

University Hospitals Sussex NHS Foundation Trust

Princess Royal Hospital

Inspection report

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Haywards Heath
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Date of inspection visit: 1 to 3 August 2023
Date of publication: 14/02/2024

Ratings

Overall rating for this location

Requires Improvement 

Are services safe?

Requires Improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Requires Improvement 

Are services well-led?

Requires Improvement 

Our findings

Overall summary of services at Princess Royal Hospital

Requires Improvement ● → ←

Princess Royal Hospital is one of the hospitals of University Hospitals Sussex NHS Foundation Trust and provides clinical services to people living in and around Haywards Heath.

At this inspection we inspected the surgery core service at Princess Royal Hospital. We found there was a deterioration in the quality and safety of the surgery service since the last inspection of surgery in 2019, resulting in a drop in their rating. There was no change to the overall rating of Princess Royal Hospital. More detail about the findings and required improvements can be found in the surgery core service section of this report.

Surgery

Requires Improvement ● ↓

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

- The service did not always have enough staff to care for patients. Mandated training did not include training about how to interact with people with a learning disability and autistic people.
- The service did not always have enough equipment to help staff provide safe care and treatment to patients. Staff did not always store and manage medicines safely.
- The service did not have full oversight of incidents and near misses as staff did not report all incidents and near misses.
- There were delays in reviewing and implementing national guidance.
- The service did not effectively plan care to meet the needs of local people, with demand outstripping capacity. People could not always access the service when they needed it and had to wait too long for treatment. There was continued evidence of long waiting times and repeated cancellations to surgical operations.

However:

- The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Locally, managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service took account of patients' individual needs and made it easy for people to give feedback.
- Locally, leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. All staff were committed to improving services continually.

Is the service safe?

Requires Improvement ● ↓

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

Mandatory training

The service provided mandatory training in most key skills to all staff and made sure everyone completed it.

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Staff received and generally kept up-to-date with their mandatory training. The majority of mandatory training had a good attendance rate for staff; the attendance was on average 92%. The trust target for attendance was 90%. However, it was not possible to identify mandatory training compliance figures for Princess Royal Hospital. The surgical division was across both Princess Royal Hospital and Royal Sussex County Hospital and the staffing data was not separated into data for each individual hospital.

The mandatory training was comprehensive and met the needs of most patients and staff. The mandatory training was aligned to the key skills in health and met the needs of patients and staff. The trust offered clinical staff training on learning disabilities, autism and dementia and on recognising and responding to patients with mental health needs. However, this training was not mandated. Since July 2022 it is a legal requirement for all staff to receive training in how to interact with people with a learning disability and autistic people. Training attendance for learning disability and autism was low at 42%. The trust had only recently provided training for learning disability and autism and was planning to improve attendance going forward.

Managers monitored mandatory training and alerted staff when they needed to update their training. Ward managers used an electronic dashboard to monitor staff compliance with mandatory training. Individual teams discussed mandatory training at their monthly meetings and staff were emailed 90 days before the training expired to book onto the training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. The trust target for attending safeguarding training was 90%. Records showed 92.8% of staff had attended the required levels of training. However, there were 27 members of staff who required level 3 training and only 14 had completed the training, which was a completion rate of 42%. The trust could not confirm when the remaining staff would complete the training. Most staff we spoke with during the inspection knew what a safeguarding concern was. All staff we spoke with knew the process of reporting a safeguarding and showed us the documentation involved and the trust intranet site with safeguarding information.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff had a good knowledge of what constituted harassment and discrimination. They understood protected characteristics. Staff said patients were treated equally regardless of gender, race, religion or any other protected characteristic. We reviewed the documentation for two patients with protected characteristics and found them both to be fully completed. The protected characteristics defined by the Equality Act (2010) are age, sex, race (including ethnicity and nationality), disability, sexual orientation, religion or belief, gender reassignment, pregnancy and maternity and marriage or civil partnership.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Most staff could describe the types of abuse adults and children could be at risk of; for example, physical, emotional, financial and including female genital mutilation.

