Care National Audit & Research Centre data for the general unit showed there were no MRSA infections in the 12 months up to December 2013, and no *C. difficile* infections in the last nine months. There were two infections in January to March 2013. In the neurological unit, there had been no MRSA or *C. difficile* infections for the past two years. There had been two MRSA infections in the last year, which were related to suturing of lines. Both had been investigated with full support from the infection control team.

## Environment and equipment

- Security of the units was good. The units were locked and visitors were required to identify themselves upon arrival and be met by staff. Neither of the units had any reception or administration staff to meet visitors, as they did not have staff in these posts, and the units were not configured with any reception areas.
- There was enough equipment for services provided, although some units were required to share equipment

if a piece was out of action for repair or maintenance. Each unit was funded and capable of supporting up to a certain number of patients requiring the highest level of support (level 3 patients). Units had sufficient numbers of ventilators for patients supported with their breathing. Each unit had spare equipment if a piece of kit failed. We checked the resuscitation trolleys and the required checks were done, but the list in the general unit was not itemised, so staff did not indicate what they had checked.

- The general critical care unit and neurological unit had good equipment, although the physical environments did not meet the latest Health Building Note 04-02 recommended guidance for critical care units. The general unit was relatively cramped in patient spaces, although staff had excellent visibility on all patients from their central staff area. The neurological unit, which will be relocated to the expanded HDU high dependency unit at Royal Sussex County Hospital later this year was small and made up of a number of small areas and narrow internal corridors. Despite this, staff were making the best use of the space. Storage space was very limited. We were concerned with how visitors coming into the unit walked directly onto the unit where two patients were located. There was no reception area to protect the patients' privacy, apart from curtains around the bed, which needed to be generally open for safe visibility for staff. There was no general area for the clinical staff to work from, which provided acceptable visibility of patients. One of the bed spaces, where patients could be nursed in isolation, led onto an internal garden area, which is rare in intensive care settings. This was an area treasured by staff and patients. One family in particular who made use of it said, in a letter to staff, "Thank heaven for the garden and you letting [the patient] turn his face to the sun." Another patient wrote to say, "Your kindness, allowing me to go out into the sweet air and sunshine has nourished me beyond words..."
- The units had good flexibility for supporting the most unwell patients. The general unit had the facilities to admit up to five patients who required intensive care (level 3). The unit also had two dialysis machines, so it was able to admit and support patients who needed dialysing. The nurse in charge of the general unit said equipment could be rented, when needed, if more complex patients were admitted or additional equipment was needed. The neurological unit was able



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to admit up to six patients needing level 3 care (so all beds could be utilised). There was limited organ support on the neurological unit. For example, there was no access to dialysis. Patients who needed multiple organ support were transferred to the general unit.

- The pumps used to automatically administer medicines were regularly checked. This was done at nurse handover.

## Medicines

- Medicines were managed safely, although some storage arrangements needing to be improved. For example, there were medicines stored in the neurological unit, which were in unlocked drawers, alongside patients. The units had good support from the pharmacy team.
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- Patient records were maintained safely. We reviewed a number of electronic patient records in the general units and found them to be well completed with all the relevant information and indicators. There were comprehensive, clear and monitored nursing notes. An audit of patient records in the general units in April 2014 had found some areas less well completed and staff said these areas had been highlighted and they would be measured each month. In one set of records on the general unit for a patient who was due for discharge shortly, paperwork was not fully completed. For example, there was no information regarding the patient's MRSA status to handover to the receiving ward.

- Consultants recorded their conversations with patients and relatives in recently introduced formal documentation. Those consultants' notes of conversations with patients and their relatives that we read were mostly clear and legible. The notes included conversations around resuscitation wishes or advanced directives, withdrawal, or escalations of care, and relatives' concerns.
- Multidisciplinary input was well documented. There were good notes made by multidisciplinary team members, such as speech and language therapists, physiotherapists and dieticians. There was good use of relevant care bundles, including, for example, catheter care, venous thromboembolism care and line care.
- Some patients in the units required restraint for many reasons, often including high agitation and delirium. Where restraint had been used, the general units were not actively using care plans to support patients or other patients affected by the use of restraint, neither had staff documented its frequency and duration for review and analysis.

## Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Patients were able to give their consent when they were mentally and physically able. Staff acted in accordance with the law when treating an unconscious patient or in an emergency. Staff said patients were told what decisions had been made, by whom and why, if and when the patient regained consciousness or when the emergency situation had been controlled.
- Staff acted in accordance with the Mental Capacity Act 2005 when patients were unable to make their own decisions. Patients were assessed by the medical staff to decide if they had the capacity to make their own decisions. This process was recorded in the patient's medical records. If a patient was assessed as not being able to make a decision about treatment when one was needed, the treatment would be given in their best interests. The decision about what was in the patient's best interest was made by the medical team, including doctors and nurses, and those who spoke for the patient, including close family or carers, and, if required, an independent mental capacity advocate (IMCA). The forms the Princess Royal Hospital used for assessment of capacity followed all best practice guidelines.



# Critical care

- Staff understood and acted in accordance with the Mental Capacity Act 2005 if it was decided to temporarily deprive a patient of their liberty.

## Safeguarding

- Vulnerable people were protected against abuse or potential abuse. Staff were aware of the signs of abuse or potential abuse for vulnerable adults in their care or children linked to patients or their relatives. Staff were clear about how to report abuse and their responsibilities to do so. Staff gave us examples of situations where this had arisen and the steps they took. This included robust reporting and follow-up by the responsible staff at both local and trust-level. Patients admitted with or acquiring pressure damage to their skin would be reported to safeguarding. The neurological staff said they had cause to raise safeguarding issues in the past, and had a lead for the department to assist with the process.

## Mandatory training

- Mandatory training was on track to meet trust targets. We reviewed the mandatory training records for the nursing staff on both units. Due to the nature of patients admitted to critical care, the majority of nursing staff were required to undertake almost the whole suite of mandatory training provided. Most of the standard courses completed were over the 75% completion target and most staff were booked on courses. This did not include staff who were on planned, unplanned or unavoidable absence. There were, however, problems at the trust with the e-learning software, which was criticised by staff in many departments. We were told this was being addressed by the IT department and system upgrades were taking place to resolve the issues. Staff workbooks for training had been considered as a great success by staff who found this format good for learning.
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## Management of deteriorating patients

- The critical care unit and wards in the Princess Royal Hospital used recognised new early warning scores (NEWS) to manage deteriorating patients. The outreach team, who were part of the development and roll-out of NEWS in April 2013, reported NEWS was used well within the wards. They said staff knew when the scores indicated risks were at such a level as to require input from the outreach team. The outreach nurse told us staff on wards would sometimes act upon lower scores if other indicators were a risk factor. Critical care or ward medical staff would be asked for input if escalation or advice was required.

## Nursing staffing

- The critical care units used the Royal College of Nursing guidance to determine nursing staffing levels. Patients who were ventilated (level 3) were nursed by one nurse to one patient. Patients in high dependency beds (level 2) were nursed with one nurse for two patients.
- Each shift had structured handover sessions for the nursing team. Patients were then handed over individually, at the bedside, to the nurse taking over their care by the nurse finishing their shift.
- Substantive nursing staff levels for staff in post versus the establishment were not adequate, but the matron in the neurological unit and nurse manager of the general unit said full staffing was usually achieved with the use of temporary staff. Levels of substantive nursing staff were improving following an ongoing recruitment programme and recent appointments. However, there were still vacancies in both the general and neurological unit. At the end of March 2014 in the general unit:
  - There were two WTE (whole time equivalent) vacancies for healthcare assistants out of three posts.
  - There were seven and a half WTE vacancies for nurses out of 36.5 posts.
  - This was a total of nine and a half WTE vacancies out of 39.5 posts, or 23%. This rate had not fluctuated significantly over the 12 months from April 2013 and was around 22% on average. The data we were supplied with was basic, but bank and agency spend correlated to some extent with staff shortages, through sickness or vacancies.

# Critical care

- Sickness rates at the end of February 2014 were 3.9% or slightly below the 4% England average. On average for the 11 months to February 2014 they were 5.4% which was above the trust average of 3.8%.

In the neurological unit at the end of March 2014:

- There were five and a half WTE vacancies for nurses out of 40 posts. This was a rate of 13.7%.
- Over the previous 12 months the vacancy rate had increased from 2.2% in April 2013, to the current high. We were advised this was partially down to the move of the unit to the Royal Sussex County Hospital in Brighton and staff not wanting to relocate and securing jobs elsewhere. This was borne out by the staff turnover figures, which were high at an average of 17%.
- The sickness rate fluctuated throughout the 12 months from April 2013 and at the end of February 2014 was 6.9%, which was above the England average of 4%. At the peak in December 2013, sickness absence had been 10.5%.
- The data we were provided with was basic, but the spending on temporary staff (almost entirely bank and not agency staff) did not mirror the vacancy rates. There was some correlation with the sickness rates, but not with the vacancies in substantive posts.
- The units had, therefore, placed a high reliance upon bank staff and some agency staff. Nursing staff vacancies on the general unit were high, particularly around band 6 nurses. There were three agency nurses working in the general unit on longer-term contracts to provide continuity. Funding to support critical care had enabled band 5 nurses to access the intensive care unit course to allow them to gain promotion to the vacant level 6 posts.

## Medical staffing

- The general critical care unit was consultant-led. There were two ward rounds each day, led by the consultant with the morning round having input from all other relevant staff, including junior doctors, nurses, pharmacists and Allied Healthcare professionals.
- There was good consultant cover in both the critical care units. There were 13 consultants who were regularly on duty in the units. Both units were covered by consultants who worked in rotational blocks of three or four days. For example, one consultant may have worked Monday to Thursday one week and then Friday

to Sunday the following week and covered both units. The consultant hours covered, as a minimum, 8am to 9pm on weekdays and 9am to 4pm on weekends. Consultants had an on-call rota to provide telephone consultations when not on-site and this extended to returns to hospital and late stays, as required.

- Consultant handovers took place at each rota change. This was, therefore, done each Monday morning and Friday morning. Some consultants would talk with their colleague coming onto the rota on the evening before, if there were particularly difficult cases or if longer explanations were required. An hour was allowed on-site for the full rota handover.
- There was a good consultant to patient ratio. There was one consultant on duty covering both units and 14 beds (which was slightly below the recommended maximum ratio of 1:15). The consultants were fully committed to the critical care units when they were on-call or on duty and did not have other responsibilities within the hospital to attend to.
- Locum use at the Princess Royal Hospital was limited. There were no consultant locum's used at the time of our visit, and the 13 consultants working in the critical care unit would change their rotas among themselves to cover colleagues. There was some locum use among junior doctors with more night-time activity occurring at the Princess Royal Hospital.
- There was a good range of teaching for junior doctors. Teaching was delivered by the supervising consultant each Tuesday from 4pm, which was 'pager free' so as to not be interrupted unless there was an emergency.
- The units had support from qualified medical staff elsewhere in the hospital. The general unit was located adjacent to the operating theatres and if staff needed help with, for example, difficult airways, support was available from the anaesthetists working in theatre. Medical staff could also reach the neurological unit from the main building in under a minute.

## Major incident awareness and training

- The trust had a major incident escalation plan for business continuity that included actions for critical care. The critical care facilities at the Princess Royal Hospital were, however, not able to fully double their capacity in 48 hours to follow national pandemic

# Critical care

emergency protocols. The unit did not undertake emergency surgery and there was no provision for critically ill patients to be cared for in the post-anaesthetic recovery unit.

## Are critical care services caring?

Good



Critical care services were safe. Incidents were being reported, investigated and learned from. Infection prevention control processes were done well and unit-acquired infection rates were low. Safety risks for patients were being monitored and tracked systematically. The environment in the general unit was acceptable, although, in many areas it did not meet the current building guidelines. The environment in the neurological unit was small, and did not allow of a good visibility of patients. There was very limited storage or staff working space. The privacy and dignity of patients was also compromised by entrance into the unit being directly off a public corridor. Equipment, overall, was well-maintained and there was adequate provision. Records were well documented and analysed for emerging risks and possible deterioration.

There were some issues to be resolved with the safe storage of medicines, but these were recognised by staff.

Nursing staffing levels were improving, but there was a high use of bank and agency staff to cover the level of vacancies and staff unplanned absence. Nursing staff levels were planned to meet the needs of patients and meet the guidelines of the Royal College of Nursing. Medical cover was good and consultants worked in blocks of days to provide consistency to patients and their relatives.

Staff ensured patients' rights were protected by appropriately using the provisions of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Consent was done well and the law was adhered to where valid, informed consent was not obtainable at the time of need. The outreach team worked effectively to support patients who were accommodated elsewhere in the Princess Royal Hospital and responded to deteriorating patients.

## Incidents

- The general critical care unit and the neurological unit had no cause to report a Never Event (a serious incident that should be avoided if systems work as required).
- The units had a good culture of incident reporting, analysing, sharing and learning. Staff said they used the incident reporting triggers to recognise what were reportable events. We reviewed the incidents for the general unit for the last year and there was a high level of reporting of various degrees of seriousness. This indicated an open culture of reporting incidents within the department. We looked at a sample of incidents reported by the general critical care unit in the last two years. Most reported incidents had been allocated to an investigator and had action plans, where required. The majority of incidents were reviewed by the lead nurse. The general critical care department had developed and produced a newsletter called 'Risky Business' to raise awareness of incidents and share learning and development. The newsletters we read included, notes from the safety and risk action meeting, highlighted actions not yet completed and listed themes in incident reports from the previous quarter. A recent incident in the general critical care unit had led to the decision to expand the outreach team to seven-day, 24-hour provision, from the current Monday to Friday day-time only (8am to 8pm) service. In the neurological unit, an error in counting of controlled drugs led to a change in procedures and no further incidents. Incidents elsewhere in the Princess Royal Hospital were shared with the local teams for learning and development.
- Mortality and morbidity (M&M) was reviewed at local level. The general critical care unit held monthly M&M meetings where a range of staff attended from different disciplines connected with the patients to be discussed. The neurological unit also had monthly M&M meetings and relevant staff attended to discuss individual cases.

## Safety thermometer

- The units were performing within expected levels for patient harms. This included hospital-acquired pressure ulcers (which were low), venous thromboembolism, falls with harm, and catheter use with urinary tract infections. The nurse in charge of the general unit, matron and one of the senior nurses in the neurological

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unit described how all patients admitted had risk assessments which included their fluid balance and nutrition levels (Waterlow and MUST scores). Turn charts were established to prevent pressure damage to skin.

- Results of safety checks relating to patients were displayed in the units in public areas. The general critical care service had a recently-introduced robust audit of safety observations and scores (referred to as 'nursing metrics'). The unit had been late to introduce audits of these standard, widely used and essential safety measurements for patients, but this was being done. In April 2014, in the first collection of data, the audit had delivered some good but some less satisfactory results of compliance, but the majority were 100% compliant. The matron told us the results would be used at safety and risk meetings, handover, and leadership meetings. In areas where improvements were identified, the practice educator would arrange training and development sessions and look for identifiable improvements. The mixed results had reinforced the need to collect and monitor this data on an ongoing basis. The results for the neurological unit had been collected and monitored for some time, as part of the neurological surgery division. The division was above the trust average score for February 2013 to January 2014 for all measures, except observations and comfort rounds, which were just below the trust average.
- Nursing care included the major themes in patient harms. Venous thromboembolism (VTE) risks were checked each day, as was skin integrity. Fluid balance was monitored throughout the day and charts were assessed to look for deterioration in key indicators. The neurological unit reported 100% harm-free care in January 2014 (the most recent data available) which was up from just below 80% in November 2013. The falls rate in the unit was zero in January 2014, which was a significant improvement from over 10 per 1000 bed days 12 months earlier. Pressure damage was also zero in January 2014.

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- Medicines were managed safely, although some storage arrangements needing to be improved. For example, there were medicines stored in the neurological unit, which were in unlocked drawers, alongside patients. The units had good support from the pharmacy team.
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- Consultant handovers took place at each rota change. This was, therefore, done each Monday morning and Friday morning. Some consultants would talk with their

# Critical care

colleague coming onto the rota on the evening before, if there were particularly difficult cases or if longer explanations were required. An hour was allowed on-site for the full rota handover.

- There was a good consultant to patient ratio. There was one consultant on duty covering both units and 14 beds (which was slightly below the recommended maximum ratio of 1:15). The consultants were fully committed to the critical care units when they were on-call or on duty and did not have other responsibilities within the hospital to attend to.
- Locum use at the Princess Royal Hospital was limited. There were no consultant locum's used at the time of our visit, and the 13 consultants working in the critical care unit would change their rotas among themselves to cover colleagues. There was some locum use among junior doctors with more night-time activity occurring at the Princess Royal Hospital.
- There was a good range of teaching for junior doctors. Teaching was delivered by the supervising consultant each Tuesday from 4pm, which was 'pager free' so as to not be interrupted unless there was an emergency.
- The units had support from qualified medical staff elsewhere in the hospital. The general unit was located adjacent to the operating theatres and if staff needed help with, for example, difficult airways, support was available from the anaesthetists working in theatre. Medical staff could also reach the neurological unit from the main building in under a minute.

## Major incident awareness and training

- The trust had a major incident escalation plan for business continuity that included actions for critical care. The critical care facilities at the Princess Royal Hospital were, however, not able to fully double their capacity in 48 hours to follow national pandemic emergency protocols. The unit did not undertake emergency surgery and there was no provision for critically ill patients to be cared for in the post-anaesthetic recovery unit.

## Are critical care services responsive?

Requires improvement



Due to pressures elsewhere in the Princess Royal Hospital, the units were not able to respond at all times to the need

to admit or discharge patients. This had resulted in some elective operations being cancelled when a critical care bed was needed on the general ward, or patients needing to be moved from the neurological ward to admit higher-need patients. Too many patients were being discharged at night or their discharge into the hospital was delayed, which meant new patients were not able to be admitted.

The unit was able to meet the individual needs of patients and provided personalised care. There were telephone translation services available at short notice and support for people with cognitive impairment or other disabilities. Complaints from patients were infrequent, but these were responded to and shared with staff to improve future care and treatment.

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

- The service was not able to meet the needs of patients requiring general critical care at all times. There were plans to increase the number of beds in the general unit in 2015. Senior staff said the trust management were well aware of the problems. Elective surgery work was now remotely managed and improvements were being seen in reducing the demand for planned admissions.
- New ways of working to forward plan had been introduced. For example, a new standard operating procedure (SOP) for general critical care admissions following elective surgery had been developed and approved by a multidisciplinary team. This included communication between critical care and surgical teams, at what point to consider cancelling procedures and who would make that decision. Patients were now given an earlier warning of cancellations.