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Staff knew how to make a safeguarding referral and who to inform if they had concerns. Ward areas displayed boards which had information on what to do if staff had a safeguarding concern. In addition, we were shown the local intranet page which had information on what abuse was and the process to follow if staff suspected abuse had occurred. Staff had access to an up-to-date guidance policy, via the internal intranet, called Safeguarding Adults Policy. They also had access to a policy for Safeguarding Vulnerable Children and Looked After Children Policy.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The hospital had an infection, prevention and control team who had primary responsibility for providing advice and expertise in all aspects of infection prevention and control. There was an antimicrobial stewardship group which included a representative from the pharmacy team.

Patients were screened for presence of Meticillin-resistant Staphylococcus aureus (MRSA) at their pre-assessment appointment. This policy was under review by the Director of Infection Prevention and Control with a view to screening the patient for this infection nearer the date of surgery.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. All areas were visibly clean. Cleanliness of the clinical areas was audited by the head of nursing for that area. Records showed all areas of infection prevention and control were covered as part of the audit. Action plans had been developed to drive improvements and progress was monitored in monthly review meetings.

The service performed well for cleanliness. Ward managers collected electronic data on the fundamentals of care which included infection prevention and control. Concerns were escalated to the matrons and heads of nursing and action plans to address any issues were developed and monitored. Staff had access to policies and procedures, via the internal intranet, which supported them in managing infection prevention and control.

Patient-Led Assessments of the Care Environment (PLACE) Programme had recommenced following the COVID pandemic. PLACE assessments are an annual appraisal of the non-clinical aspects of NHS and independent/private healthcare settings, undertaken by teams made up of staff and members of the public (known as patient assessors). In the most recently published PLACE assessment of Princess Royal Hospital (2022), the hospital scored 96% for cleanliness of the hospital environment.

The service monitored the number of patients who had hospital acquired infections such as Meticillin-resistant Staphylococcus aureus (MRSA), c-difficile, pseudomonas aeruginosa, methicillin-susceptible staphylococcus aureus (MSSA), e-coli and klebsiella. A hospital-acquired infection is an infection that is acquired in a hospital or other healthcare facility. Records showed average rates of the following infections in the 3 months before the inspection; 16 cases of c-difficile, 4 cases of pseudomonas aeruginosa, 18 cases of MSSA, 56 cases of e-coli, 24 cases of klebsiella and 2 cases of MRSA. In comparison with NHS trusts in the area this trust was either in the low 25% (worse than) or 50% (similar to) of trusts. Records showed that all cases of these infections had been investigated by a root cause analysis investigation. An action plan was developed and implemented to prevent a reoccurrence of the infection.

Staff used records to identify how well the service prevented infections. Hand hygiene audits were undertaken weekly by ward staff. Validation audits were undertaken monthly by a member of the hospital Infection Prevention and Control Team. Weekly ward Infection Prevention and Control assurance audits were undertaken in all clinical areas. Monthly

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environmental validation spot check audits (which included decontamination of equipment) were undertaken by the Infection Prevention and Control Team monthly. A commode audit was also undertaken monthly. Results were verbally fed back at the time of the audit and further information and photos were uploaded via the electronic audit system. Leaders used the audit results to tackle poor practice and drive improvements. All areas we visited were visibly clean and staff complied with infection prevention practices.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE, including surgical facemasks, nitrile gloves and plastic aprons, were available in all areas we inspected. Clinical handwashing sinks and alcohol hand gel were available in all areas we visited. All staff in clinical areas were bare below the elbow. On the day of inspection all staff we saw cleaned their hands in accordance with the World Health Organisation five moments of hand hygiene. The 5 moments of hand hygiene instruct clinical staff to wash or decontaminate their hands before and after patient contact, after exposure to bodily fluids, before a clean or aseptic procedure and after contact with the patients' surroundings. There were hand hygiene stations outside ward areas and at regular intervals inside the ward areas. Each hand hygiene station displayed instructions for washing hands, the 5 moments of hand hygiene, alcohol gel and soap and a clinical sink.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. In all areas we visited we observed staff cleaning equipment after patient use and using 'I am clean' stickers to denote equipment was clean and ready to use. This included ward areas and the operating theatres.