## Access and flow

- The general critical care unit and the neurological unit were unable to provide a responsive service at all times, due to the poor flow of patients through the Princess Royal Hospital and elsewhere in the trust, should they need to be transferred. The units were operating at almost full capacity at all times. The issues had been raised through incident reporting and with the leadership of the trust. Consultants and nursing staff said the situation was putting patients who were not able to access the units at risk. The outreach team were supporting patients, where possible, but they were not available after 8pm or before 8am (although this was

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being increased to full-time provision in 2014). Staff reported better communication with the clinical site managers regarding discharges from critical care, but the situation remained unacceptable.

- Too many patients were being discharged from the unit at night or their discharges were delayed in both units, due to a lack of ward beds. Studies have shown discharge at night can:
  - Increase mortality risk.
  - Disorientate and create stress for patients.
  - Be detrimental to the handover of the patient.
- Delayed discharges restricted new patients from being admitted and could result in cancelled elective surgery.

## Meeting people's individual needs

- Equality and diversity were considered. Staff had been trained to recognise and support people with different needs. Each unit had an equality and diversity 'Red Box'. This was a resource for staff and patients about various different strands of equality and diversity. The box we looked at included information on vision and hearing impairment, the Mental Capacity Act 2005, sexual orientation, interpreter services, learning disabilities, different religions and faiths – including a comprehensive guide to supporting patients from the Muslim faith, produced by the Sussex Muslim Society, guidance for supporting older people and the trust equality bulletin. All the information was current and some was offered in different languages. One nurse told us staff wanted the outcomes for people to be as good as possible, but this sometimes meant the inputs into care were different, in order to take into account different needs.
- There were translation services available. There were leaflets available in a range of languages. Staff could use a telephone translation service that we were told was available on short notice. Staff who had used it said it was excellent. The unit was able to arrange face-to-face translation with appropriate notice.
- The trust had staff who were experienced in supporting patients with learning disabilities. The units were able to access specialist staff for advice. Carers and relatives were also encouraged to attend the unit and provide advice and support. Care workers and families were encouraged to visit the units in order to offer advice and guidance.
- There were pathways of care for people with dementia. The unit followed the trust's pathways known as the

Butterfly Scheme. Staff said they could access support from the Princess Royal Hospital's specialist nurse and the unit had a link nurse who had a wider knowledge of dementia and how to provide the right care for confused patients.

## Learning from complaints and concerns

- Complaints were addressed and changes made, if required. The unit did not receive many complaints. The general critical care had only had four in the period February 2013 to January-2014, which was one of the lowest divisional rates in the trust. The neurological unit had 26 in the same period, which was also comparatively low. People who had complaints were directed to the Patient Advice and Liaison Service, or could talk with the matron or a senior member of staff. The neurological nursing staff said a recent complaint about visiting hours had resulted in them being reviewed and made more flexible.

## Are critical care services well-led?

Good



The critical care teams were motivated and supported groups. The medical and nursing leadership were strong and well-respected both within and outside of the departments. There were good governance arrangements for auditing and monitoring services. Staff learned from things that did not go well, and celebrated and recognised success.

There was a duty of candour among staff in critical care services and risks, problems and emerging concerns would be escalated to senior management without hesitation. The values and behaviours of the staff at local level were known and understood and staff had contributed to the wider search for a new set of values and behaviours at a trust-wide level.

## Vision and strategy for this service

- The general critical care leadership team reflected the requirement to deliver safe, effective, caring, responsive and well-led care and treatment. The matrons, nurse service managers and consultant clinical lead were committed to their patients, staff and units. Nursing staff

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team leaders were well supported and well respected by their own teams. All staff we met were committed to high quality, compassionate and safe care and treatment.

- The matron for the general unit, which included the general unit in the Royal Sussex County Hospital, was a strong and respected presence. However, the post was an interim role and had been for the past 12 months. No decision had been made at divisional level about this role being substantive.
- There was a plan to increase the size of the general critical care unit. A four-bed extension to the service was planned for 2015 to meet the needs of post-operative patients. The neurological unit was moving to the Royal Sussex County Hospital in autumn 2014 and it was understood by all concerned that this would need to be well-managed. There had been extensive plans and consultation about the move, but some areas were still to be resolved.

## Governance, risk management and quality measurement

- The general critical care units had a consultant leading on clinical governance. The units collected, analysed and audited a range of information. This included risks, safety and quality indicators. There was a weekly leadership meeting on the general unit each Monday morning and a monthly safety, quality and performance (SQP) meeting, which fed into a divisional SQP meeting held twice each month. We reviewed the standing agenda for the general unit SQP meeting and the presentation from the April 2014 meeting. Key themes, risks, quality and safety were highlighted and discussed. This included actions already taken to address the concerns and challenges and what risks had been elevated to the trust risk register. The general unit knew where its key risks and challenges were and this were clearly articulated. The minutes of the meetings were forwarded also the trust chief nurse.
- There were quality meetings held each quarter with the emergency department and general intensive care unit, to share experiences, discuss incidents and look for mutual improvements to services.
- Not all staff felt they had access to governance meetings. A doctor we spoke with on the neurological unit said not all medical staff got to attend governance meetings, even on an occasional basis.

## Leadership of service

- Leadership of both the critical care units was strong. Staff we met at all levels said they were well-supported and had clear reporting responsibilities to their managers and staff reporting to them. Nursing staff commented on how there was not a great deal of interaction between the general and neurological units. They thought better cooperation between nursing staff would have led to each seeing the issues for the other more clearly and empathetically.
- The general unit had planned away days for senior staff, which included the matron, clinical lead and service manager. The neurological unit had 360° feedback for senior staff. The matron of the neurological unit said they had “a fantastic team that do a fantastic job in the facilities we’ve got”.
- The leadership of the service covered both the general critical care unit at the Princess Royal Hospital in Haywards Heath and the unit at Royal Sussex County Hospital in Brighton. The matron and lead consultant managed both services and were in regular attendance. All but four of the consultant staff worked across both sites. This enabled a shared commitment to the same visions and values. Staff at both units spoke of their colleagues in the other unit and were knowledgeable about their strengths and challenges.
- The financial situation of the general unit was discussed in performance meetings. Staff were, therefore, aware of how they contributed to the financial position of the hospital and their unit and where over or underperformance affected finances.

## Culture within the service

- Some staff we spoke with knew of and supported the trust’s values and behaviours project. A number had been involved with the working groups.
- Some senior trust staff were visible to staff in the units. The chief executive officer (who had been in post for a year) and the chief nurse were respected within the service for their openness and support. Most staff had met with them, seen them or were aware of their visits to the department.
- Staff were committed to working within critical care. The staff we met had all elected to work in the discipline of critical care and were looking to increase and develop their skills, as time and funding allowed.
- Openness and honesty was expected and encouraged within the department. Staff told us their managers

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always had time to listen and gave guidance, advice and support. We were told the nurse service manager (or nurse in charge) of the general unit was “very helpful” and “a good role model”. The matron and nurses in charge of the neurological unit were said to be “caring” and “dedicated to the department and the patients”.

## Public and staff engagement

- Staff were recognised for their abilities and contribution. Band 5 nurses, for example, were fast-tracked as much as possible for promotion to higher grades.
- All staff we met said they had a voice and that their opinions were valued and heard. There were staff meetings with minutes and actions produced. There was good attendance at the previous four meetings. The minutes, for example, asked staff to ensure they were aware of the trust’s values and behaviours project, where general communications were placed, requested staff to ensure patient information was secure at all times and gave new information about procedures and equipment. Nursing staff in the neurological unit said







they found it hard to broaden their horizons and there was limited time available to read all the trust information as well as trying to learn or investigate new skills and practices.

- Due to the nature of critical care units, members of the public generally did not engage with staff on, for example, service design. However, the general unit did survey relatives and ask their opinion on the care and respect shown to the patient and to them.

## Innovation, improvement and sustainability

- As part of the trust’s status as a major trauma centre, the critical care service will be evolving and changing in 2014 with the relocation of the neurological service from Haywards Heath and an increase in bed numbers in 2015 for the general unit from eight to 12 to accommodate increases in urology and orthopaedic surgery. Staff have been concentrating on the neurological service move for some time and have had little time or energy, due to access to service issues, to focus on other plans for innovation, improvement and sustainability.

# Maternity and family planning

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

## Information about the service

Princess Royal Hospital provides an antenatal department with a day assessment unit, eight (mostly en-suite) labour rooms, three of which have birthing pools, an emergency operating theatre and recovery facilities. There is a mixed ante and postnatal ward (Bolney Ward) with 25 beds that included a 24 hour triage system. There is a neonatal special care baby unit on-site. If a woman is likely to deliver her baby before 34 weeks gestation, she will be transferred to the Royal Sussex County Hospital in Brighton, where there is a neonatal intensive care unit (the Trevor Mann Baby Unit). The gynaecology department provides a 12-bed ward (Horsted Keynes Ward) for elective surgery, outpatient clinics and an early pregnancy unit (EPU – open three days a week).

There are around 2,300 births a year. Medical cover is provided by 16 (a mix of full-time and part time) consultants and their teams. Midwives and specialist midwives offer a range of specialist services and are supported by maternity support workers, nursery nurses and a team of ancillary staff. Some of the medical and midwifery staff also work at the Royal Sussex County Hospital run by the trust.

Community services are provided by three teams of community midwives and cover the whole Brighton and Sussex University Hospitals NHS Trust community area. Antenatal care, parent craft and postnatal clinics are provided in 12 children's centres throughout the area.

Women are able to access specialist midwifery services in the community from a midwife specialising in teenage pregnancies and a midwife specialising in substance misuse and homelessness.

The trust have level 2 UNICEF Baby Friendly initiative status and are aiming to achieve level 3 by late 2014.

The trust reported a Never Event in March 2013. A full investigation was carried out and findings and an action plan were shared with the women's division Quality and Safety Committee.



# Maternity and family planning

## Summary of findings

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## Are maternity and family planning services safe?

Requires improvement



Culture is impacting on safety lack of MDT approach

Midwifery levels were sufficient to provide a safe service throughout the obstetrics and gynaecology (O&G) departments. Sickness levels amongst midwives were higher than in other areas of the trust and above the England average.

Some staff told us they were often afraid of reporting incidences for fear of grievances being taken up against them by staff that may have been involved in the incident report. Some medical staff reported difficult working relationships with the midwifery management team and some of the midwives, who they said did not treat them with respect. All staff who spoke to us were worried that, as a result, lessons were not always learnt and practice moved forward, as required.

Some doctors reported tensions in the consultant group and said that some people were not engaged in the multidisciplinary approach to a woman's care.

Consultants were not always able to be reached by pager when on-call, meaning the more junior medical staff did not always get the support required when dealing with complex or difficult situations.

We saw staff and visitors using good hand hygiene procedures throughout the departments we visited.

The trust risk register stated that there was no replacement programme in maternity for some essential equipment. This had been an issue since 2009 and in January 2014 the equipment replacement programme was still being reviewed.

Specialist pathways were in place for high-risk women who had diabetes or epilepsy, for example. There was no pathway in place for maternal request caesarean section, which meant there was no mechanism in place for questioning the decision.

The trust had a higher elective caesarean section (England 10.7% - trust 13.2%), emergency caesarean section (England 14.6% - trust 15.4%) and instrumental delivery

# Maternity and family planning

(England 5.9% - trust 8.0%) rate compared to the England average. The trust had developed a service improvement plan for increasing the proportion of normal births that includes implementation of midwife-led pathways

## Incidents

- There was a Never Event reported in March 2013 that was thoroughly investigated and systems put in place to prevent recurrence. A Never Event is a serious incident that should be avoided if systems work as required. The report and action plan was shared with the women's division Quality and Safety Committee and the patient safety team, meaning that improved practice will continue to be monitored.
- The unit reported ten moderate patient safety incidents between March 2013 and March 2014.
- Midwifery staff were clear about incidents that required immediate escalation to the senior obstetrician and midwifery manager on-call, such as maternal death or a baby born in a poor condition.
- We were given an example of lessons learnt locally, following an incident where a woman missed having an anti-D injection. Systems were changed in order to ensure the same problem could not happen again. It was felt the changes had been embedded in practice.
- Nursing and midwifery staff felt there was good feedback following serious untoward incident investigations.
- Many staff that we spoke with reported that they were often afraid of reporting incidents, for fear of grievances being taken up against them by staff that may have been implicated in the incident report. They were worried that, as a result, lessons were not always learnt and practice did not move forward, as required.
- We spoke to the community manager, who told us the community midwifery service used the online reporting tool. Staff we spoke to told us they were able to use the system and knew how to report incidents to their line manager. We were told there was an average of two incidents a week, which usually related to dog bites or blood tests not being followed up.
- Currently 6% of women gave birth at home and we were told 90% of home births were low-risk. We were told there were always two midwives present when birth was imminent, to ensure good outcomes. All community midwives take part in the home birth service. The home

birth community midwife is based in the hospital at night and goes to the home birth when required ensuring that the labour ward coordinator is aware of where she is going.

- Fully equipped pool cars were in close proximity to the maternity unit to ensure rapid response to home birth. We were told that there was a transfer rate of 1-2% to the maternity units at Brighton and Sussex United Hospitals and Princess Royal Hospital.
- We were told any women who were identified as being high risk were identified on the shared drive computer system, which was overseen by the midwifery supervisors.

## Safety thermometer

- We saw incidents of new venous thromboembolism's (VTE), urinary catheters and urinary tract infections (UTI) were reported via the Safety Thermometer system. Although the trust rates for VTE and UTI were consistently above the England average, the results were not specifically attributed to the obstetrics and gynaecology (O&G) departments. We saw feedback from Safety Thermometer results displayed on many of the units we visited.

## Cleanliness, infection control and hygiene

- Incidents of infection were reported as required.
- Specialist midwives are involved in screening women with more complex needs such as drug and alcohol abuse. They ensured infection control practices were in place and reported any infection control risks to the appropriate teams.
- MRSA incidences in the trust were higher than the accepted range and C. difficile rates were within an acceptable range. No cases had occurred in the O&G units category.
- We saw most staff observing good hand hygiene practices and using gloves and aprons where necessary. There were hand-washing sinks available throughout the departments with liquid soap, paper towels and pedal bins at each one.
- Liquid hand sanitising gel and notices encouraging its use were displayed at the entrances to all of the O&G departments.
- Hand hygiene audit results were displayed in most of the areas we visited.
- We saw midwifery and medical staff adhering to the 'bare below the elbows' policy.

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- We saw evidence that all community midwives and support workers had received infection control training.
- We were told that, although the external company that provide cleaning services had scored 97% in cleaning audits of the antenatal unit, on occasion, staff felt that the antenatal unit was not sufficiently clean and had to call the cleaning team to reassess the cleanliness of the unit. The situation was ongoing at the time of the inspection.

## Environment and equipment

- Resuscitation equipment, monitoring equipment and ultrasound scanning equipment was regularly serviced and checked for expiry dates. There were some gaps in equipment testing and recording on the gynaecology ward.
- Staff reported that they had access to sufficient equipment in all departments.
- The community manager told us that all equipment used by the community midwives was checked daily to ensure it was fit for purpose. We were told that homebirth bags and satellite navigation systems were in place in three pool cars.
- The trust risk register stated that there was no replacement programme in maternity for some essential equipment. This had been an issue since 2009 and in January 2014, the equipment replacement programme was still being reviewed, with no confirmation on when replacements would be made.
- The trust risk register stated that ultrasound equipment was outdated and in urgent need of replacement. The equipment was on the capital replacement programme 2013/14 as high risk and has not yet been replaced, which could result in poor imaging and the potential to miss foetal abnormality. Funding had been allocated (in March 2014) and the process of securing new equipment was underway. The equipment had not been replaced at the time of the inspection in May 2014.
- The environment was clean and tidy, with a lot of natural light. There was a security system in place on the labour ward and postnatal ward, to ensure that staff knew who was accessing the units. It was easy for patients to move between the O&G departments. Signage was clear and lifts were available.

## Medicines

- Medical gases and medicines were stored securely, according to trust policies.

- We saw midwives checking medicines appropriately, before dispensing them to a patient.
- There had been two drug errors made on the gynaecology ward in the past 12 months. The pharmacist had been informed and additional training and support had been implemented to prevent further occurrences.

## Records

- Pregnant woman had handheld records that they kept with them and took to every antenatal appointment. We looked at three sets. They were well organised, detailed and included contact details if people needed advice.
- There were systems in place for when information needed to be shared between internal and external bodies. For example, password protected documents.
- There were some gaps in the recording of routine observations of blood pressure and pulse on the gynaecology ward.

## Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- We saw appropriate consent forms had been signed by patients to agree to specific tests and surgical procedures in all of the departments we visited.
- Midwifery staff we spoke with showed a good understanding of the Mental Capacity Act 2005 and its relation to decision making in the antenatal, labour and postnatal period.
- We saw records that showed all midwives and support staff had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- We did not see any reference to the Mental Capacity Act 2005 on the obstetrics and gynaecology department induction programme. The trust Mental Capacity Act 2005 policy (November 2013) stated that all medical staff had to undergo Mental Capacity Act 2005 training at least once. It stated that e-learning was available via the learning and development team.
- We saw that some perinatal mortality post-mortem consent forms had not always been completed properly. This meant that they were returned to the unit and the patient had to be called back in to complete more of the form. We were told that staff had been trained in how to complete the forms properly. We saw from the doctor's induction programme from April 2014, that the bereavement midwife presented a session on post-mortem consenting.

# Maternity and family planning

## Safeguarding

- Midwifery and nursing staff were aware of adult safeguarding and child protection reporting systems within the trust.
- The trust had an effective system for 'flagging' an at risk woman during her pregnancy, labour and in the postnatal period. There were specialist midwives involved in safeguarding cases. We saw good communication between hospital-based staff and community midwives around at risk women.
- The safeguarding midwife had a slot about child protection issues and training on the obstetrics and gynaecology department induction programme for new intakes of doctors.

## Mandatory training

- Staff on the maternity units reported, and records confirmed, that staff were able to attend mandatory training sessions. Records showed that not all staff on the gynaecology unit had completed their mandatory training. For example, in safeguarding adults, manual handling and basic life support.