Staff worked effectively to prevent, identify and treat surgical site infections. Records showed staff monitored surgical sites regularly and escalated concerns about potential surgical site infections to the medical team. General and specialist surgery had employed a nurse who led on preventing surgical site infections. The trust had a surgical site infection team who collected data, identified areas for improvement opportunities and supported practice development on the wards. This trust did not provide us with surgical site infection data so we are unable to comment on their performance.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. In all areas we visited patients had access to call bells and these were answered promptly by staff when used. Patients told us they had no hesitation in alerting staff to any issues they needed assistance with during their stay in the hospital.

The design of the environment followed national guidance. All areas, including wards and the operating theatres had been designed to meet DH Health Building Notes 04-01. The operating theatres had recently had an extensive refurbishment. Most ward bed areas had piped oxygen, which was compliant with the health and safety executive directive oxygen in the workplace. Portable oxygen cylinders were available if needed when there was no piped oxygen by the bed area. Fire exits were clearly marked, and all fire extinguishers had relevant checks completed.

All wards and the operating theatres had a locked entry door system; visitors needed to be admitted by staff after pressing an entry buzzer. Visitors told us there was no delay in being admitted to the wards.

Staff carried out daily safety checks of specialist equipment. Records evidenced staff completed daily checks of equipment to be used in the event of an emergency. Staff ensured consumables were in date and present. This included essential equipment within the operating theatres and on the wards.

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The service did not always have enough suitable equipment to help them to safely care for patients. Staff told us there was not enough monitoring equipment or computers on wheels (COWs) on the wards. This led to a delay in staff being able to check patients' vital signs or access the electronic systems needed to monitor patients notes and test results.

Staff disposed of clinical waste safely. In all areas we visited, waste was separated correctly. Waste was divided into general waste, infected waste and recycling. Bins were clearly labelled, and the correct waste collection bag was in the correct bin. Waste was collected regularly from ward areas and stored in a locked bin store while awaiting disposal. All used equipment in the operating theatre were decontaminated in the central sterile services department.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS2) was used in the service to identify patients at risk of deterioration. We reviewed 10 patient records and found the scores were completed correctly. When a concerning score was calculated staff escalated the patient for medical review. During the day the wards had doctors to review patient and out of hours the wards were supported by an outreach team who specialised in caring for deteriorating patients. The outreach team monitored NEWS2 scores remotely and did not need to be alerted to review the patient.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff knew about and dealt with any specific risk issues. The patient record included a range of risk assessments which included – falls, pressure areas, sepsis, nutrition and venous thromboembolism (VTE). Staff knew about and dealt with any specific risk issues. We reviewed 10 records during the inspection and found them to be completed correctly. Records showed that compliance with VTE assessments was between 95% and 100% in the 3 months before the inspection.

The hospital had implemented a sepsis care bundle which educated staff on the risks of sepsis in patients. Sepsis is a life-threatening reaction to an infection. Sepsis management was taught as part of the Acute Illness Management course (AIMs), which all nursing staff were required to complete. There were further simulation scenarios included on sepsis on the preceptorship programme. Records showed 82 staff across the surgical division had completed the sepsis learning. However, this data was for Princess Royal Hospital and Royal Sussex County Hospital. There was no way to determine how many or the percentage of staff working at Princess Royal Hospital who had completed this training.

Compliance with the World Health Organisation (WHO) theatre checklist was monitored every month via 2 audits: an observational audit of practice and a retrospective audit of documentation. The operating theatre department used dedicated audit software to record and analyse their performance. Reports produced were shared at the Peri-Operative Standards Meeting which was responsible for audit and governance in theatres. In addition, compliance was also reported to the Surgical Divisions Governance meeting. The data was included on the Trust's Quality and Safety Scorecard. In the 3 months before the inspection Princess Royal Theatres completed 2 out of the 3 monthly audits and scored between 94% and 98.2% compliance with the WHO checklist. In the month the observational audit was missed the retrospective audit showed a 90% compliance rate with the checklist.