## Management of deteriorating patients

- Obstetric early warning scores were in place and staff knew what to look for and how to report any concerns they may have had. We saw that completed charts and repeated observations had taken place in the required time frames.
- We saw the 'Unexpected Situations and Emergencies During Home birth' flowcharts were in place. For example: breech, neonatal resuscitation and postpartum haemorrhage.

## Midwifery staffing

- Staffing was based on the dependency of the patients using the services. On the labour suite, two new birthing pools had recently been installed and, as a result, the number of midwives had been increased. Nursery nurses were on duty 24 hours a day to provide support to postnatal women.
- Handovers were held at every shift change. There were handovers between medical staff on the labour suite, which were detailed and described concerns.
- The midwife to birth ratio was 1:30. This was not always seen as adequate by midwives. Royal College of Midwives (RCM) latest advice says there should be an average midwife to birth ratio of 1:28 births.

- There was an appropriate mix of midwives, specialist midwives, maternity support workers and nursery nurses on the obstetric departments. Staff on the obstetric wards worked 12 hour shifts and felt that was helpful, in terms of continuity, for patients. There was a mix of midwives, trained nurses and healthcare assistants in the gynaecology clinics and on the ward. Staff reported that staffing levels had been low recently, but that two new staff had been employed and would soon be in post.
- There was limited use of agency and bank staff throughout the O&G departments. All bank and agency staff has been subject to the trust's own induction and recruitment processes.
- Sickness levels were higher than other areas in the trust, at 5% – higher than the England average of 4.3%. Staff told us they often felt under pressure, due to perceived poor working relationships between staff groups.
- The community manager told us there were no vacancies across the community team and the turnover was low. We were told there was a midwifery bank to call on from both the community midwifery team and the acute maternity units at both hospitals. We were told that the recruitment processes were slow and could take up to three months from a midwife being recruited to starting in post.

## Medical staffing

- There were 16 consultants (not all full-time) working in O&G. Some worked across both of the trust's sites. They are supported by registrars, junior doctors and F1 doctors. It was reported to the inspection team that not all consultants were willing to carry pagers when on-call, meaning they were not always available to support members of the medical team at all times. On the day we visited Princess Royal Hospital, we met the locum consultant on duty.
- Locum doctors were used in the O&G department. We were told that the same locums were used in order to provide some consistency. Locums told us they felt supported by the medical and nursing staff. They said they had received the trust's induction training and had access to statutory training.
- Some doctors reported tensions in the consultant group and said some were not engaged in the multidisciplinary approach to a woman's care. They reported it was worse when consultants from both sites had to meet together.

# Maternity and family planning

- There was 24 hour medical cover for the ante and postnatal ward (Bolney Ward), the labour suite, post and the gynaecology ward (Horsted Keynes Ward).
- Staff on the gynaecology ward reported that not all patients were routinely reviewed by a consultant on a daily basis, due to the infrequent availability of the consultants.

## Major incident awareness and training

- The trust had a major incident escalation plan for business continuity. Senior staff told us that there were protocols to follow when issues needed escalating and a list of people to whom the incidents needed to be referred.
- Staff had some knowledge of what constituted a major incident. They said they would report any issues to their line manager and work with them, as required.
- We saw records that showed community staff had completed fire awareness training..

## Are maternity and family planning services effective?

Requires improvement



Guidelines and policies were written in line with national guidance and best practice recommendations.

The ability to carry out frenulotomy on-site, before discharge, meant babies could learn how to breastfeed effectively more quickly than if they had to come back to the Princess Royal Hospital for the procedure.

The trust had a higher than expected elective and emergency caesarean section and instrumental delivery rate than the England average. The trust had a draft maternity service improvement plan designed to increase the proportion of normal births in order to reduce these higher rates.

The O&G unit had a research midwife who is involved in national research projects. They was also a specialist midwife who had won a national award and spoke on national study days about her area of expertise.

The gynaecology ward often had outliers from other specialities, which meant planned gynaecology operations sometimes had to be cancelled.

Multidisciplinary working was reported as being poor between some consultants and the rest of the teams with poor attendance at multidisciplinary team meetings.

There was medical support available 24 hours a day. Some consultants were unwilling to carry a pager, so were not always available to other members of the medical team who needed advice.

We were told that one consultant was always late for planned antenatal clinics, meaning that women sometimes had to wait for over two hours for their appointment. This had been reported via the incident reporting system and has been happening for over a year.

## Evidence-based care and treatment

- The O&G unit used nationally recognised guidelines, such as: 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour'.
- Staff were updated about new policies and procedures at their respective departmental meetings and where appropriate via the Maternity Liaison Services Committee which contributes in the development of these.
- Specialist pathways were in place for high-risk women who had diabetes or epilepsy, for example. There was no pathway in place for maternal request caesarean section, which meant there was no mechanism for questioning the decision.
- The gynaecology ward used the enhanced recovery programme. This was because research suggests if a patient gets out of bed as soon as possible and eats and drinks as soon as possible, their recovery from an operation is quicker and complications less likely to develop. The ward works with women to encourage them in this approach and there are leaflets available that are relevant to the operation a women is having.
- We saw evidence of NICE guidance in place for 'Best Practice for Teenagers in Care 2010'.
- The community maternity service covers 56 clinical bases, 41 GP surgeries, three health centres and 12 children's centres. The level of IT connectivity across all of the clinical bases was variable and impacted on the midwives abilities to review blood results in a timely way, book clinic appointments and review incidents and governance reports.
- The IT difficulties were increased in areas where GPs no longer wanted midwives based in their surgeries.



# Maternity and family planning

## Pain relief

- Epidural and pain relief such as ENTONOX® and Pethidine were available throughout labour. There were three birthing pools that midwives reported were well-used and helped relieve pain for some women.

## Nutrition and hydration

- There were midwives, maternity support workers and nursery nurses available at all times to help new mothers with feeding their babies.
- Women were encouraged to breastfeed and there were specialist midwives available and advice displayed to help new mothers. The trust's breastfeeding policy was last updated in April 2013. There was a feeding room available 24 hours a day.
- We were told that four midwives in the trust were trained to carry out frenulotomy (release of tongue-tie) on babies on the post natal ward. This meant that babies could learn to breastfeed effectively more quickly.
- Women told us that there always fresh water available and it was topped up regularly, especially during their labour. Women told us that the food they had throughout their stay was good and freely available.

## Patient outcomes

- There were no reported maternity outliers for the trust.
- The trust used the 11 Royal College of Obstetricians and Gynaecologists indicators set out in the Patterns of Maternity Care in English NHS Hospitals guide to help develop and improve pathways available to women. The trust had not developed fully all the suggested pathways.
- There were 107 maternal readmissions between October 2012 and September 2013, across the trust. This is below the expected 132.5 number for England.
- The trust had a higher elective caesarean section (England 10.7% - trust 13.2%), emergency caesarean section (England 14.6% - trust 15.4%) and instrumental delivery (England 5.9% - trust 8.0%) rate compared to the England average. The trust had developed a service improvement plan for increasing the proportion of normal births, which included implementation of midwife-led pathways. Guidance for indication for caesarean section for medical and non medical reasons was in place.

- In the last quarter of 2013, there were 1,475 deliveries across the trust. This was a rise on the previous two quarters and was taken into account when looking at staffing levels on the labour suite.
- There were 1,021 emergency caesarean sections, higher than the expected England average of 997.5. There were 876 elective caesarean sections, also higher than the expected England average of 782.5. The trust had a draft maternity service improvement plan designed to increase the proportion of normal births, in order to reduce the higher rates of caesarean sections and instrumental deliveries. The plan included midwife-led pathways and development of a multidisciplinary working party.
- The trust actively encouraged vaginal birth after caesarean section (VBAC). Midwives told us the success rate was good and continuing to improve.
- The Princess Royal Hospital has a Special Care Baby Unit (SCBU). The neonatal readmission rate for the trust between October 2012 and September 2013 was 310 compared to the expected England number of 279.6%.
- There were no reported unplanned maternal admissions to the critical care unit.

## Competent staff

- Staff reported they received appraisals regularly. Midwives reported good access to their supervisor of midwives. Supervisors of midwives told us they had access to training to ensure their ongoing competency.
- Medical appraisal and revalidation rates for the women's and children division were at 96%, as of 28 February 2014.
- The trust had a specialist midwife who worked with women who have alcohol problems, the travelling community and the homeless. She had won a national award and gave talks on national study days about foetal alcohol spectrum disorders and had contributed to research on the antenatal care of the travelling community.

## Facilities

- Some areas of the gynaecology service reported limited space for storage of equipment.
- The day assessment unit had two bays with curtains that provided some privacy. The unit was cordoned off from the main antenatal clinic area was not very private. The midwife running the unit said having the radio on in the antenatal clinic helped as her conversations with people were not then easily overheard.



# Maternity and family planning

- Seven of the single rooms on Bolney Ward could not be used to look after high-risk women, as the staff were not able to move the beds from the rooms in case of emergency, due to the shape of the rooms and the size of the door opening.

## Multidisciplinary working

- Multidisciplinary working was reported as being poor between some consultants and the rest of the teams. Poor attendance at some multidisciplinary team meetings was reported.
- Multidisciplinary team working between sites with community midwives, McMillan nurses and community nurses was good and meant that women were discharged and supported appropriately.
- Communication with the community maternity team was reported as being very good, resulting in effective discharges.
- We saw systems in place for communication with GPs for both the ante and postnatal periods.
- The Princess Royal Hospital had a neonatal special care baby unit catering for babies born after 34 weeks of gestation. Women expected to deliver their baby prior to 34 weeks would be looked after at the Royal Sussex County Hospital where there was a neonatal intensive care unit.

## Seven-day services

- Midwife and support staff cover remained consistent throughout the week, 24/7.
- There was consultant cover 24 hours a day, seven days a week with 40 hours labour ward cover and 24 hour on call, accessible to the gynaecology ward as required.
- Some midwives and medical staff reported that not all consultants were happy to carry a pager and so medical staff did not always get the support they needed.
- Midwives told us there was 24 hour pharmacy support.

## Are maternity and family planning services caring?

Good



Staff were compassionate and caring on the obstetrics and gynaecology units. Women and their families told us they felt involved in their care and well-informed. Specialist midwifery advice and emotional support was good.

## Compassionate care

- The NHS Friends and Family Test for maternity started in October 2013. There was a 25% response rate on average. Overall, the majority of respondents would be 'extremely likely' or 'likely' to recommend the Princess Royal Hospital.
- The CQC maternity survey results for 2013 showed that under 'care during labour and birth', 'staff during labour and birth' and 'care in hospital after birth', the trust was performing the same as other trusts nationally. The trust performed better than other trusts around partners being able to be involved as much as they wanted during labour and birth.
- Patients we spoke to across all departments were happy with the care and support they had received. One patient said, "We are satisfied with the care, food and information we have been given. The staff, [both] nursing and medical, have been very caring." Another said staff were, "very friendly" and, "Excellent nursing from [the nurse] yesterday." Women told us they had one-to-one care while they were in labour.
- We were told by a client who had accessed one of the children's centres: "Getting into the system was easy and I feel very well informed." We saw information was given to the client about the website where women can access a range of information leaflets. We observed the midwife was reassuring in their approach and gave the client specific information regarding their pregnancy, antenatal classes and the availability of midwifery contacts.

## Patient understanding and involvement

- Women we spoke with told us they felt involved with, and fully informed about, their care. They had patient handheld records that detailed all the care and support received before and after pregnancy. These included contact details should the woman require any advice or help.
- Nursing and midwifery staff wore name badges. Staff told us patients liked to know the staff names and found it easy to distinguish between the different staff groups.
- The Maternity Liaison Services Committee met on alternate months. Parent representatives on the committee visited the departments regularly to seek the views of women using the services.

# Maternity and family planning

- We saw a midwife complete a risk assessment for a woman who was expecting twins. The midwife also made a referral to hospital for a hospital delivery, as a home birth would not be appropriate due to the increased risks associated with a multiple pregnancy.

## Emotional support

- There was a specialist bereavement midwife and bereavement service that won a Sussex compassion award in the past. There was also a bereavement support group that met regularly.
- The postnatal ward manager told us they had good working relationships with the community midwives and local GPs, so felt they were able to handover any concerns they may have about a woman's wellbeing on discharge.
- We observed a midwife comforting a woman whose baby had spent some time on the special care baby unit. She offered practical advice and spent time with her.

## Are maternity and family planning services responsive?

Good



The O&G department has responded to patients needs and has improved the options available to women with the introduction of 24-hour triage, increased hours in the day assessment unit and more birthing pools on the labour ward.

The gynaecology ward often had outliers from other wards and, as a result, gynaecology operating lists had been cancelled.

Workforce planning was ongoing, but specialist services were not always covered when the specialist was on leave or sick.

Women were seen within expected timescales from antenatal through to postnatal. There was 24-hour medical cover, although a consultant was not always available on the labour ward.

There was good access to translation services and learning disability services. There was level access to shower facilities on Bolney and Horsted Keynes Ward.

Formal complaints were dealt with using the trust's policy. There was information about how to contact the Patient Advise and Liaison Service. There was a feeling amongst staff groups that the lack of engagement by some of the consultants, managers and midwives around complaints reviewing or incident reporting meant that lessons were not being learnt and, as a result, improvement to practice did not always happen in a timely fashion.

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

- The obstetrics unit had introduced 24-hour triage service and a day assessment unit, which are both very successful. We were told that this had reduced the amount of admissions to the unit, thereby improving flow. The trust was committed to increasing the proportion of normal births and was aiming to have a midwife-led birth unit which should, in turn, reduce the length of stay for women.
- Managers told us workforce-planning was in place and they knew in the near future, due to pregnancies in the staff group, they were going to have some short-term vacancies and had already started work on filling those vacancies.
- Some specialist services, such as screening services, did not always have cover arranged for planned or unplanned absences.
- There was a part-time antenatal screening coordinator at the Princess Royal Hospital.

## Access and flow

- The gynaecology ward used the enhanced recovery programme. This is because research suggests if a patient gets out of bed and eats and drinks as soon as possible, their recovery from an operation is quicker and complications are less likely to develop. The ward worked with women to encourage them in this approach and there were leaflets available that were relevant to the operation a woman is having.
- Low capacity on some of the general surgical wards meant that the gynaecology ward often had outliers from other wards. Sometimes gynaecological patients were on other wards waiting for a bed on the gynaecology ward. This meant that occasionally gynaecology operating lists had been cancelled.
- Bed occupancy across the trust for the maternity services between October 2013 and December 2013 was 75.1 % compared to the England average of 58.6%.

# Maternity and family planning

- The head of midwifery met with the risk manager every two weeks to discuss capacity issues that might affect the smooth transition of a woman from labour ward to postnatal ward. Outliers on the gynaecological ward meant operating lists may have been cancelled, with women having to wait longer for their surgery.
- Women were seen within expected timescales from antenatal through to postnatal. Some women had to wait two hours past their appointment time, because their consultant was consistently late for the start of the planned clinic.
- The home birth service was restarted in May 2013 with a new working pattern for midwives and additional resources and has seen an increase in the home birth rate from around 3% to 6%. We were told that it was unlikely the home birth rate would increase above 10%, as the trust does not have a midwifery-led unit. A business case has been developed for a midwifery-led unit, but the outcome is not yet known.
- The midwife worked closely with the safeguarding nurse for maternity services and completed detailed risk assessments in partnership with the safeguarding team, social services and the children's nurses who are linked to the health-visiting service.
- The aim of the service is to promote a normal birth by providing young women with a comprehensive package of care that promotes the normality of child birth.
- The specialist midwife for substance misuse, the homeless and travellers told us that travellers in the local area knew there was a midwifery service they could access. Currently, there were 20 travellers who had self-referred themselves for care to the specialist midwife. We were told one stop clinics had been put in place to provide a flexible and responsive service to the travellers and clinics were provided on both hospital sites.

## Meeting people's individual needs

- There was good access to translation services via Sussex Interpreting Services. Staff told us the service responded quickly to their requests.
- For women who had a learning disability (LD), a plan would be developed during the antenatal or preoperative period and support and advice gained from their current LD team, if they had one, or the trust's own LD service, if required.
- The acute gynaecology pro forma included a 'brief dementia diagnostic assessment', to be completed for all emergency admissions of patients aged 75 years or more. This was to be filled out within 72 hours of admission. The form advises staff as to what actions to take. For example: follow the Brighton and Sussex United Hospitals NHS Trust dementia pathway (available via the intranet) or complete a formal assessment tool and add to the notes.
- We spoke to the specialist midwife, who provides the teenage pregnancy service for a case load of 30 to 40 young women each year. We were told that, although the national rate of teenage pregnancy is reducing, the level of complexity has increased. Within the Brighton and Hove area there is a high level of deprivation, domestic abuse and substance misuse.

## Learning from complaints and concerns

- There was a feeling amongst nursing, midwifery staff and managers that, due to lack of engagement from some of the consultants around complaints and the review of incident reporting, lessons were not being learnt and improvements did not always happen in a timely fashion.
- All formal complaints were dealt with using the trust's internal policy. Staff told us informal complaints would be directed to the person in charge at the time. If they were not able to deal with the issue, we were told patients were advised of the Patient Advice and Liaison Service. We saw information about how to contact the Patient Advice and Liaison Service on the units we visited.

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

Requires improvement

Leadership requires improvement.

This department has serious on going cultural issues which has affected patient safety and staff sickness. There was a lack of leadership amongst a small group of consultant staff, for example consultants not willing to hold a pager

# Maternity and family planning

and not attending key meetings. There was a high level of grievances. Senior managers have struggled to address these issues but the trust now has the services of an external agency to help address this.

There was some concern among staff that not all incidents were being reported, due to the culture in the service within and between some staff groups and, as a result, improvements may not have taken place.

The O&G had an organised governance programme and risk management procedures in place.

Despite the above staff reported good leadership of clinical care within the O&G departments. They had good feedback from their line managers and felt they could approach them about issues. There was a lot of respect for each other within the nursing and midwifery teams, who were committed to providing good services, which met the needs of the local population.

Engagement with the public and staff was ongoing and we saw evidence that the departments reacted well to comments and suggestions.

## Vision and strategy for this service

- We were told of plans to increase the ratio of normal births with the hope that the number of caesarean sections would fall in line with national rates.
- There were plans to increase the midwife-led pathways for 'vaginal delivery after caesarean section' breech, low-risk twins and obesity. Women who had a previous caesarean section were being actively offered a 'vaginal birth after caesarean section' (VBAC) option at VBAC clinics. The current uptake rate was 58%. The trust is aiming to introduce midwife-led pathways for VBAC with the aim of 75% uptake.

## Governance, risk management and quality measurement

- The O&G service had a risk team who received all the information reported via the incident reporting system. These were discussed at governance meetings. We were told that some consultants did not attend the governance meetings they were invited to. Due to the disengagement of a group of consultants, it was reported that there was limited shared vision working or learning.
- There were regular governance meetings, including the supervisor of midwives, the Maternity Services Liaison Committee, perinatal and morbidity meetings,

maternity audit and protocol meetings. The trust risk register had entries relating to the O&G units. These were known about within the unit and reviewed regularly in order to provide feedback on actions taken.

- Managers told us they thought there was a robust audit cycle.

## Leadership of service

- Staff reported good clinical leadership within the O&G departments. They had good feedback from their line managers and felt they could approach them about issues. They felt the management were powerless to deal with the issues of culture and harassment that existed within a small group of staff.
- Staff were aware of who the chief executive and chief nurse were and said they were both very approachable.
- During our visits to midwife community bases, we observed there was strong local leadership in place and noted the community midwifery service was incorporated into the midwifery governance framework. We saw documentary evidence of the fact that all staff had completed appraisals and attended midwifery supervision sessions.

## Culture within the service

- Staff were aware of the values and behaviours work going on throughout the trust to encourage staff to respect and support each other and work together to strive for excellence. Some staff told us it would make no difference to the problems within the O&G units.
- There was a lot of respect within the nursing and midwifery teams. We were told about the difficult issues with the small group of consultants, which has made some working relationships very difficult.
- In order to try to address some of the cultural issues on the O&G unit, the trust had secured the services of an external agency to work with medical staff across the trust. The process started on 23 May 2014.
- Prior to, and during, the inspection, we had a number of concerns raised to us that were related to concerns around the culture and practice of the small group of staff referred to throughout this section of the report. The senior management team were made aware of these issues.
- We were impressed with the enthusiasm and professionalism of the staff, despite a large number of them having concerns about the poor working relationships within the consultant group.

# Maternity and family planning

- Some doctors reported tensions in the consultant group and said some were not engaged in the multidisciplinary approach to a woman's care. They reported it was worse when consultants from both sites had to meet together.

## Public and staff engagement







- The Maternity Services Liaison Committee included a number of parent representatives. They attended the meetings and visited the maternity departments to get feedback from patients and their families.
- The NHS Friends and Family Test survey had a good response within the O&G unit, with mainly positive feedback. The test results were displayed in some units in the department.

- Staff told us they took part in the NHS staff survey. They told us they do get feedback about the results on internal staff surveys.

## Innovation, improvement and sustainability

- Four midwives within the trust were trained to carry out frenulotomy procedures to release a tongue-tie and aid successful breastfeeding.
- There was a feeling amongst the staff, that innovation and improvements did not always happen due to the longstanding issues with the culture in some staff groups.

# Services for children and young people

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

## Information about the service

Our inspection consisted of visiting the SCBU only, since there were no other inpatient services provided to children at the Princess Royal Hospital.

The special care baby unit (SCBU) at the Princess Royal Hospital is designated for babies who do not require intensive care. There are eight cots on the unit, in two nurseries adjacent to each other. The unit is linked with the Trevor Mann Baby Unit (TMBU) at the Royal Sussex County Hospital and staff are rotated between the two sites.

The unit is only one of two units in the UK lead by a team of advanced neonatal nurse practitioners (ANNPs), supported by consultant neonatologists. An ANNP is an autonomous, highly trained specialist nurse. They are trained to care for sick and premature babies. An ANNP can independently prescribe medicines for neonates.

Women who are likely to deliver before 34 weeks gestation, or whose baby is likely to require high dependency or intensive care, are transferred to the Royal Sussex County Hospital. There are facilities at the Princess Royal Hospital for short-term ventilation and stabilisation of babies prior to transfer. Infants requiring short periods of care on continuous positive airway pressure (CPAP) or high-flow nasal cannula (HFNC) are routinely managed at the Princess Royal Hospital.

During 2013, there were 253 babies admitted to the SCBU. 54 of these were born outside of the hospital. 62

admissions, out of a total of 253 were for neonates born at 33-36 weeks gestation. 149 admissions were for neonates born between 37 and 42 weeks gestation. There were a total of 28 twins admitted to the unit during the year.

During 2013 there was an average of 81% cot occupancy.

We spoke with two parents and five members of staff, including: medical, nursing and administrative staff.



# Services for children and young people

## Summary of findings

We found the SCBU to be safe. There were adequate procedures to follow in the event of any incidents or accidents. The unit was clean and staff followed the trust's policies on the prevention and control of infection.

Medicines were managed appropriately and baby records were comprehensive and included appropriate risk assessments.

Nursing and medical (including ANNPs) staffing levels were adequate and there were enough appropriately skilled and experienced staff on duty at all times.

The services for babies on the SCBU were effective. The unit used evidence-based care and treatment and had a clinical audit programme in place.

There was evidence of effective multidisciplinary working and the service operated safely over the seven-day week.

There were procedures in place to ensure competent staff. However, half of the ANNPs had not received an appraisal within the past 12 months. The matron told us that there were plans in place to address this.

Staff were compassionate and provided effective emotional support to parents. Parents were positive about their experience. One person said, "I am 100% satisfied with the care we have received".

Parents were involved in decisions about their baby's care and treatment.

We found services responsive. Service planning and delivery to meet the needs of local people and flow arrangements were in place.

People's individual needs were met and there were effective systems in place to receive and act on feedback from parents.

The service was well-led. All of the staff we spoke with told us that there was a positive culture within the unit and effective leadership.

There were regular safety and governance meetings, as well as effective processes for measuring and ensuring quality standards.

Innovation and sustainability was evident within the unit.

# Services for children and young people

## Are services for children and young people safe?

Good



We found the SCBU to be safe. There were adequate procedures to follow in the event of any incidents or accidents. The unit was clean and staff followed the trust's policies on the prevention and control of infection.

Medicines were managed appropriately and baby records were comprehensive and included appropriate risk assessments.

Nursing and medical (including ANNPs) staffing levels were adequate and there were enough appropriately skilled and experience staff on duty at all times.

### Incidents

- There had been no Never Events between December 2012 and January 2014. There had been no reports of recent serious incidents.
- There was one early neonatal death on the unit in 2013 due to Hypoxic ischaemic encephalopathy (HIE). The baby was transferred to TMBU at the Royal Sussex County Hospital, but later died.
- There was a 'safety trigger' list that instructed staff about when to complete an incident form. These triggers included failure or lack of equipment, poor communication or lack of consent, failure in documentation, and failure of the child protection policy.
- 'Clinical incident triggers' included extravasation injury, facial/nasal damage in relation to CPAP, cross-infection and medication errors.
- We reviewed the information given to us about clinical incidents. The information related to both the TMBU at the Royal Sussex County Hospital, as well as the SCBU at the Princess Royal Hospital. We were not able to distinguish the data between the different sites. The majority of reported incidents were in relation to drugs and prescribing, with the majority of these having 'no harm' for the patient without staff having to receive any additional training.

- The staff we spoke with confirmed that medication errors were the most common reason for incident reporting. They told us that electronic prescribing that had been recently introduced was effective because it reduced the number of medication errors.
- All of the staff we spoke with explained the correct procedure in order to report incidents and said that they felt confident to do so.
- The matron told us that there would be a full investigation if an incident was reported, along with actions to reduce the risk of a repeat occurrence.
- There was a perinatal mortality and morbidity meeting held monthly. This was a joint meeting with staff from obstetrics and gynaecology. There was a quarterly presentation of the neonatal mortality and morbidity review at the neonatal clinical governance meeting.

### Safety thermometer

- The safety thermometer was not used on the SCBU.

### Cleanliness, infection control and hygiene

- During our inspection, we noted that all of the areas in the unit were clean and free from hazards.
- People were instructed to remove their outdoor clothing and wash their hands properly before entering the unit. This was to help facilitate infection prevention and control.
- 'Bare below the elbow' policies were adhered to at all times, in all of the areas we visited.
- The staff we spoke with could explain the trust policies concerning infection prevention and control. There was adequate personal protective equipment (PPE) in all areas. This included aprons, gloves and different coloured waste and laundry bags.
- We found that infection control audits, such as hand hygiene and ward cleanliness were carried out on a regular basis. The results were displayed on the unit. The recent audit for 'cleaning matters' showed a 99.38% in compliance.
- The matron told us that there was no need to have separate isolation facilities on the unit. They said that babies were adequately isolated in their cots, as required.
- We observed the staff regularly washing their hands after contact with a baby. PPE was worn as appropriate.

### Environment and equipment

- The environment within the SCBU was safe.

# Services for children and young people

- Equipment was appropriately checked and cleaned on a regular basis.
- There was adequate medical and resuscitation equipment to help ensure the safety of babies.
- We noted that there were two rooms for families to stay in overnight with their baby in order to help prepare them for their child's discharge.
- There was a designated area for parents and relatives.

## Medicines

- Medicines were stored correctly, in locked cupboards or fridges, when necessary. Fridge temperatures were checked and recorded on a daily basis.
- We looked at the medical administration records for the babies on the unit. All of the required information was detailed, with no gaps in the records. Medicines were clearly written by the medical staff and the advanced neonatal nurse practitioners (ANNPs).
- Nursing staff that were not autonomous prescribers transcribed some medicines using patient group directives (PGDs). We noted that staff had received the appropriate training and the procedure for transcribing medicines had been followed.

## Records

- During our inspection, we reviewed the records for the babies on the unit. We noted that these were detailed and included the appropriate risk assessments in relation to the baby's needs.
- Records were kept securely and were accessible to healthcare staff, as appropriate.

## Consent

- The medical and nursing staff we spoke with told us that they explained all interventions thoroughly to the parents. They said that verbal or written consent was obtained depending on what the intervention was.
- There was information about consent displayed in the information area in the unit.

## Safeguarding

- All of the staff on the unit had received safeguarding training at an appropriate level.
- The staff we spoke with could explain the procedure they would follow if they thought there was a safeguarding concern and said that they felt confident to do this.

- There was information available to the staff regarding domestic violence. This included what actions they should take if they suspected or were informed about domestic violence.
- There was information available to parents and relatives about safeguarding and domestic violence. This included a link to obtain the information in a variety of languages, besides English.

## Mandatory training

- The majority of the staff on the unit were up to date with their mandatory training. There were arrangements in place to ensure all staff would be up to date in the near future.

## Management of deteriorating patients

- There was either a senior doctor or ANNP on duty at all times. This meant that, if a baby deteriorated, there would be a senior person present to assist with the child's care and management.
- A neonatal consultant was on-call at all times and none of the staff reported any difficulties or delays in receiving attention from a consultant.
- We noted that the babies on the unit were appropriately monitored and their vital signs recorded on a regular basis.
- MRI, spiral CT and nuclear medicine investigations were all available, as required.

## Nursing staffing

- SCBU nursing staff numbers were assessed by the use of the British Association of Perinatal Medicine (BAPM) acuity tool.
- We saw evidence that there were the appropriate number of skilled and experienced staff on duty at all times. This ensured that there was a minimum of one nurse to four babies. We noted that there were two nurses on duty each shift and that one of these would be a band 6 nurse, who had completed the neonatal education pathway. A nursery nurse supported the unit during the day.
- The matron told us that there was 'proactive' recruitment on the unit. This meant that posts were advertised and filled before a person left. This ensured there were adequate numbers of nurses to safely staff the unit.
- The staff told us that any shortfalls in nursing staff numbers due to sickness would be covered by the unit's permanent staff.

# Services for children and young people

- There was either a senior doctor or ANNP on duty at all times.

## Medical staffing

- There was either a senior doctor or ANNP on duty at all times.
- The neonatal consultants rotated between the Princess Royal Hospital and the Royal Sussex County Hospital. There was a consultant presence on the unit during the day for four days a week. This was in addition to the cover provided by the ANNPs.
- A neonatal consultant was on-call at all times and none of the staff reported any difficulties or delays in receiving attention from a consultant.
- Handovers between medical staff and the ANNPs took place at the beginning of each shift.

## Administrative staffing

- The staff on the SCBU told us that there was inadequate administrative cover, due to one person having to undertake the “equivalent of three people’s jobs”. We noted that there was one administrative staff member and they had to cover the labour ward, the central delivery suite, the SCBU and the postnatal ward. This was because the person was covering staff off work due to sickness. This meant that the person had to continuously attempt to prioritise their workload, with insufficient time to undertake all administrative duties.

## Are services for children and young people effective?

Good



The services for babies on the SCBU were effective. The unit used evidence-based care and treatment and had a clinical audit programme in place.

There was evidence of effective multidisciplinary working and the service operated safely over the seven-day week.

There were procedures in place to ensure competent staff. However, half of the ANNPs had not received an appraisal within the past 12 months. The matron told us that there were plans in place to address this.

## Evidence-based care and treatment

- There were clear standards for the care and treatment of infants in the SCBU, based on the NICE and Royal College of Paediatrics and Child Health (RCPCH) guidelines.
- The medical staff we spoke with said that these standards were updated appropriately if there were any changes in the national guidelines.
- The plans of care for the babies on the unit were regularly reviewed and updated. There was a ward each morning at 9am. This was held with the consultant, doctor, ANNP and nurses to review and assess how the infant was progressing, and whether further treatment options needed to be considered.
- We saw evidence of local audit activity. This included the audit of blood cultures (microbiology), infection control and gastroschisis.

## Pain relief

- Pain was assessed and relieved in accordance with the guidelines from the RCPCH.
- Nurse-controlled analgesia was audited on a regular basis.

## Nutrition and hydration

- The unit encouraged mothers to breastfeed their babies. There were facilities for mothers to express and store their milk.
- The unit supported mothers who did not breastfeed their babies. There were facilities for the safe preparation of powdered and modular feeds.
- The babies that had not developed the ability to breastfeed were fed by a nasogastric tube. This was a tube that was passed through their nose and into their stomach.
- During our inspection, we observed a nurse feeding a baby through a nasogastric tube. We noted the amount of milk given was directly proportionate to the baby’s weight.
- Babies were weighed on a regular basis, and their fluid intake and output was recorded.

## Patient outcomes

- The unit participated in the National Neonatal Audit Programme (NNAP), the NHS Newborn Hearing Screening programme, the Neurodevelopmental Outcome programme, the Neonatal Transport Service programme and the National HIV and Syphilis Surveillance programme.

# Services for children and young people

- There was no evidence of risk regarding readmission rates in the neonatal unit.
- Weekly neonatal follow-up clinics were held on-site. The aim of the consultant neonatologists was to provide comprehensive follow-up of high-risk infants until two years corrected age. This helped to ensure that infants received the appropriate care and treatment to meet their needs, with the aim being to give them the best possible outcome.

## Competent staff

- There was a structured educational programme in place for the nursing staff. This included nurses completing the neonatal pathway, neonatal surgical modules, and their degree and master programs.
- Staff were able to access the Advanced Neonatal Life Support and PaNSTaR courses.
- There was an established local faculty group that oversaw educational governance within the unit.
- The process of simulation training commenced in 2013 and has been progressed throughout the current year. The staff we spoke with that had undertaken this training said it was both effective and beneficial in relation to their competence in their current roles, because it imitated a real-life situation.
- During our inspection, we reviewed whether staff had received an appraisal within the past 12 months. Despite the ANNPs being autonomous prescribers, less than half had received an appraisal within the last 12 months. The matron told us that there were plans in place to address this.
- The matron in charge of the neonatal units told us that the ANNPS rotated between the two main sites of the trust to help maintain their competency and skills levels. They said that this was being extended to include all nursing staff.

## Multidisciplinary working

- There was access to numerous specialist services, including: paediatric diabetes, physiotherapy, pharmacy services, audiology, ophthalmology and a breastfeeding adviser and maternity counsellor.
- The medical and nursing staff told us that there were weekly multidisciplinary family and social meetings on the units. These involved the nursing staff that had cared for the baby, a health visitor or consultant in child protection and a paediatric social worker.
- The neonatal outreach team worked collaboratively with staff in the discharge and support of the babies

from the unit. The team worked closely with the families and helped them prepare to take their baby home by supporting them in feeding and caring for their infant. The outreach team supported families for approximately four weeks (or the expected due date) following discharge from the unit.

- One of consultant neonatologists and the community paediatric team coordinated the discharge and follow-up of infants that required home oxygen. This helped to ensure a smooth transition from the hospital to the home setting and offered parents continued support in the management of their child.

## Seven-day services

- The unit was supported by a team of radiologists who provided an on-call service 24 hours a day.
- Staffing levels remained the same at all times, with the exception of the nursery nurse (who worked day-time only) and the consultant (who went to the unit four times a week and was on-call at all times).
- There was access to a pharmacist at all times either on-site or through the on-call system.

## Are services for children and young people caring?

Good



Staff were compassionate and provided effective emotional support to parents. Parents were positive about their experience. One person said, "I am 100% satisfied with the care we have received."

Parents were involved in decisions about their baby's care and treatment.

## Compassionate care

- The matron told us that there was a 'Parent Forum' that met on a quarterly basis. The forum consisted of parents of babies who had been cared for on the SCBU at both the Princess Royal Hospital and Royal Sussex County Hospital. The group undertook activities that helped to ensure the SCBU continued to deliver compassionate care and determined whether anything required improvement.

# Services for children and young people

- We spoke with two parents during our inspection. They told us that they could not fault the care provided by the staff. One parent said, “The staff are very helpful and always around.” Another parent said, “I am 100% satisfied with the care.”
- We noted that the feedback from parents about the care their baby had received from staff was positive on all accounts. Parents described the staff as “caring, kind, considerate and compassionate”.
- The staff on the unit ensured the babies’ privacy was maintained at all times. This included their policy on not giving any information about a baby to anyone except the baby’s parents.

## Patient understanding and involvement

- A wide range of information was available for the parents. This included booklets about the unit, and a copy of the Bliss parent information guide. This information was only provided in the English language. Staff told us that translation services were accessible for parents whose first language was not English.
- There were training sessions for parents on infant resuscitation techniques. These were held on a regular basis and parents were given the choice as to whether they wished to participate or not.
- The parents we spoke with during our inspection told us that they had been fully involved in making decisions about the care of their baby. They said that both the medical and nursing staff encouraged their involvement and made sure that they understood what was being said to them.
- Each baby had a named consultant and a named ANNP.