The Royal College of Radiologists safety checklist had been implemented at the hospital. The use of the safety checklist was audited annually. Compliance with the safety checklist was between 48% and 52% in the last audit completed in 2022. The hospital did not provide us with a plan to improve the compliance with this safety checklist. There was therefore no assurance that performance with this safety measure had improved.

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Staff shared key information to keep patients safe when handing over their care to others. Staff used a handover sheet to record key information when handing over care to other staff. When moving wards, an electronic handover was given to the receiving ward. The patient notes were available in real time to all staff. For complex patients there would be a call between wards to discuss the issues.

Shift changes and handovers included all necessary key information to keep patients safe. Each area had a safety huddle twice a day. All staff on duty attended the huddle and were updated on all key information. We observed several huddles during the inspection and saw there was a standard agenda. This covered for example: staff wellbeing and staff numbers; patient infection status (covid), and incidents or events for learning.

Nurse staffing

The service worked flexibly but were not able to ensure there were enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

The service did not always have enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The staffing rotas were created using an electronic rostering system and agreed 6 weeks in advance by ward managers and matrons who ensured the system had safely allocated staff. Bank and agency staff could be used to fill gaps in the rota. The surgical matrons had a staffing huddle 3 times a week and reviewed any gaps across the division. Staff were moved to ensure minimum safe staffing levels. Additionally, staffing was reviewed periodically during the day across the division and any gaps were addressed. Staffing was monitored through the safer staffing reports.

In the operating theatres the daily risk assessment of the level of risk against the recommended staffing and skill mix template was completed. Any deficit was escalated to senior leaders in the team to resolve. Theatre staff told us that they were regularly moved to the Royal Sussex County Hospital (RSCH) to cover gaps in the rota. This made them feel vulnerable as they were allocated to theatre lists at the RSCH which they felt did not have the correct skills or experience to work safely. Leaders told us that the skills of the staff member were considered when moving staff to the RSCH. However, there was no formal guidance policy for moving staff between sites although a risk assessment was completed.

The service had low vacancy rates, low turnover rates and low sickness rates. However, despite this the number of nurses and healthcare assistants did not match the planned numbers. Records showed that in the three months before the inspection fill rates of shifts for nurses and healthcare assistants varied between 30% and 95%. The hospital did not provide us with data to show fill rates once staff had been moved to poorly staffed areas. Staff levels were reviewed regularly during the shift and staff were moved according to the risk of low staffing. Staff told us this was frustrating as they preferred to work on their own ward but understood the safety of the patient was the most important consideration. The staffing data provided by the trust was for surgical services across Princess Royal Hospital and Royal Sussex Hospital. This meant it was not possible to have an accurate assessment of the safety of staffing at Princess Royal Hospital.

Surgery

The service had moderate rates of bank and agency nurses. If possible bank staff were used to fill vacant shifts. In the three months before the inspection Twineham Ward had 4 shifts filled by agency nurses and 373 shifts filled by bank nurses, Ansty Ward had 33 shifts filled by agency nurses and 325 shifts filled by bank nurses and Newick Ward had 4 shifts filled by agency nurses and 68 shifts filled by bank nurses.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. During the inspection staff could describe how they orientated a temporary member of staff to ensure patients were kept safe. Agency staff on duty told us they had a full induction and were orientated to the ward area at the start of the shift. However, there was no paper record to confirm this had happened. Managers told us they tried to block book agency staff to provide some continuity for the patients and teams.