## Emotional support

- There was information about how parents and families could access different support groups displayed in the information area in the unit.
- Both of the parents we spoke with said that they had received excellent emotional support.
- The unit had access to a parent counsellor and/or support from the chaplaincy team.

## Are services for children and young people responsive?

Good



We found services responsive. Service planning and delivery met the needs of local people and flow arrangements were in place.

People’s individual needs were met and there were effective systems in place to receive and act on feedback from parents.

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

- The SCBU benefited from the development of tertiary services at the Royal Alexander Children’s Hospital. These included respiratory, medicine, cardiology and gastroenterology specialities.
- Infants with ongoing medical or surgical needs beyond their neonatal period were transferred to the RACH.

## Access and flow

- There were eight cots within the SCBU. The cots were predominantly used for babies born on at the Princess Royal Hospital after a 24-week gestation period. Women who were likely to deliver before 34 weeks gestation, or whose baby was likely to require high dependency or intensive care were transferred to the Royal Sussex County Hospital.
- If a baby deteriorated on the unit and required intensive care, they were transferred to the Royal Sussex County Hospital.

## Meeting people’s individual needs

- The SCBU had been chosen as one of the pilot sites for the Bliss Family Friendly Accreditation Scheme. This project was being carried out with nursing staff, parents and Bliss, working in partnership to achieve the standards set by the Department of Health to improve the areas that really mattered to parents. These areas included: access to psychological and social support and communication and inclusion in decision-making. The standards that the unit aimed to achieve included the staffing of the unit, professional competence,



# Services for children and young people

education and training and care of the baby and family experience. Once 90% of the standards are met, the unit will be awarded with the Bliss Family Friendly Accreditation.

- The matron told us that the unit aimed to meet the spiritual needs of parents and families. They explained that there was a chaplain on-site and on-call out-of-hours, and that they had access to religious leaders from other faiths.
- There was a breastfeeding adviser available for women that required their help.
- The staff we spoke with explained the importance of meeting the parents' needs when preparing for discharge of their baby. They said that they worked closely with the neonatal outreach team. We noted that there were two individual rooms for parents to stay and sleep in, with their baby, before going home. The staff explained that they supported the parents during this time to help build their confidence to be able to independently care for their child at home.

## Learning from complaints and concerns

- The SCBU used 'Fabio the Frog' as a tool to receive real-time patient/parent feedback. This allowed the unit to obtain the opinion of parents in a timely manner. This meant that they could act on any negative comments immediately. The staff said that this helped them to deliver more effective and efficient care and helped to improve the experience of the families they cared for.
- Parents were posted a parent evaluation form to their home address after their baby's discharge. The matron told us that the forms were audited, and if they received any negative comments then they would be addressed to continuously improve the quality of the service.
- There was information about how parents could access the Princess Royal Hospital's Patient Advice and Liaison Service, displayed in the information area on the unit.
- All of the staff we spoke with knew the correct procedure to follow if someone wished to make a complaint.

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

Good



The service was well-led. All of the staff we spoke with told us that there was a positive culture within the unit and effective leadership.

There were regular safety and governance meetings, as well as effective processes for measuring and ensuring quality standards.

Innovation and sustainability was evident within the unit.

## Vision and strategy for this service

- The neonatal services, including the SCBU, had a programme of research, clinical governance and education in place. Their goal was to continuously improve the quality and safety of clinical care, working alongside the multidisciplinary team.

## Governance, risk management and quality measurement

- A full programme of research, clinical governance and education was in place. The unit's aim was to continue to improve the quality and safety of clinical care through clinical governance, education and multidisciplinary working.
- The unit participated in the National Institute for Health Research (NIHR) for improving the quality of care and outcomes of preterm infants.

## Leadership of service

- There was a defined leadership structure in place for both the nursing and medical staff.
- All of the staff we spoke with said that they felt well-supported by their line manager.
- The nursing staff we spoke with told us that the consultants, medical staff and ANNs had excellent leadership skills. They said that this promoted team work and helped to ensure there was a calm and therapeutic environment.
- All of the staff we spoke with said that they felt valued.

## Culture within the service

- The department of neonatology won the Brighton and Sussex University Hospitals NHS Trust team of the year award for 2013.

# Services for children and young people

- The staff we spoke with said that there was a positive culture within the service. They told us that quality and patient/parent experience was seen as everyone's responsibility.
- Both the medical and nursing staff we spoke with said that everyone worked well together and that there was a strong ethos of team working.

## Public and staff engagement

- The matron told us that there was a 'parent forum' that met on a quarterly basis. The forum consisted of parents of babies who had been cared for on the SCBU at both the Princess Royal Hospital and Royal Sussex County Hospital. The group undertook activities that helped to ensure the SCBU continued to deliver high quality care and determine whether anything required improvement. The group helped to design parent questionnaires and assisted with the development of parent information leaflets.

- The matron said that the members of the group were highly valued and their views were sought on how staff could improve the quality and safety of the service they provided, including the experience of babies and their families.

## Innovation, improvement and sustainability

- The unit participated in multi-centre studies, as well as locally initiated projects. These included a 'neocirculation' research project and the multi-centre European PANNA study, which investigated the effects of anti-retroviral agents in HIV-positive mothers and their babies.
- The unit used electronic prescribing/drug charts and electronic recording of patient records/observations. We saw evidence that this had reduced medication errors.

# End of life care

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

## Information about the service

The Brighton and Sussex University Hospitals Trust has a specialist palliative care (SPC) team that demonstrates a high level of specialist knowledge, service delivery and strategic planning. The SPC team comprises of a one full-time palliative care consultant and three part-time palliative care consultants, 4 full-time and one part-time clinical nurse specialist, one end of life care facilitator, two part-time patient pathway coordinators and a chaplain and a spiritual team leader. There are the End of Life Care Facilitators and an End of Life Care Link on most of the adult clinical areas across the Trust.

The SPC Team are engaged in the NHS Improving Quality's Transforming End of Life Care in Acute Hospitals (2012) that aims to improve the quality of end of life care within acute hospitals, enabling more people to be supported to live and die well in their preferred place.

We saw evidence that systems were in place for the referral of end of life (EOL) and palliative patients to the SPC team for assessment, review and the ongoing management of patients. This ensured that patients received appropriate care and support with up to date symptom control advice for adults with advanced, progressive and incurable illness in their last year of life.

During our visit to Princess Royal Hospital, Haywards Heath, we spoke with members of the specialist palliative care team, including the team leader and the palliative care consultant, discharge liaison nurse, porters, mortuary staff and frontline staff on the wards. We noted that the SPC team supported and provided evidence-based advice to

other health and social care professionals, and we were told by ward staff that they were highly regarded across the trust. We saw evidence that urgent referrals were seen on the same day. In the last year (2013/14) the SPC team had received 1,220 patient referrals across the trust.

We visited a variety of wards across the trust, including Clayton Ward, Ardingly Ward, Baycombe Ward, Pyecombe Ward, Poynings Ward and labour wards, the intensive therapy unit (ITU), surgical ward Hurstwood Park Neurosciences Centre and hospital mortuary. We reviewed the medical records of nine patients at the end of life, observed the care provided by medical and nursing staff on the wards and spoke with three family members whose relatives were receiving end of life care. We received comments from our public listening event and from people who contacted us separately to tell us about their experiences. We reviewed other performance information held about the trust.

# End of life care

## Summary of findings

Training relating to end of life care was extensively offered across the trust with study days arranged twice per month. A monthly end of life newsletter, annual conference and intranet site was found to be very informative and comprehensive and could be accessed by all staff at any time of the day.

The trust was actively engaged in the NHS Improving Quality's Transforming End of Life Care in Acute Hospitals (2012), that aims to improve the quality of end of life care within acute hospitals. Streams of work being undertaken included, the development of amber care bundles and advance care-planning.

The Liverpool Care Pathway (LCP) was the pathway patients were placed on in the last few days of life, but across the trust we found that not all areas were using the LCP and individualised care plans were in use. The trust is developing their 'Recognising and caring for a dying person and their carers' policy that will be released for consultation at the next end of life steering group on the 2 July 2014, to replace the LCP on the 15 July 2014.

Multidisciplinary team working was good and the SPC Team and end of life facilitator engaged well with all staff to improve services and raise end of life issues across the trust.

We saw evidence, during the inspection, of multidisciplinary team working between the SPC clinical nurse specialist, the lung cancer and the head injury clinical nurse specialist's to ensure continuity of care. Patients were reviewed together to provide a holistic approach to care. The SPC clinical nurse specialist would be able to give advice on areas, such as: complex symptom management, psychological and spiritual needs.

Staff said end of life care was sensitive and caring. We observed the SPC nurse reviewing patients. The patients were reviewed in professional, caring, compassionate manner.

We spoke to one family whose relative was receiving end of life care. We were told that "care was very good, it is excellent" and "staff are very caring to patients and their families".

A multidisciplinary team approach was in place to facilitate the rapid discharge of patients to their preferred place of care. Out of the 100 patients discharged, only seven patients were readmitted to hospital to die. This means that 93 patients achieved their 'preferred place' of care and death.

There were regular SPC team meetings where performance data, complaints and incidents were discussed.

The end of life care facilitator was able to demonstrate examples of practice that the team were proud of, which included providing a holistic approach to patients receiving palliative or end of life care and an educational series where the SPC team are involved in developing policy documents with other professionals.

We found little evidence of what happens above the SPC team when it comes to the trust's strategy around end of life care. We found that end of life care was not a regular agenda item at board meetings and the trust had no strategy to implement the recommendations of the End of Life Care Strategy (2008). This was confirmed by the medical director, who told us that, "End of life care is not looked at by the board, with the exception of patient journey stories."

# End of life care

## Are end of life care services safe?

Good



There was a multidisciplinary SPC team available five days per week, with the hospice providing support out-of-hours. End of life care on the wards was provided by the ward staff, who reported they were able to provide adequate end of life care. Medicines were provided in line with guidelines for end of life care. Generally, our findings showed that do not attempt cardio-pulmonary resuscitation (DNA CPR) forms were being completed correctly.

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### Incidents

- On Clayton Ward, the ward manager told us that incidents were reported to the matron and entered on the online reporting system, Datix. An 'after action review' was undertaken. The learning from the incident resulted in the introduction of a falls checklist and reassessing patients to see if medication was at fault, 'falls alarms' issued to patients at risk and high-risk patients being placed in high-visibility beds.
- There were systems in place to feed back to staff include handover sessions, monthly ward newsletter and a communications folder. A recent newsletter covered topics, including: the rotas, Datix reports and nursing metrics.

### Cleanliness, Infection control and hygiene

- Overall, the standards of cleanliness and hygiene on the wards we visited were adequate.
- We saw that the wards and mortuary viewing area we visited were clean and well maintained. In all the patient areas the surfaces and floors were covered in easy to clean materials, which allowed high levels of hygiene to be maintained throughout the working day.
- We saw that ward and departmental staff wore clean uniforms with arms 'bare below the elbow' as per the policy and that personal protective equipment (PPE) was available for use by staff in all clinical areas.

- The Infusion Room on Clayton Ward was well maintained and the standard of cleanliness and hygiene was high. The room consisted of reclining chairs and paper curtains around each chair which were changed monthly. Good hand washing facilities were available.

### Environment and equipment

- We were told by staff that a sturdy concealment trolley, wheelchair and trolleys were available to transport obese patients around the hospital. Patients outside the safe working load would have to be transferred to the mortuary on their bed.
- On the wards we visited, we were told by staff that they did not have any problems getting mattresses and syringe drivers for patients, but one ward manager said that the "introduction of an equipment library would be helpful".
- On Clayton Ward, the resuscitation trolley had 12 months of records that confirmed that the trolley was checked daily.

### Medicines

- The Liverpool Care Pathway (LCP) medicine guidelines comprehensively set out the medication for patients receiving end of life care. Staff we spoke to were able to show us these guidelines.
- We were told by the ward managers on Clayton Ward and the Neurological surgical Ward that medication for end of life care was available on the wards and was easily accessible.
- We checked the storage of the controlled drugs on both these wards we found that access to the controlled drugs was restricted to the appropriate designated staff. Storage of the controlled drugs was in a secured locked inner cupboard within a metal locked cabinet secured to the wall. On both wards, a compliant controlled drug register was in place. We found no discrepancies between the stock (controlled drugs in the cupboard) and the controlled drugs record book. The controlled drugs, we checked were in date.
- We were told by the ward managers that medication was checked by the night staff to ensure drugs were in date and the register was completed correctly. We saw the register was up to date and clearly filled in.
- We observed medication was stored in locked fridges in Clayton Ward. The fridges were locked and records confirmed that the temperature of the fridge was checked daily by the nurse in charge of the ward.

# End of life care

## Records

- Across the wards we visited, we found that paper medical records were in use and were stored in lockable filing boxes at the nurse's station.
- The trust was introducing an electronic record system, which would give all staff access to patients' medical records. An end of life care tab will be available when the system is implemented, but we were told that EOL care was at the end of the roll-out programme. Earlier end of life implementation would support the NHS Improving Quality's Transforming End of Life Care in Acute Hospitals (2012) and allow staff across the trust to assess the wishes and preferences of patients.
- We saw the SPC clinical nurse specialist input review information into the medical records.
- The SPC records contained information to plan the appropriate care to ensure patients' needs were met. This included a holistic needs assessment, which would cover the control of symptoms, discussions with the patient and family around the wishes and preferences of the patients, including the Preferred Priorities of Care publication and any other support required, such as: social, psychological or spiritual.
- While visiting the ward areas, we randomly checked seven medical records containing do not attempt cardio-pulmonary resuscitation (DNA CPR) forms.
- We saw that all decisions were recorded on a standard form with a red border. A new format of DNA CPR form had been developed, after feedback from the staff, and is being introduced across the trust.
- We found the DNA CPR forms were at the front of the notes we checked, allowing easy access in an emergency and being compliant with the 'Resuscitation Policy C007'.
- When we visited Poynings Ward in the morning, we found that three of the DNA CPR forms were not completed correctly.
- The registered nurse (RN) check DNA CPR forms daily. This is to ensure all forms are completed correctly and patients' safety is not put at risk.
- Generally, our findings showed that DNA CPR forms were being completed correctly. Completing the DNA CPR forms ensured that appropriate decisions were made and the safety of patients was not being put at risk.
- The mortuary manager told us that effective systems were in place to log patients in to the mortuary. We were

walked through the process and were shown the ledger type book that contained the required information. We observed that the book was completed appropriately and neatly and was completed in a respectful way.

## Mental Capacity Act, Consenting and Deprivation of Liberty

- We were told by the SPC team that Mental Capacity Act 2005 assessment forms were available on the hospital intranet. We saw an example of the incapacity form that included 'assessment of patient's capacity', 'assessment of alternative decision-makers', 'consulting with others' and 'details of decisions taken'.
- On the Dementia Ward, we were told that there had been new staff in the ward and they had received Mental Capacity Act 2005 training two weeks prior to our inspection.
- We did not find evidence of Mental Capacity Act 2005 assessments with the one DNA CPR form that documented that patients lacked capacity. We concluded that there were no systems or processes evident around actioning Mental Capacity Act 2005 assessments. Staff could not tell us the correct procedure. This meant that the correct procedures were not being followed to protect vulnerable people.

## Training

- We were told by the SPC team that end of life training was not mandatory. This was confirmed when we visited the wards, as some staff had received end of life training and some had not.
- Continuing professional development takes place within the SPC team and includes a 'Journal Club', which took place monthly. Areas discussed recently included: 'Assisted Death' and 'Dementia in Primary Care'. The team discuss a 'case of the week' after the multidisciplinary team meeting each week as well as attending away days with the gynaecology, haematology and oncology teams.
- We spoke with a junior doctor on Ardingly Ward, who told us end of life training had been given by the end of life facilitator, but felt further training was required. During working hours, the doctor would call for support from the palliative care consultant.
- We were given a demonstration by the end of life care facilitator of the end of life care intranet site. which could be accessed by all staff at any time. The site included information, such as: national policy guidance,



# End of life care

trust policies and procedures relating to end of life care, rapid discharge pathway, videos and resources, multi-professional training days and an online booking system for end of life care study days.

- The end of life care facilitator was actively involved in running end of life care training courses for staff across the trust. We saw that evidence of the training was available to all staff groups. Sessions that were due to take place included 'Spiritual care assessment', 'Advance care planning process', 'Agitation and the psychosocial aspects of care'.
- We saw that study days were organised over two days per month (May 2014) for all staff to maximise their knowledge around EOL care. Subjects covered included: 'Advance care planning', 'Amber care bundles' and the 'Liverpool Care Pathway for the Dying Patient Version 12'.
- Attendance at the study days was poor, due to staff not being released from the wards. On Ardingly Ward we spoke with a healthcare assistant who had only received mandatory training and no EOL care training. We were told "if training is given, then it will be in our own time".
- The end of life care facilitator had a 15 minute slot during the induction programme for new staff to raise awareness around the importance of 'advance care planning' and the need for all to plan for their future care. This is one of the key drivers in the NHS Improving Quality's Transforming End of Life Care in Acute Hospitals (2012) programme
- On Ardingly Ward, the ward manager told us that they had two palliative care link nurses who would be attending the annual EOL conference on the 9 June.
- On the Hurstwood Park Neurosciences Centre Ward we were told by the ward manager that all staff were trained on the syringe drivers. Training was undertaken yearly by the company who develop the syringe driver. We were unable to confirm this during the inspection.
- The trust data around syringe driver training showed that in the 12 months ending April 30 2014, a total of 625 nursing staff attended in the small ambulatory pump training day. This figure was comprised of 301 'new' trained staff (either new to Brighton and Sussex United Hospitals NHS Trust or recent graduates) attending a mandatory session for Infusion Devices Study Day and 324 staff that attended an Infusion Devices Update Day required after three years.
- The mandatory training (for syringe drivers) includes a one hour Royal College of Nursing accredited course.

- Study days were arranged for EOL care link nurses on the wards and information then cascaded down to nursing staff at ward-level through handovers and ward meetings. We were told that on the Hurstwood Park Neurosciences Centre Ward, Ardingly Ward and Balcombe Wards, end of life link nurses were in post.
- The portering supervisor told us that the training of porters around mortuary duties is learnt on the job.
- The mortuary manager told us that he had no input into the training of porters within the Princess Royal Hospital.
- The chaplain told us that they run a course on 'Assessing peoples spiritual needs', as staff are often anxious around the subject and that requests to support patients was usually received from the SPC team or doctors.

## Management of deteriorating patients

- The ward manager on the Hurstwood Park Neurosciences Centre Ward told us that patients were often admitted when it was unlikely they would recover, for example, following a brain haemorrhage. A best interests meeting would then be undertaken with the family and the patient would be nursed for comfort.
- The ward manager on the Hurstwood Park Neurosciences Centre Ward told us that they use the Liverpool Care Pathway 'Diagnosing dying: flow chart and symptom management', but do not use the Liverpool Care Pathway.
- Patients that are recognised as dying would be commenced on the Liverpool Care Pathway after discussion with the consultant and the multi-professional team, patient and relatives. Decision-making is guided by the 'Diagnosing dying flow chart' on page two of the Liverpool Care Pathway for the Dying Patient Version 12.
- On the Hurstwood Park Neurosciences Centre Ward, the ward manager has been involved in the working group that have been developing the AMBER care bundles (meaning: assessment management best practice engagement recovery uncertain care bundles). This will be used to support patients that are assessed as acutely unwell, deteriorating, with limited reversibility and where recovery is uncertain. The ward manager told us that no patients had gone through amber care bundles to date, as more training was required.

# End of life care

## Nursing Staffing

- The SPC Team is made up of four full-time clinical nurse specialists and one part-time clinical nurse specialist.
- An EOL care facilitator works across the trust. This is a full-time position.
- During our inspection, we asked ward managers about their staffing levels and whether they had enough staff when they had to nurse patients. We were told on Clayton Ward if 1:1 nursing is required to support a patient receiving end of life care, an extra healthcare assistant will be brought in to support.
- The organ transplant specialist nurse is part of a small team of nurses across the South East and covers the organ transplant service across the trust.

## Medical Staffing

- Four palliative care consultants were available across the trust. One full-time post employed by Brighton and Sussex United Hospitals NHS Trust was supported by three part-time consultant posts.
- Medical cover was provided four times per week for half days at Princess Royal Hospital. During periods of absence, it was intended that both sites were covered by a senior clinician (consultant) at least twice a week.

## Are end of life care services effective?

Good



As a consequence of the NICE quality standards relating to EOL care, the SPC team based their care on these standards. The SPC team and EOL care facilitator provided evidence-based advice to other healthcare professionals across the trust.

The trust was actively engaged in the NHS Improving Quality's Transforming End of Life Care in Acute Hospitals (2012), that aims to improve the quality of end of life care within acute hospitals. Streams of work being undertaken included the development of amber care bundles and advance care planning.

The Liverpool Care Pathway was the pathway patients were placed on in the last few days of life, but across the trust we found that not all areas were using the Liverpool Care Pathway and individualised care plans were in use. The trust was developing their 'Recognising and caring for a

dying person and their carers' policy that will be released for consultation at the next end of life steering group on the 2 July 2014 to replace the Liverpool Care Pathway on the 15 July 2014.

Team working was good and the SPC team and EOL facilitator engaged well with all staff across the trust to improve services and raise EOL issues across the trust.

Recent changes to the DNA CPR component of the resuscitation policy included policy compliance and an escalation of issues using a red and amber flag system (the red flag requires immediate corrective action as they present a risk to patient safety) to ensure patients' safety was never compromised.

## Evidence-based care and treatment

- Use of national guidelines – the National End of life Care Strategy (2008) published by the Department of Health, sets out the key stages of end of life care, applicable to adults diagnosed with a life-limiting condition. The NICE end of life care quality standard for adults (QS13) sets out what end of life care should look like for adults diagnosed with life-limiting conditions.
- Brighton and Sussex University Hospitals NHS Trust had partially implemented NICE quality standards for improving supportive and palliative care for adults, with the introduction of a specialist palliative care (SPC) team and end of life care facilitator.
- The trust was actively engaged in the NHS Improving Quality's Transforming End of Life Care in Acute Hospitals (2012), which aims to improve the quality of end of life care within acute hospitals, by supporting the implementation of five key enablers, which include: advance care planning, amber care bundles and the palliative rapid discharge home to die pathway.
- We saw evidence across all the wards and departments we visited, that the SPC Team and the end of life care facilitator supported and provided evidence-based advice to other health and social care professionals. For example: on complex symptom control.
- A recent release from the Leadership Alliance for the Care of Dying People (March 2014), confirmed that there will not be a national tool to replace the Liverpool Care Pathway. The palliative care consultant told us that through the end of life steering group the new

# End of life care

'Recognising and caring for a dying person and their carers' policy was being developed. The replacement to the LCP is due to be ready and in use by the 15 July 2014 across the trust.

- The EOL care facilitator told us that the NICE quality standard (QS13) had been discussed at the end of life steering group. Working groups had been set up to focus on and report back to the group on particular standards. This was confirmed in the minutes of the EOL steering group. (29 August 2013)
- The End of Life Group had developed a 'Verification, Certification and Notification of Adult Deaths at Brighton and Sussex United Hospitals NHS Trust' policy, which was intended for all staff involved in the care of the dying and recently bereaved.
- The policy took into consideration multiple faiths and ensured that systems were in place so that burial could proceed within one day, and in order to do so, the 'Medical Certificate Cause of Death' (MCCD) had to be processed immediately. Out of normal hours, the clinical site manager would be the point of contact.

## Pain Relief

- Patients commenced onto the Liverpool Care Pathway required regular assessments to ensure that symptoms were managed effectively. These would be completed by nursing staff to show compliance and demonstrate that pain was reviewed every four hours.
- Patients under the care of the SPC team reviewed patients' pain control daily and ensure that PRN (pro re nata or 'as needed') medication is prescribed so that through the period of adjustment any breakthrough pain can be managed.
- On Ardingly Ward we observed the SPC clinical nurse specialist had identified that one patient's medication had not been prescribed, so the clinical nurse specialist asked the junior doctor to amend the prescription.
- We reviewed the medical records of one EOL patient where it was agreed that a syringe driver was necessary. We saw that staff had responded to the direction promptly.
- During daily reviews, medical and SPC teams commenced EOL medication through a syringe driver, when symptoms required pain to be managed in a controlled, effective way.
- We saw two patients on EOL medication who were comfortable with their pain being well controlled.

## Nutrition and hydration

- On Clayton Ward the ward manager told us that EOL patients were all nursed according to their individual needs and were able to eat and drink normally would carry on until their condition changed. We were told that a dietician would review all EOL care patients.
- One EOL patient was receiving food through percutaneous endoscopic gastrostomy (PEG). As the patient's condition changed, the dietician would advise the nursing team of the nutritional requirements of the patient.
- The ward managers on Pyecombe Ward, Ardingly Ward and Poynings Ward told us that patients on EOL care would be referred to both the dieticians and the speech and language therapist for an assessment, to ensure patients' needs were achieved. Specialist foods might be recommended.
- The Liverpool Care Pathway documentation contains a 'food and hydration' section which staff were required to complete every four hours.

## Competent staff

- Integrated workings of the SPC team and end of life care facilitator demonstrated a high level of specialist knowledge, service delivery and strategic-planning and provided wards and departments across the trust with up to date, holistic symptom control advice for patients in their last year of life.

## Patient outcomes

- The Princess Royal Hospital contributed to the National Care of the Dying Audit, which was released on the 15 May 2014. The trust performed well in the areas of access to information relating to death and dying, medication protocols around symptom control and protocols promoting patient privacy. Areas where the trust did not perform well included: trust board representation, formal feedback processes and a review of the care after dying policy.
- We were told that the trust developed their 'Recognising and caring for a dying person and their carers' policy that will be released for consultation at the next end of life steering group at the beginning of July 2014, to replace the Liverpool Care Pathway on the 15 July 2014.
- We spoke to the palliative care consultant, who told us the Liverpool Care Pathway was being used to support EOL patients. After guidance from the Department of Health (October, 2013), the Liverpool Care Pathway has to be phased out by trusts by 14 July 2014.

# End of life care

- Staff received guidance from the trust around the continuing use of the Liverpool Care Pathway, which specified that a senior clinician, in consultation with the healthcare team, had to make the decision to commence patients onto the Liverpool Care Pathway and decisions should not be made out-of-hours.
- The trust data showed that, between January 2013 and December 2013, 540 patients were commenced on the 'care pathway for the dying'. Since October 2013, there has been a fall in the number of patients commenced on the 'care pathway of the dying' (57 patients). This fall is due to the Department of Health's statement in October 2013 when consultants stopped using the Liverpool Care Pathway to the same extent as before.
- On the wards we visited, staff were able to show us a decision-making algorithm (or a step-by-step procedure based on a set of guiding principles) that ensured the necessary decisions and communications were completed before placing a patient on the Liverpool Care Pathway.
- Ward staff we spoke to confirmed that the trust was continuing to use the Liverpool Care Pathway for EOL care, however, some wards we visited were using parts of it such as the medication guidance and the algorithm to identify the 'dying patient'.
- We found some wards were still using the pathway and others not but all would access the SPC team. Following referral to the SPC Team, the team work collaboratively with the clinical team leading a patient care. SPC advice may be provided through direct patient assessment and care or by supporting other professionals, such as: ward staff and cancer clinical nurse specialist's.
- On Ardingly Ward and the Poynings Ward we were told that the staff were aware of advance care planning, but were not using it at the moment
- The SPC clinical nurse specialist submitted medical reviews of the patients referred to the SPC team into the Somerset Cancer Register. This is used to register both cancer and non-cancer patients. The SPC team could access the system, along with oncologists.
- Patients referred to the SPC team are reviewed by the team on a regular basis, depending on the needs of the patient. On assessing the patient, the SPC team would decide the patient's level of need. Patients would be reviewed by the SPC team daily, weekly or only once (for advice only). We saw evidence of daily reviews on Clayton and Ardingly Wards.
- We were told by the SPC team that the intensive therapy unit (ITU) had comprehensive systems and processes in place to support patients requiring EOL care, including: 'the withdrawal of treatment protocol'. Staff could tell us about the protocols they followed.
- We spoke with the portering manager about the arrangements for transporting patients to the mortuary. We were told that porters received training to ensure that they were able to carry out the necessary procedures in the mortuary at weekends and overnight.
- We reviewed the audit undertaken by the resuscitation officer (2012/13). Areas where information was not completed properly included 'no review date' (30/73) – failure to authorise emergency decisions within 72 hours and 'wrong signature in the consultant's box' (13/73). From the findings, the DNA CPR form was redesigned, posters had been developed to support staff around how to complete the form and the development of an escalation protocol. Educational opportunities had also been arranged.
- The medical examiner would review the deceased patient's clinical information to establish that the clinical care received was appropriate. Any areas where care may have been improved would be input into a Datix report and would be used to improve learning within the trust.
- The medical examiner would contact the family to ask what they thought of the care. This information was fed back to the end of life steering group to support service improvements within EOL care.

## Multidisciplinary Team working

- The SPC team multidisciplinary meeting was held on Tuesdays at 2pm with a video-conference link between Princess Royal Hospital and Royal Sussex County Hospital, to ensure all staff within the team were included.
- Patients known to the SPC multidisciplinary team who had been discharged or died, were discussed on Friday mornings. The achievement of 'preferred place of care' was further assessed and documented at this meeting.
- The lung, head and neck cancer multidisciplinary team meetings were attended by a palliative care consultant, but there was no cross-cover during any periods of absence.
- A weekly, joint lung cancer clinic was attended on a Tuesday morning by a palliative care consultant, but there was no cross-cover during any periods of absence.

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- A palliative care consultant would attend the joint head and neck cancer clinic on a Wednesday morning on an ad hoc basis, if there were urgent and complex palliative care needs.
- We saw evidence, during the inspection, of multidisciplinary team working between the SPC, the lung cancer and the head injury clinical nurse specialists to ensure continuity of care. Patients would be reviewed together to provide a holistic approach to care. The SPC clinical nurse specialist would be able to give advice on areas such as complex symptom management, psychological and spiritual needs.
- On Clayton Ward and the Hurstwood Park Neurosciences Centre Ward, we spoke to the ward managers who told us that a ward round takes place either weekly or daily and were attended by the medical team, matron, occupational therapist, physiotherapist, pharmacist and discharge nurse. The handover sheet would be discussed and plans would be made around discharge planning and where deteriorating patients were discussed. Any decisions around stopping active treatment were also discussed.
- On a Monday afternoon, Tuesday afternoon, Thursday afternoon and Friday morning the palliative care consultant would undertake a ward round to review the management of the patients referred to the SPC Team.
- The teams were working on 'advanced directives'. These would be linked to the OASIS system (an electronic patient tracking record, known as the Online Applicant Status and Information System). The SPC clinical nurse specialist told us that the SPC team were engaging with the pulmonary rehabilitation team around EOL care. The respiratory nurse and physiotherapist will meet with the SPC clinical nurse specialist two to three times a year

## Seven day services

- We were told by the SPC team that systems were in place (such as palliative care consultant on-call rotas) to provide timely SPC and advice at any time of the day or night for people approaching the end of life or receiving palliative care who might benefit from specialist input.
- At the time of our inspection, the SPC team were not staffed or funded to provide a seven day per week visiting service.
- Out-of-hours St Peter and St James Hospice gave telephone advice and support to Princess Royal Hospital staff.

- A junior doctor told us that they felt confident in the support mechanisms that were in place for EOL patients and would contact the hospice out-of-hours, if needed.
- The chaplaincy team could be contacted via the ward staff. Out-of-hours, the chaplain could be contacted via the switchboard.

## Are end of life care services caring?

Good



Patients were cared for with dignity and respect and received compassionate care. Feedback from patients and relatives was positive, stating they felt fully informed and involved in their treatment and care. Medical and nursing staff were seen to be compassionate and caring, involving patients and their friends and families.

## Compassionate Care

- Staff said end of life care was sensitive and caring. We observed the SPC nurse reviewing EOL patients. The patients were reviewed in a professional, caring and compassionate manner.
- We spoke to one family whose relative was receiving EOL care. We were told that "care was very good, it is excellent" and that "staff are very caring to patients and their families".
- On Clayton Ward, we observed an EOL patient being nursed in a single room. We were told by the ward manager that family could stay by the bedside overnight and that visiting hours were open. This was confirmed by a family member who had stayed overnight by their relative's side and told us that the staff overnight were "very good and very caring".
- We were told by the family that they would be happy for their relative to stay on the ward, as staff knew the patient and that they "[could not] fault the care".
- On Ardingly Ward, family members told us their relative was very settled and that "the nurses were really lovely and care was brilliant". The family told us they were "free to come and go" and that "staff were approachable and explanations were always given".
- We were told by the SPC clinical nurse specialist that the family had stayed overnight. The family told us that food and drinks had been offered during the evening and in the morning.



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- On Ardingly Ward, relatives had the use of a quiet room and drinks and food would be offered to the spouse of the EOL patient. The ward manager told us that they support the families with information and take time to listen to any concerns they have.
  - During the inspection, we observed the palliative care consultant having a consultation with a relative of an EOL patient.
  - The SPC team appointed a 'key worker' to each of their patients to ensure continuity of care for both the patient and family. For some patients, the cancer site-specific Macmillan clinical nurse specialist would remain the key worker when SPC medical advice was provided. If required, the key worker role would be handed over to the community key worker, on discharge.
  - On the wards we visited, we were told us that all patients would receive a named nurse, who would remain with the patient during their stay in hospital.
  - On the Hurstwood Park Neurosciences Centre Ward, the Patient's Voices survey for April 2014 included comments such as: "very polite and caring staff" and "very understanding and empathetic" and "nursing care has been outstanding". However, negative comments included: "poor hot food" and "noisy at night".
  - The ward manager in the ITU at Hurstwood Park Neurosciences Centre Ward told us that they are working with the Royal Alexander Children's Hospital in Brighton and a child psychologist to put systems in place to support children through the sudden death of a parent. This will include a bereavement box and books.
  - On visiting the labour ward, we were shown a memory box, which was given to parents after the loss of a baby. The box contained a blanket and flower, a support leaflet, a candle, teddy, camera, a box for a lock of hair and a foot print.
  - A midwives and parents support (MAPS) room was available outside the labour ward for couples who had lost a baby. The room had a double bed, en suite facilities and a cold cot. Couples could spend time with the baby, and as the room was set away from the labour ward, it was very private.
  - The 'butterfly room' in the labour ward was available for mothers and their stillborn babies to spend time together. A cold cot was available for the babies.
- and procedures, such as communication skills around talking to families and the development of an advance care planning service to ensure that patients' quality of life was enhanced as they moved towards EOL care.
- The bereavement officer told us that they offer individualised appointments. They were able to make referrals to the spiritual/chaplaincy team. No other support was available. Relatives were signposted to see their GP if further support was required.
  - Medical staff at the Hurstwood Park Neurosciences Centre Ward were reported to be good at communicating with patients and family about patients' care plans. Families would be invited into the ward to meet with the multidisciplinary team to discuss their relative's care plan.
  - We were told "consultants are good at communicating with the patients and family" and they are also good at identifying when further active treatment was not benefitting the patient.
  - On the Hurstwood Park Neurosciences Centre Ward, the ward manager told us they encouraged relatives to get involved in the mouth care of EOL care patients.
  - The organ tissue transplant coordinator explained to us in detail how families could get involved and support their relative through the organ transplant process. The promise to the family is that they can stay with their relative from when they go into theatre, all the way to the chapel of rest.
  - On Ardingly Ward, we were told that relatives were trained to deliver food through a nasal gastric tube or percutaneous endoscopic gastrostomy (PEG).

## Emotional Support

- All the specialist palliative care team had completed the training necessary to enable them to practice at level 2 for the psychological support of patients and carers.
- All team members who were practicing at level 2 received monthly clinical (group) supervision for at least one hour by a level 3 or 4 practitioner, in compliance with the specialist palliative care measures.
- Volunteers were available from the chaplaincy to provide emotional and spiritual support. The ward manager on the Hurstwood Park Neurosciences Centre Ward told us that they used volunteers to sit with patients day or night and that the chaplaincy team provided a good service.