The data for long term agency workers was reported monthly and monitored by the trust's temporary staffing team. The clinical lead provided support and oversight in conjunction with the ward manager, this included managing under-performance where necessary. Agency workers were encouraged to feel part of the team and provided valuable support to ensure the hospital met safe staffing ratios. The hospital participated in agency performance management processes, for example by completing agency worker feedback forms. Records showed the theatre induction tool covered fire protocols, environment, emergency equipment, theatre standards, documentation, medicines management, patient collection, local policies, infection prevention and timesheets / agency badges.

Medical staffing

The service mostly had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, there were challenges with medical staff support for patients operated on at the hospital by Royal Sussex County Hospital surgeons.

The service had enough medical staff to keep patients safe. The medical staff matched the planned number. Records showed that there were enough medical staff on duty to care for the patients. Medical staff we spoke with on the day of inspection did not identify an issue with staffing.

The service had low vacancy rates for medical staff. The trust did not keep separate data for the Princess Royal Hospital but the medical vacancy rate for the Royal Sussex County Hospital and Princess Royal Hospital was 6.04% at the time of inspection.

The service had increasing turnover rates for medical staff. The trust did not keep separate data for the Princess Royal Hospital but the medical turnover rate for the Royal Sussex County Hospital and Princess Royal Hospital was 10.94% at the time of inspection. This was an increase since August 2022 when the turnover rate was 8.8%. It was not possible to comment on the sickness rates for medical staff as the hospital had not provided this information when it was requested.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. Records showed that locum doctors were employed as needed and had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The medical staffing department reviewed the skill mix of medical staff on duty and ensured all shifts were filled with medical staff competent to fulfil the role required.

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The service always had a consultant on call during evenings and weekends. Medical staff confirmed during the inspection there was always a consultant on call, however we were unable to verify this with records as they were not submitted to us by the hospital after the inspection. Staff said that surgeons from the Royal Sussex County Hospital operated at the Princess Royal hospital once a week. There was an agreed pathway of care with support from the onsite medical team, however this was not always effective when a complication occurred as the operating doctor had left the site. It was often difficult to get medical support for the patient if there was a complication after the operation as the operating doctor had left the site. This increased the risk of avoidable harm to patients. Staff said they had raised this risk with managers, but the issue had not been resolved.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. During the inspection we reviewed a selection of 10 notes and found records were comprehensive. Patient notes were a combination of paper notes and electronic notes.

When patients transferred to a new team, there were no delays in staff accessing their records. Patient notes in an electronic format could be accessed from any terminal in the hospital. Nursing notes were kept in paper format and shared with the new team caring for the patient.

Records were stored securely. In all areas we visited paper notes were stored in locked trollies which meant only those with authority could access them. All computer terminals could only be accessed with an individual log on, and password protected. All terminals not in use were locked to prevent unauthorised access.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, medicines were not always stored correctly.

Staff followed systems and processes to prescribe and administer medicines safely. The Trust had an electronic prescribing and administration (EPMA) system for medicines which had inbuilt safeguards and reports were run routinely to ensure safe prescribing. There were some issues that had been identified that were due to be addressed on the next upgrade. Some of the guidance documents that were in use by staff were out of date. This included guidance about what medicines to continue to administer when a patient was nil by mouth. The medicines management policy was available to staff via the internal intranet.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff completed medicines records accurately and kept them up to date. The trust's electronic prescribing and medicines administration process supported safe review and recoding of medicines.

Staff did not always store and manage medicines safely. A light sensitive medicine was stored on open shelving and in glass fronted cabinets across multiple locations. When raised with staff the product of concern was removed from stock and replaced.

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Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. However, in the discharge lounge, we saw that one patient had not been informed about changes to their medicines and arrangements had not been put in place to ensure that they continued to receive their medicines correctly post-discharge, the staff in the discharge lounge ensured this was rectified before they went home.

Incidents

Staff recognised incidents and near misses. However, staff did not report all incidents and near misses. Local managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Local managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Managers shared learning with their staff about never events that happened elsewhere. Staff of all grades said they were encouraged to report incidents and near misses and the electronic incident reporting system was accessible and easy to use. However, staff said they tended to only report the more serious incidents as they were often too busy to report the more minor incidents. Review of national data indicated that trust wide from October 2022 to October 2023 the trust reported fewer incidents than trusts of similar sizes and complexities. The trust also recognised, detailed in the Patient and Quality Committee report for August, September and October 2023, that incident reporting across the trust was low.

The service had an incident reporting policy staff could refer to as a reference for updated guidance on reporting incidents. During the inspection we reviewed the documentation of 5 incidents and found them to have been reported, investigated and learning shared in line with the trust policy.

Staff reported serious incidents clearly and in line with trust policy. Staff described the reporting procedure for the trust and told us how they reported serious incidents via the electronic reporting system.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Senior staff in the hospital described duty of candour and when it should be used with patients and families. The investigation reports checked that duty of candour had been carried out correctly. Records showed that in the 12 months prior to the inspection duty of candour was applied each time it was required.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they received feedback from their managers about the incidents they reported.

Staff met to discuss the feedback and look at improvements to patient care. Records showed that learning from reported incidents was shared widely within the service. This was via staff meetings, safety huddles and newsletters.

Locally, managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We saw a completed investigation which focused on areas of good practice, care delivery problems, service delivery problems, root causes, concerns raised by family, immediate safety actions and a final risk rating.

Locally, managers debriefed and supported staff after any serious incident. It was evident, through conversations with staff, the wellbeing of the staff involved in incidents was considered and they were supported throughout the investigation process. Locally, leaders told us there was the opportunity for hot and cold debriefs following an incident. They also ensured staff were signposted to wellbeing and support services as needed. Locally, leaders facilitated after

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action reviews which promoted a no blame culture for reviewing incidents. After action reviews are learning-focused discussions that are designed to help the team and the organisation's leaders discover what to do differently in the future. However, there remained a lack of confidence amongst staff that incidents escalated to senior management at trust level were effectively considered and responded to.

Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. However, delays in review of some NICE guidance meant it could not be assured that all trust guidance was in line with national guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff used a patient clinical pathway record to plan, give and evaluate care and treatment. The document referenced National Institute for Health and Care Excellence (NICE) guidance for each plan of care. NICE and trust guidelines were available on the trust intranet. Staff said guidance was easy to access, comprehensive and clear to follow. They showed us how they accessed the guidance.

The trust had a policy for the Implementation of NICE Guidance and Quality Standards. Governance structures were in place to oversee and monitor the implementation of relevant NICE guidance across the hospital. Trust wide, out of 58 items of NICE guidance relevant to the surgical division, 10 were within 3 months of publication or update, (the new phase of implementation). There were 4 fully implemented guidance documents and 1 was in the action plan phase. However, 43 had not had yet had baseline assessments completed which meant it could not be fully assured the service was following national guidance.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. A review of information shared about the patient in a handover showed staff considered the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. We saw patients regularly being offered hot drinks and snacks. Fresh water was freely available and kept topped up by staff. Patients were offered 3 hot meals a day and there were 2 planned rounds in addition offering snacks such as biscuits or cake. Patients were supported to eat and drink if needed. Patients were generally positive about the quality and quantity of the food provided.

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Patients who had an extended stay in the post operative recovery room were provided with hot and cold drinks, sandwiches and soup if their condition allowed it.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Patient records in relation to nutrition were complete and up to date with dietitian reviews if needed. Nutrition and fluid care plans were followed with fluid balances totalled and acted upon appropriately. Staff used a nationally recognised screening tool. Records showed that between 87% and 100% of patients who required a nutritional assessment had received one.

Staff had access to a specialist team of dieticians who provided expert advice and care for patients with complex nutritional needs. In addition, there was a range of electronic guidance documents for staff to refer to at any time on the internal intranet.

Patients waiting to have surgery were not left nil by mouth for long periods. The hospital had implemented a policy call 'sip till send' which allowed patients having some procedures to sip water until they went to the operating theatre. This prevented patients from becoming dehydrated while waiting to go to the operating theatre.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately.