## Patient/Family Involvement in Care

- We were told by the SPC team that, as part of their role, they had developed EOL and palliative care processes



# End of life care

- A MAPS support booklet has been developed for parents called 'You don't have to cope alone'. This gave the contact details of the bereavement counsellor and details of the support group that was run every month.
- The trust held three annual memorial events for parents and families whose baby or child has died. One is also held for adults who have died. These are well attended and the response to which has been supportive and of value in their time of grief

## Are end of life care services responsive?

Good



All patients requiring end of life care could access the SPC team, with 26% of referrals not relating to patients with cancer. The team received 1,220 referrals in 2012/13 and aimed to review all urgent referrals within 24 hours.

Following the Shipman Report, a medical examiner (ME) was introduced into the trust. This role provides feedback to the SPC team on the care patients received within the trust. This was a source of learning for the SPC team and frontline staff.

A transplant coordinator was available to talk to patients and families and gave information around tissue and organ transplantation. Information leaflets for families whose relatives were receiving EOL care were available in all areas.

We found 'equality and diversity' boxes in place, which contained a guide to beliefs, customs and diversity for staff on the wards we visited. This ensured that staff were able to respect the traditions of different faiths at the time of death.

A multidisciplinary team approach was in place to facilitate the rapid discharge of patients to their preferred place of care. Out of the 100 patients discharged, only seven patients were readmitted to hospital to die. This meant that 93 patients achieved their preferred place of care and death.

### Access

- We were told by the SPC team that referrals are 26% non-cancer and 74% cancer.
- All patients within the trust, requiring palliative or EOL care, have access to the SPC team, Monday to Friday, 9am to 5pm (except on bank holidays). Referrals were

prioritised as urgent if, for example, the patient was referred while in the ED, the acute medical unit or if the patient had unstable or unresolved symptoms, despite regular medication aiming to control these symptom(s).

- Through a triage system, the team aimed to see all urgent referrals within one working day and routine referrals within two working days.
- Outside office hours, medical advice was available via the consultant on-call at the local specialist palliative care unit, which is St Peter and St James Hospice.
- Inpatient referrals to the SPC team could be made via the SPC webpage or face-to-face referrals could be made to a member of the team. Urgent advice was available from the clinical nurse specialist who could give telephone advice prior to reviewing the patient.
- Outpatient referrals could be made in writing or via email to the palliative care consultants
- We were told by the ward manager on the Hurstwood Park Neurosciences Centre Ward that not all patients were referred to the SPC team, but the team will be contacted even if it is only to let the SPC team know a patient was on their ward.
- In 2013/14, 1,621 patients were referred to the team, which resulted in 6,840 contacts lasting approximately 30 minutes. This was approximately 25% of the total deaths in the trust.
- A bereavement midwife was available at Princess Royal Hospital 15 hours per week.
- Following the Shipman Report, a medical examiner was introduced into the trust. The medical examiner was available across the trust weekdays (9am-4pm). Referrals could be made via the bereavement office.
- The bereavement officer carried out the administration of a deceased patient's documents and belongings, issuing the Medical Certificate of Cause of Death (MCCD), providing practical advice and signposting relatives to support services, such as funeral directors. The bereavement office could be contacted Monday to Friday, from 8am to 4pm.
- Families wishing to view their relatives in the 'chapel of rest' could contact the mortuary between 9.30am and 4pm, Monday to Friday, to arrange an appointment. A more streamlined approach to bereavement support services would help relatives at this difficult time. For example: by coordinating collection of the MCCD and an opportunity to view the deceased relative through one central point.

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## Discharge arrangements

- Systems were in place to facilitate the rapid discharge of patients to their preferred place of care. The SPC nurse explained that a multi-professional approach was in place, which included an occupational therapist (OT), to secure rapid discharges to the preferred place of care.
- On the Hurstwood Park Neurosciences Centre Ward, we were told that not all EOL care patients are referred to the SPC team. In such cases, the ward would manage their rapid discharge.
- The SPC team coordinate and liaise with the discharge team to provide advice relating to care packages, including care home placement, assessment for future community palliative care support, assessment for hospice admission and assistance with utilising the rapid discharge pathway for end of life care for patients who wish to die at home or in a care home.
- The discharge liaison nurse told us that systems were in place to secure funding to discharge patients to their preferred place of care or preferred place of death. We were told discharges could be arranged in as little as 24 hours, if required. The team had to engage with the Clinical Commissioning Groups (CCG) of West Sussex, East Sussex and Brighton and Hove.
- Staff on Ardingly Ward told us that the East Sussex CCG take longer to make decisions, which can affect whether a patient may achieve their preferred place of care. There were no issues with the West Sussex CCG process.
- If on occasions the team have to seek vacancies in the care sector. The discharge liaison nurse would visit the ward daily to ensure there were no changes to the discharge plan.
- At our listening event, we were informed by a representative of a local patient participation group, that the referral process did not happen on one occasion. Although a bed was found by the patient's family, staff did not make the referral from Balcombe Ward before the patient died.
- We were given an example by the SPC Team, where 100 patients had been discharged to their preferred place of care. Out of the 100 patients, only seven patients were readmitted to hospital to die. This means that 93 patients achieved their preferred place of care and death.

- We saw comprehensive documents were in place to ensure the rapid discharge of EOL patients. This would ensure that patients were transferred home with all the necessary medication, support and documentation in place.

## Meeting the needs of all people

- The SPC team had developed an information leaflet for families whose relatives were receiving EOL care. The information, called Palliative Care Team, allows patients and relatives to find out more about the team and the care and services they provide.
- After medical teams had discussed the DNA CPR form, the patients and relatives were given an information leaflet that explained the topic, covering areas such as, 'What cardio-pulmonary resuscitation means', 'Do people recover after resuscitation?' and 'Does DNA CPR mean not for active treatment?'. This ensured patients and carers were kept well-informed on decisions that affected them.
- All information leaflets informed patients that an interpreter could translate the information, if required.
- We saw evidence of holistic needs assessments that the SPC clinical nurse specialists undertook, which included: symptom assessment and management, psychological needs, complex spiritual needs, complex social, preferred priorities of care and advance care planning.
- The SPC team supported carers by: providing support for complex issues that could not be supported by the ward team, by contacting and updating community services as appropriate and providing guidance with carer support, benefits advice and letters of support, for example, for employers.
- The ward managers on the wards we visited were able to explain the procedures that took place after the death of a patient. We were shown the pack, which contained all the necessary documentation, including wrist bands, a notification form and a flow diagram around tissue donation. Body bags were available on the ward.
- We were shown that systems were in place to identify patients on the ward and in the mortuary who had the same surname, including discreet orange dots placed on the patients' medical records and on the ward board.
- On the wards we found 'equality and diversity' boxes, which contained a guide to 'Beliefs, customs and

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diversity' for staff to refer to, along with laminated copies of 'Care of the dying Muslim and Jewish patient.' This ensured that staff were able to respect the traditions of different faiths at the time of death.

- The bereavement officer carried out the administration of a deceased patient's documents and belongings, issuing the medical certificate of cause of death, providing practical advice and signposting relatives to support services, such as funeral directors. The office was open Monday to Friday, 9am to 3.30pm.
- We were told by staff on several of the wards that normal visiting times were waived and that families were able to visit at any time.
- There was a named chaplain for each world faith across the trust. There were no multi-faith rooms available at the Princess Royal Hospital however people of faith were welcome to use the designated sacred spaces in each of the hospitals.
- We saw information leaflets were available called 'While you are in hospital' and we asked patients if they had seen the leaflets which contained information on how to contact faith leaders and what to do when you got to the hospital.
- The chaplaincy service had developed 'calling cards'. These cards were left at the patients' bedsides to let patients know they had had a visit from the chaplain, along with contact details if the patient wished to contact the chaplain.
- There were systems in place to support staff that experienced sudden deaths. Debriefings took place with senior staff within 24 hours and the chaplain, if requested, was present. Further support was available through occupational health.
- We found that booklets were available for families that were bereaved because of suicide or sudden death called 'Help is at hand'. We saw a leaflet titled: 'Information for parents of babies who die at or around the time of birth'. These were available for parents to take away and read in their own time.
- The transplant coordinator explained to us that they are approaching patients and families to give information around tissue and organ transplantation. We saw that the information booklets were available for patients and families to read and make decisions in a non-pressured environment.

- Princess Royal Hospital has a viewing suite where families could come and visit their relatives. We visited the area and saw that the viewing suite was divided into a reception and viewing room.
- The suite was clean, fresh and provided facilities for relatives, such as seating and tissues. We were told by the mortuary staff that families are supported during the viewing and that they would ensure that relatives knew what to expect and were safe. Religious symbols can be added to the room upon request by relatives.

## Complaints

- We were told by the end of life care facilitator that any EOL care patients received by the Patient Advice and Liaison Service team were passed on to the facilitator who would make contact with the family to resolve any issues in a timely manner.
- Formal complaints were brought to the EOL steering group by the chief nurse. The group would discuss the complaints and discuss ways in which improvements could be made.
- We saw that several complaints were around the DNA CPR process. We observed that the trust had reviewed the DNA CPR component of the resuscitation policy and that an escalation protocol for nurses and healthcare professionals, along with guidance for all in completing the DNA CPR forms had been developed.

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

Good



Leadership of the SPC team was good, with good team working, although there were varying views regarding the recognition of and importance of EOL care at board-level. However there was limited trust level leadership of EOL. EOL care was not a regular agenda item at board meetings and the trust had no strategy to implement the recommendations of the End of Life Care Strategy (2008).

Quality and patient experience was seen as a priority, with staff feedback about the service being positive.

There were regular SPC team meetings, where performance data, complaints and incidents were discussed.

The EOL care facilitator was able to demonstrate examples of practice that the team were proud of, which included

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providing a holistic approach to patients who were receiving palliative, or EOL care and an educational series where the SPC team were involved in developing policy documents with other professionals

An end of life steering group was in place, but this lacked involvement from executive level staff

## Leadership of service

- There was good leadership of the SPC team led by the palliative care consultant and the specialist palliative care nurse team leader.
- We found the end of life care facilitator engaged well with multi-professional staff and services across the trust, spreading the importance of end of life care to every corner of the hospital. However, more board-level support would help to embed the EOL care work streams.
- We were told by the medical director that his role provided executive support for the end of life facilitator in developing and implementing education and training, across the trust.
- The lead palliative care consultant oversaw strategic team development jointly with the lead cancer nurse and the SPC team leader.
- Duties included: ensuring that objectives of multidisciplinary team working were met, ensuring that care was given according to recognised guidelines and appropriate information being collected to inform clinical decision-making in support of the governance/audit.
- We found little evidence of what happened above the SPC team, concerning the trust's strategy around EOL care. We found that EOL care was not a regular agenda item at board meetings and the trust had no strategy to implement the recommendations of the End of Life Strategy (2008).
- This was confirmed by the medical director, who told us that, "end of life care has been looked at mainly through the patient journey stories".
- The medical director told us that his ambition around end of life care was "the need to make it a core business and the need to ensure consistency".
- An end of life steering group was in place, but we found that there was a lack of engagement from non-palliative care staff across the trust. The medical director and chief nurse have attended three meetings each in the last year.

- The medical director told us that they or the nurse director were committed to attending the end of life steering group in the future.

## Culture within the service

- All the staff we spoke to spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and everyone's responsibility. This was very evident in the SPC team and their patient-centred approach to care.
- We found that staff had a 'can do' attitude. Which meant that the staff were very patient-centred and wanted to deliver good care through good training and support. The EOL facilitator had a proactive approach to developing the workforce and ensuring the training of staff fitted the changing needs of the patients.
- Across the wards we visited, we saw that the SPC team worked well together with nursing and medical staff and there was obvious respect not only between the specialities, but across disciplines.

## Vision and strategy for this service

- The palliative care consultant told us that the development of a seven-day service was a priority.
- Compliance in implementing the NHS Improving Quality's Transforming End of Life Care in Acute Hospitals (2012), was another key objective.

## Governance, risk management and quality measurement

- We found that the SPC team had regular team meetings in which performance issues, concerns, complaints, and general communications were discussed.
- The lead cancer nurse would attend these meetings and feed concerns into the divisional nursing meetings.
- An operational policy was in place that set out the aims and objectives of the SPC team. This was updated annually.
- We were told by the medical director that the new 'Recognising and caring for a dying person and their carers' policy would be ratified by the board, cascaded throughout the teams and that a unified trust policy would be in place by the 15 July 2014.

## Innovation, learning and improvement.






- We saw that the end of life facilitator had organised the yearly Brighton and Sussex United Hospitals NHS Trust End of Life Care Conference, which took place on the 9

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June 2014. All staff were invited to attend the conference and could book through the end of life care intranet site. On the day of the inspection, 100 staff had registered on the course.

- The end of life care facilitator had developed a regular end of life care newsletter. In the February 2014 Newsletter, subjects covered included 'A roundup of all activities', 'Role of the funeral director', 'Essential conversations'. These newsletters were used to cascade information around end of life care across all areas of the trust and to all staff.
- We saw the Princess Royal Hospital had a comprehensive 'Resuscitation Policy (C007)', which included recent changes to the DNA CPR component of the policy. This included changes to the form layout, validity and policy compliance and an escalation of issues using a red and amber flag system.
- There was an educational series in which the SPC team are involved in developing policy documents with other professionals, such as the critical care outreach nurse consultant nurse, the resuscitation service manager and the chaplain.
- Providing study days for staff around 'Spiritual care assessment', 'Advance care planning process', 'Agitation' and 'The psychosocial aspects of care'.
- Development of a working party to develop and implement the amber care bundles within the trust.
- Partnership working with the Royal Alexander Children's Hospital around support for bereaved children.
- The expansion of medical examiners, across the trust.
- The facility for staff across the trust to shadow the SPC team.
- The distribution of the Preferred Priorities for Care booklets (14,000 of which were given out across the trust).

# Outpatients

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

## Information about the service

The Princess Royal Hospital is an acute teaching general hospital located in Haywards Heath. The hospital has an outpatient department on the main hospital site and offers outpatient services at Hurstwood Park Neurosciences Centre.

We visited the main outpatient department, where clinics were held at least five days per week and sampled a wide range of outpatient services. For example: medical digestive diseases, physiotherapy, cardiology, ear, nose and throat (ENT), endoscopy, radiology, rheumatology and orthopaedic services. We also sampled neurology outpatient services, which are based on the main hospital site at Hurstwood Park Neurosciences Centre.

We spoke to five staff, 27 patients and four relatives. We received comments from our public listening event and reviewed other performance information provided by the trust.

## Summary of findings

We spoke to patients using the service and they told us they felt safe while attending the unit and undergoing their treatment.

Attendance at children's safeguarding training was mandatory for all staff in the outpatient department. All outpatient staff had attended training in adult and children's safeguarding and attendance rates were 100%.

We spoke to the relative of a patient attending the eye clinic, who told us how caring everyone was and how they helped to ensure their relative's appointments were made at a time to suit them.

Staff told us about the centralised booking system (the Hub) for all outpatient services, which had been put in place across the trust in October 2013. They reported that outpatient clinic bookings through the Hub had caused significant difficulties for patients attending outpatient services at the Princess Royal Hospital. One area of concern raised by staff from outpatient services was their lack of involvement in the planning meetings with the Hub.

The consultant for the medical digestives clinic, which was due to start at 1.30pm (and had been double-booked for the surgical medical digestives clinic) found that there were no patients booked until 3pm, which incurred wasted clinic time. No one was able to clarify why these incidents had occurred and what would be done to address the failing in services.



# Outpatients

We found clinics worked in isolation and while governance arrangements were part of the Division there was no overarching governance framework in place for outpatient services. Staff were not engaged in the implementation of the Hub and had become frustrated about the process.

## Are outpatients services safe?

Good



We spoke to patients using the service and they told us that they felt safe while attending the unit and undergoing their treatment. We observed that patients were cared for in a clean and hygienic environment. We observed that mechanisms were in place to monitor the effectiveness of the cleaning and decontamination of equipment.

We observed that patient records were placed outside clinic rooms in open boxes. We were told by staff that this was a long-standing arrangement and staff expressed concerns around patient confidentiality. We were told the outpatient department were trying to obtain 11 lockable trolleys to enable the notes to be stored securely.

Attendance at children's safeguarding training was mandatory for all staff in outpatient services. All outpatient staff had attended training in adult and children's safeguarding and attendance rates were 100%.

Medical staffing for clinics was set in conjunction with the template, which sets out the number of clinics and doctors required for each session. However, the Hub had continued to experience problems with cancelled clinics due to insufficient doctors being allocated to run a clinic.

### Incidents

- Staff in the outpatient department used an online reporting tool (Datix) to record any accidents, incidents or 'near misses' that occurred. We were told that all staff had received training in the system and knew how to report an incident to the manager or nurse in charge. The level of incident reporting was low and no 'near misses' had been recorded.
- The radiology manager, who had responsibility for x-ray clinics on both hospital sites, told us they would feed back any learning from incidents and accidents to staff at their regular staff meetings. For example, we saw evidence of an investigation which had included the involvement of the health and safety executive (HSE). The incident concerned a patient who had been exposed to a second dose of radiation, due to the failure of scanning equipment.

# Outpatients

- We spoke to staff in the main outpatient department, who told us they were aware of the Datix system and knew how to report incidents.
- We were told by the imaging manager that it was important to focus on issues which might arise due to the contrast medium used in imaging procedures that could have an effect on patients with reduced renal function.

## Cleanliness, infection control and hygiene

- There were systems in place to reduce the risk and spread of infection. Patients spoken to told us the department was cleaned to a good standard. We observed cleaners cleaning equipment in all areas of outpatient services.
- We observed areas in the main outpatient department, clinic rooms and corridors were cleaned to a good standard. We were told the cleaning audit in April 2014 had a rating of 98%. There was access to hand sanitising gel for staff to use between patients.

## Environment and equipment

- We noted that the outpatient department was purpose-built and fit for purpose. We noted the resuscitation trolleys had been checked daily and that this was clearly documented. Equipment was checked every morning to ensure it was fit for purpose. When equipment failed, staff followed guidance for decontamination and arranged for the electronics and medical engineering department to collect, repair and return the item.

## Medicines

- We were told by staff that there was good information available for patients concerning changes in their medication. Medicines were stored correctly, in locked cupboards or fridges in the outpatient department.

## Records

- We observed that patient records were placed outside clinic rooms in open boxes. We were told by staff this was a long-standing arrangement and staff expressed concerns around patient confidentiality. We were told the outpatient department were trying to obtain 11 lockable trolleys to enable the notes to be stored securely.
- We noted the condition of some patient records were not in good order and this was particularly in relation to large patient folders. We were told there wasn't a problem with missing notes.

## Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- We were told staff had become more aware of mental capacity issues concerning the vulnerability of patients who used transport services. We were told it was essential that patients were supported throughout their outpatient experience. Staff told us support was accessed from the safeguarding team if patients required additional support. Staff had all received training in the Mental Health Act 2005. Staff were aware of how to access the safeguarding team if patients required support.

## Safeguarding

- Attendance at children's safeguarding training was mandatory for all staff in outpatient services. All outpatient staff had attended training in adult and children's safeguarding and attendance rates were 100%.
- The radiology manager told us the x-ray clinics did their best to ensure all staff were released to attend either face-to-face training, or to complete the online training module. We noted that not all staff were up to date with their children's safeguarding training, although attendance for adult safeguarding had improved.
- We noted that the system for capturing staff attendance every three years was difficult to navigate. We were told that this contributed to a small number of staff being out of date, each year.
- Safeguarding information was available to staff in the main outpatient office.

## Mandatory training

- A designated clinical lead oversaw the attendance of staff mandatory training in the radiology clinics. We were made aware that it was sometimes difficult to ensure all staff met their training requirements due to clinical need in the clinic.
- We were told by the imaging manager that mandatory training was up to date in the department and compliance was 90%.

## Management of deteriorating patients

- Staff had access to emergency equipment in the event of a patient becoming unwell. In the event of a patient's condition deteriorating, a 999 call would be made and the patient would be transferred to the appropriate hospital for emergency treatment.

# Outpatients

## Nursing staffing

- We spoke to nursing staff, who told us that the staffing levels were sufficient to meet the care and support the needs of patients in the outpatient department. We were told that, at times, it was necessary to move staff around if there were any staff shortages or due to staff sickness.
- We observed throughout our inspection that there appeared to be sufficient staff to support patients' care and support needs.
- We were told by staff that one of their biggest problems was the need for specialist nurses to travel between Royal Sussex County Hospital in Brighton and Princess Royal Hospital outpatient clinics, which could cause a delay in clinic start times.
- There were no nursing or support staff vacancies at the time of the inspection. Staff turnover was very low and many of the nursing staff was experienced and skilled practitioners in outpatient treatments.

## Medical staffing

- Medical staffing for clinics was set in conjunction with the template, which sets out the number of clinics and doctors required for each session.
- In order to maintain cover, there was a system in place via the patient access managers and speciality leads, for notifying the booking Hub of any planned leave in order to prevent short notice cancellations due to lack of medical staff. This was relevant particularly where communication between the Hub and patient access managers regarding planned and unplanned leave had not occurred.
- However, the Hub continued to cause problems, with staff having to cancel clinics due to insufficient doctors being allocated to run a clinic.
- A consultant who was planned to run a cardiac clinic had been double-booked by the Hub. 12 patients that were booked to attend the second cardiac clinic had to be sent home. Datix reports were forwarded to the Hub by the matron for outpatient services.
- On the same day, a digestive diseases clinic had been cancelled by the Hub and the attending patients were also sent home.

## Major incident awareness and training

- The trust had a major incident plan, which set out key responsibilities and actions to be taken by the first

responders and other staff. The policy included details of business continuity plans. Staff had attended training in fire evacuation training and knew how to respond in the event of an emergency.

## Are outpatients services effective?

Not sufficient evidence to rate

Patients told us that "overall" they were happy with the effectiveness of the outpatient service at the Princess Royal Hospital and found the staff to be friendly and supportive. Staff were unaware of the cancellation rates in their own outpatient areas or in the wider outpatient department.

Incident reports about the Hub were received daily and identified where patients were incurring real harm due to the length of outpatient waiting times. We saw evidence of where outpatient clinics had been double-booked or cancelled and the distress this had caused to patients.

## Evidence-based care and treatment

- The outpatient department followed the relevant NICE guidance. For example, in the treatment of cardiac pain, emergency procedures and awareness of the Mental Capacity Act 2005. NICE guidance was speciality-based within the speciality or division. The relevant guidance for staff to access was kept in the sister's office in the outpatient department.
- Nurses attended competency-based training built on NICE guidance or Standards for Better Health. For example, compression bandaging for the management of leg ulcers, and care of patients with diabetes and dementia.

## Patient outcomes

- We noted that the level of requests and potential delays in the endoscopy service could have had an impact on the bowel cancer screening audit.
- There was a lack of clarity and understanding in the outpatient department concerning information about patient outcomes. The matron and outpatient sister did not receive feedback on meetings about the referral to treatment times (RTT), the did not attend (DNA rates and the progress with the Hub. There were also a number of incidences when both cardiac and digestive diseases clinics were overbooked while 20 patients attended the clinic. This caused the clinics to overrun

# Outpatients

and affected the outcome of each patient's treatment, because the time allocated to each patient was reduced. Patients had become upset and verbally aggressive with staff, as further delays had been incurred on two already oversubscribed clinical services.

- We identified that there were delays relating to specific clinics. For example, cardiac and digestive diseases and rheumatology clinics. Rheumatology patient cancellations by speciality were 24.4% and DNA rates 9.75%.
- The trust had continued to achieve the 18 week RTT standard, with 96.6% of patients complying with the outpatient standard. The NHS operational standard for outpatient services is 95%.
- However, orthopaedic and digestive diseases did achieve compliance in March 2014, orthopaedics was 96.5% and digestive diseases 98.9%. However these two specialties have amassed a backlog of patients waiting for surgery and these two specialities have failed the incomplete pathway standard. Performance against the six-week target for 'diagnostic tests' was within the required standard.
- In the minutes of the Executive Quality and Safety Committee for April 2014, concerns were raised around patient outcomes concerning the number of daily Datix reports received regarding the Hub. Datix reporting had shown real harm being caused to patients by these delays. Complaints had continued to be received from patients, who were angry, upset and really suffering. They found the explanation they were given about the difficulties around the Hub difficult to understand.

## Competent staff

- Staff appraisals were undertaken every six months and a plan was in place to complete all appraisals in 2014. We observed that 90% of appraisals had been completed in the department, with staff being responsible for booking their appraisal sessions with their manager.
- Staff were able to access training for specialist areas in the outpatient department and we noted a number of staff had received cannulation training. They had been supported to undertake their practical assessments in clinical areas in the hospital. We noted first year student nurses were allocated placements in the outpatient department.

## Multidisciplinary working

- Referrals were made to other disciplines to support patients in the outpatient department. For example, the learning disabilities nurse, the dietician and the translation service. We saw information around the department of other services available to patients in the trust and provided by other agencies. The outpatient service had good relationships with GPs in the local area.

## Seven-day services

- Outpatient services were provided over five days with some clinics run in the evenings. There were no plans at the current time to run seven-day services.

## Are outpatients services caring?

Good



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# Outpatients

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## Seven-day services

- Outpatient services were provided over five days with some clinics run in the evenings. There were no plans at the current time to run seven-day services.

## Are outpatients services responsive?

Requires improvement



Patients had expressed frustrations and concerns around the implementation of the centralised booking system (the Hub). The objective of this had been to centralise the booking system in order to provide a robust governance structure to waiting list management and improve the access for patients and users.

Initial problems with the Hub had resulted in a backlog of 5,000 referrals and a delay into pathways of up to six weeks. Incident reports had continued to be received around the risks to patients caused by the delays in referral and treatment times. Plans were in place to address the service shortfalls.

One patient told us that they had been told their appointment had been cancelled when they had not received an appointment. The patient was told they would need to ring the booking line (the Hub) to make an outpatient appointment in the future. The patient told us that the problems they were experiencing did get sorted out eventually, but it had been really frustrating and difficult.



# Outpatients

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

- Staff told us about the centralised booking system (the Hub) for all outpatient services, which had been put in place across the trust in October 2013. They reported that outpatient clinic bookings through the Hub had caused significant difficulties for patients attending the outpatient department at the Princess Royal Hospital. One area of concern raised by staff from outpatient services was their lack of involvement in the planning meetings with the Hub.
- We noted that the percentage of patients waiting to start treatment within 18 weeks was 92.1% and the NHS operational standard is 92%. For those patients who had completed their pathway and treatment that did not involve an admission to hospital, outpatient appointments were 96.6% with the NHS operational standard being 95%. We were unable to identify if there were delays relating to specific clinics, but were told that there were long waits in cardiology, ENT and medical digestive diseases. The levels of nonattendance were particularly high for neurology and rheumatology.
- Referrals received by the Hub were not scanned into the referrals management system (RMS) for triaging (prioritising) within 48 hours. The delay had led to a backlog of 5,000 referrals because of the Hub, and a delay into the pathways of up to six weeks. The issue was addressed in January 2014. Patients were added to the waiting list once scanned at the date the patient's referral was received and therefore their waiting time was accurate. This led to pressure on the service to treat patients in 18 weeks.
- At the time of our inspection, referrals were being scanned for triage and were registered within 48 hours. A dedicated team has been in place since January 2014 to manage this. Recovery teams were in place/being developed to understand the impact and the requirement to mitigate the activity lost due to booking issues.
- The management of the two week wait pathway has been adversely affected. Joint working with the Clinical Commissioning Group (CCG) was in place to reduce the pressure with an agreed strategy to downgrade inappropriate referrals and non-compliance with patients to an urgent category.
- The minutes of the Executive Quality and Safety Committee for April 2014 clarified the actions being taken to address the ongoing concerns surrounding the efficiency and safety of the Hub. These included:
  - A dedicated email address with a 24-hour response time.
  - A new process to allow software systems involved to 'speak' to each other.
  - A new process for managing follow-up appointments (six week plus).
  - Improved ongoing communication with service managers to ensure clinic templates and clinical pathways guidance was accurate and representative of demands.
  - A data cleansing exercise of the waiting list to ensure it accurately reflected the number of patients waiting for surgery.
  - Lists of who to contact if a patient could not be booked into the required clinic.
- One patient told us they had been told their appointment had been cancelled when they had not received an appointment. The patient was told they would need to ring the booking line (the Hub) to make an outpatient appointment in the future. The patient told us they did get the issue sorted out eventually, but it had been really frustrating and difficult to do so.
- Another patient told us they regularly attended the haematology clinic and their appointment was always on time. However, the patient's relative told us about the problems with the letter they had received (from the Hub), which did not indicate which hospital their relatives appointment was for. The relative told us this was a problem for patients who had got used to going to the same site to have their blood taken, to then find their appointment had been changed to a different hospital.
- We observed the outpatient department had responded to patients' concerns and complaints by arranging its own outpatient appointments for patients. The Hub had continued to make the first outpatient appointment for patients. The outpatient department at the Princess Royal Hospital then made follow-up appointments for patients within the next six weeks. Subsequent outpatient appointments (after six weeks) were then made by the Hub.
- On the afternoon of our inspection, a surgical digestive diseases clinic in the main outpatient department was cancelled, as the consultant had been double-booked.



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The clinic had been set up by the Hub and arranged in February 2014, but no consultant had been allocated to the clinic. We were told the booking template used by the Hub was being amended to help identify who was responsible when an incident occurred. 13 patients were waiting to attend the clinic and had to be sent home.

- The consultant for the medical digestives clinic which was due to start at 1.30pm (and had been double-booked for the surgical medical digestives clinic) found there were no patients booked until 3pm, which incurred wasted clinic time. No one was able to clarify why these incidents had occurred and what could be done to address the failing in services.

## Access and flow

- We observed the x-ray booking system managed patient appointments from ED, GP referrals and outpatient services. We were told that there was a walk-in service for patients, which was available five days a week from 9pm till 4pm.
- Patients requiring urgent ultrasound and CT scans were seen within two weeks and non-urgent appointments were seen within six weeks. CT scanning was available 24 hours a day and the Hurstwood Park Neurosciences Centre CT scan was available overnight. Urgent ultrasound scanning was available via the on-call service. We were told patients waiting for musculoskeletal injections could wait for up to three months.
- There was a six-week target for all radiology procedures, except therapeutic ultrasound. The manager told us they reviewed the waiting list weekly and the results were reported to the clinical governance committee. A review of room capacity and sonography staffing was undertaken regularly to support the department in meeting the six-week target.
- On the day of our inspection we noted the wait time in the main outpatient department at 10:30am was twenty minutes.
- Staff we spoke to told us patients attending outpatient services for their first referral appointment would usually have an appointment time of 30 minutes. However, occasionally, due to a higher level of clinic activity, the first appointment would only be for 15 minutes.
- The sister of the outpatient department told us that there were a small number of problems with patient

transport. This was due to delays in collecting patients at the end of outpatient clinics. Therefore, patients could still be waiting for collection after 7pm, in extreme circumstances. The sister told us they would contact the out-of-hour's ambulance service and patients were able to access food and hot drinks while they waited.

- We were told by a patient who had attended the neurology clinic at Hurstwood Park Neurosciences Centre that their appointment had been made by the consultant's secretary. The patient told us directions to the clinic were difficult to follow, but once there, everything ran to time. When the patient asked for a copy of their scan results they were told they could collect it in the main hospital later that day, which the patient was delighted with.
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- There were delays for physiotherapy outpatient appointments with patients having to wait for up to three months, as the department had vacancies at the current time. We were told four new physiotherapists had recently been appointed.
- Patient referral access and follow-up arrangements were, in some cases, negatively impacted as a result of inadequacies of the booking Hub. The trust must ensure that patient referrals are acted upon promptly and that patients who need to be seen post-operatively have access to the correct consultant at the correct time.
- The booking system was found to have deficiencies in efficiency and effectiveness, with delays to referral and treatment, incorrect follow-up appointments booked, and wrong information being given out.

## Meeting people's individual needs

- The need for translation services for patients where English was not their first language, would be ascertained at the point of booking an appointment. A request for support was then made and checked to ensure the service would be available at the time of the appointment.

## Learning from complaints and concerns

- We were told by staff that the majority of complaints were about patient waiting times and were resolved

# Outpatients

locally. Complaints that could not be resolved were managed by the Patients Advice and Liaison Service, who liaised with the booking line for outpatient appointments. Formal complaints were investigated by the departmental manager. It was noted that there was a low level of formal complaints received in the department.

- We noted that the recent outpatient services survey results (2013) had identified failings by staff to communicate effectively to patients on the progress of the outpatient clinics across the department. We saw a whiteboard was now in place to tell patients what was happening around clinic times, and so on. The board was complete and up to date. This demonstrated that the provider had listened to patients' concerns and had made reasonable adjustments to address the shortfall.

## Are outpatients services well-led?

Requires improvement



Patients had expressed frustrations and concerns around the implementation of the centralised booking system (the Hub). The objective of this had been to centralise the booking system in order to provide a robust governance structure to waiting list management and improve the access for patients and users.

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# Outpatients

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# Outstanding practice and areas for improvement

## Outstanding practice

- In the critical care unit, the letters received from patients and their families have described outstanding care.
- The patient diary used for a while in the neurological unit, and being introduced in general critical care, provides unit survivors with a description of their stay in critical care.

## Areas for improvement

### Action the hospital **MUST** take to improve

- Ensure that there are sufficient numbers of staff for critical care and medical wards.
- Review the provision and skills mix of staff to ensure they are suitably trained to meet the needs of children who use the service.
- Ensure that patient flow does not impact on access to services and treatment.
- Ensure that equipment allocated to manage sick children or newborn babies is routinely checked to ensure it is safe for use.
- Ensure that planning and delivery of care on the obstetrics and gynaecology units meets patients' individual needs.
- Address the culture between staff groups to prevent potential harm to patients.
- Review and monitor all aspects of the Hub, in particular for high-risk patients who are unable to access urgent referrals for treatment through the Hub.

### Action the hospital **SHOULD** take to improve

- Ensure that the Princess Royal Hospital emergency department is fully integrated into the governance structure within the medicine directorate.
- Ensure that learning from incidents, accidents and complaints is disseminated among staff to ensure changes to practice are fully embedded.
- Ensure that consultants are available to support members of the medical team at all times when on call.

- Continue the work to introduce more midwife-led pathways to help normalise birth and reduce the rates of caesarean sections.
- Ensure equipment in all of the departments is checked, as required, and the outcomes recorded.
- Ensure IT connectivity across all clinical bases is at a level where all community midwives can review essential information.
- Ensure cover is in place for specialist services as part of the workforce planning.
- Ensure that senior staff for outpatient services receive the necessary performance data for referral to treatment targets and non-attendances (DNAs) to enable them to more effectively manage the outpatient services at the Princess Royal Hospital.
- Maintain the security of patient records at all times.
- Ensure that the senior staff for outpatient services are part of a wider clinical governance framework for outpatient services, across the trust.
- Ensure that staff are able to access mandatory training.
- Ensure the secure storage of medicines in critical care.
- Develop and use care plans for patients for whom restraint has been necessary.
- Maintain the privacy and dignity of patients on the neurological unit.
- Ensure the trust-wide profile for end of life care is reviewed in line with the recommendations of the End of Life Care Strategy (2008).
- Communicate changes to service configuration in a timely manner to relevant staff.

## Compliance actions

### Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services</p> <p><b>How the regulation was not being met:</b> People who use services and others were not protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of carrying out an assessment of the needs of the services user and the planning and delivery of care and, where appropriate, treatment to meet the needs and ensure the safety and welfare of the service users. Regulation 9 (1) (a) (b) HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services</p>
Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers</p> <p><b>How the regulation was not being met:</b> The provider had not protected service users against the risk of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to enable the registered person to- regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this part of the Regulations: and</p> <p>Identify, assess and manage risks relating to the health, welfare and safety of service users and other who may be at risk from the carrying on of the regulated activity,</p> <p>Regulation 10 (1) (a) (b) Assessing and monitoring the quality of service provision</p>



This section is primarily information for the provider

## Compliance actions

### Regulated activity

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

### Regulation

Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment

**How the regulation was not being met:** The registered person had not ensured that equipment was available in sufficient quantities in order to ensure the safety of service users and meet their assessed needs. Regulation 16 (2) Safety, availability and suitability of equipment

### Regulated activity

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

### Regulation

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

**How the regulation was not being met:** The provider had not taken appropriate steps to ensure that at all time there were sufficient numbers of suitably qualified and experienced persons employed for the purpose of carrying on the regulated activity. Regulation 22 Staffing

### Regulated activity

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

### Regulation

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

**How the regulation was not being met:** The provider had not ensured suitable arrangements were in place in order to ensure that persons employed for the purpose of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard including by- Receiving appropriate training, professional development and appraisal

Regulation 23 (1) (a) Supporting workers