The hospital had a specialist pain team who supported the ward areas to manage patients' pain as needed. Staff told us this team were very responsive to requests for support. Patients told us any pain they experienced was well managed and staff responded promptly if they needed pain relief.

Staff monitored the pain level of patients and recorded the information. Pain scores were recorded in most patient notes. Staff used pictorial aids to assess the pain of patients who could not communicate verbally. During the inspection we saw evidence of the use of a person-centred pain tool for people less able to verbalise. Facial and body language cues were observed as well as asking for input from the patient's family to assess pain.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. The Trust audit schedule was interlinked with the wider clinical effectiveness work streams, including NICE Guidance. Audit leads specified the standards or guidelines they were assessing when they registered a clinical audit.

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All new audit registrations and reports were reviewed during the monthly clinical audit meeting, which linked to the wider clinical effectiveness work streams. These were documented using the trust's clinical audit review summary template. Examples of audits linked to NICE Guidance over the past 12 months included: Part A (1806) STH SRH WH PRH RSCH University Hospitals Sussex Endoscopy Guide and Part A (1883) PRH RACH Surgical Equipment in Tonsillectomies A Cost, Waste, and Carbon Footprint Analysis.

The Trust participated in the national audit Intensive Care National Audit & Research Centre (ICNARC), which covered the unit-acquired infections in the blood, alongside high risks sepsis admissions. This was completed by the surgery division at Princess Royal Hospital.

Outcomes for patients were mostly positive, consistent and met expectations, such as national standards. Records showed the division generally performed well in audits. There were action plans in place to improve areas that had been identified as needing improvement. For example, the National Hip Fracture Database annual report results showed the Princess Royal Hospital performed well in relation to prompt orthogeriatrician assessment, prompt surgery and had low rates of delirium post-surgery.

Locally managers and staff used the results to improve patients' outcomes. Records showed the divisional quality score care of performance metrics was reviewed weekly by leaders. Plans were made to make improvements as needed and shared with the wider team. The executive team responsible for surgery reviewed the data monthly. Following the inspection, we reviewed the data on the quality score card and saw how leaders used the scores to improve performance over time. We noted that there had been an improvement in the number of patients with suspected sepsis receiving antibiotics within an hour of diagnosis.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Records showed the results of the previous year's audit cycle results had been used as part of an action plan to improve patient outcomes. Action plans had been monitored and actions achieved as planned.

Locally managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits. Each area collected audit data on a large range of metrics which were used to drive improvements over time. Managers held monthly meetings to discuss the results of the audit data with their teams. This was an opportunity to recognise good performance and create action plans to improve areas as needed. Staff took pride in positive local audit results.

Improvement was checked and monitored. Records showed audit meetings occurred regularly and performance was discussed with those who attended. Minutes of the meetings were made available to those who could not attend in person. In addition, real time teaching was provided in areas needing improvement and posters were displayed to act as aide memoires to staff to prompt improvement. The hospital used a number of methods to monitor and drive improvement; for example, daily safety huddles, trust message of the week, perioperative newsletter and the operating theatre had regular governance time allocated for staff to discuss quality, safety and patient experience.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

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Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Many staff had worked for the hospital for many years and had amassed extensive skill sets to care for patients. They supported more junior members of the team to increase their skill set and broaden their knowledge to maintain the high standard of patient care.

Managers gave all new staff a full induction tailored to their role before they started work. All staff completed an induction before starting work. Staff told us they remained supernumerary while completing a competency document which ensured they had the knowledge needed to work within the service. Records showed that staff of all grades had a comprehensive induction which included an orientation of their working area, policies and procedures and mandatory training.

Newly qualified nurses were enrolled on a preceptorship programme. There was a preceptorship programme for nurse associates with bespoke elements for paediatrics, theatres and internationally educated nurses. The trust had been awarded an NHSE Quality Mark for the programme.

Student Nurses in their third year of training were offered a day where they were supported to apply for a trained nurse post in the organisation and introduced to the preceptorship programme on offer as a newly qualified nurse.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisals were conducted once a year. We were told ward managers monitored when appraisals were due. The appraisal process also included compliance with mandatory training and nursing registrations. Records showed that 86.22% of staff had an appraisal in the 12 months before the inspection.

The clinical educators supported the learning and development needs of staff. The practice development team had regular meetings with new nurses and their buddies to review the competency document. Experienced staff were encouraged to complete a teaching and assessing programme so they had an enhanced knowledge of how to support learners in practice.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us that team meetings were recorded, and the minutes shared electronically with the team. We saw copies of the meeting records were also on notice boards in the staff break areas.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. New nurses were assigned a mentor and had three months of protected time. Experienced nurses said they felt supported by their ward managers and were given opportunities to develop their skills and knowledge, such as, taking on link nurse roles. A link nurse is a nurse who is responsible for providing support and education to other nurses in a particular area of practice, for example, tissue viability. This gave more experienced nurses development opportunities while providing junior staff with the support they needed to learn.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us this happened during appraisal but also more informally during the working day. Most areas had posters denoting the special interests of staff such as dementia care or pressure sore prevention.

Managers made sure staff received any specialist training for their role. Staff told us their managers encouraged them to gain specialist knowledge needed for their roles and training sessions were provided in ward areas to improve staff knowledge on topics such as end of life care or nutrition of the patient.

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Managers identified poor staff performance promptly and supported staff to improve. Managers told us action plans could be used to manage poor performance, including the possibility of transferring staff to less acute areas.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to patients and improve their care. Throughout the inspection we saw well established multidisciplinary team working in all areas. Clinical staff said nurses, doctors and allied health professionals worked well together within surgery and felt part of the team.

Staff worked across health care disciplines and with other agencies when required to care for patients. There was an electronic system to review patients to other health care disciplines. Staff told us this system worked well and other health care disciplines reviewed and made care plans for their patients. Specialist teams such as the pain team and specialist nurses had worked hard to develop relationships with all ward areas. They proactively visited all areas daily to offer specialist support to patients needing their input. Allied health professionals (AHP) worked closely with the ward teams and attended patient board rounds.

Seven-day services

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

Consultants led daily ward rounds on all wards. Patients were reviewed by consultants depending on the care pathway. Staff told us and records showed that on weekdays patients on the wards were reviewed by a consultant every day. Their care plan was reviewed and updated. Staff told us they did not always have a consultant ward round at the weekend but had support from junior doctors if needed.

Staff could call for support from doctors and other disciplines, and diagnostic tests, 24 hours a day, seven days a week. The hospital provided diagnostic radiology such as scans or x-rays and a physiotherapy service 7 days a week. Staff told us this system worked well for patients.

The adult weekend respiratory and emergency out of hours on call service provided physiotherapy cover out of hours. This was covered by one physiotherapist who worked either a Saturday or a Sunday. There was also one member of staff who was reserve on call. The physiotherapist treated any patient with a respiratory need on Intensive Care Unit, High Dependency Unit and any of the surgical wards. The member of staff then remained on call from 16:30 until 08:30 the next day. They could be called out to treat any patient with a deteriorating respiratory condition by the Nurse in charge, a doctor or the Outreach team.

Orthopaedic fractured neck of femur unit was covered by a one physiotherapist and a technical instructor or assistant who worked either Saturday or Sunday. They treated all patients who were day one post operation and any patients where they could expedite a discharge. The elective orthopaedic unit based at the Sussex Orthopaedic Treatment Centre had physiotherapy staff cover seven days a week.

Doctors had access to all key diagnostic services in a timely manner 7 days a week to support clinical decision making. Magnetic Resonance Imaging (MRI) scans, Computerised Tomography (CT) scans and X-rays could be requested 7 days a week if there was a clinical need. Radiologists provided a 24 hours 7 days a week service to report urgent imaging.

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Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

The service had relevant information promoting healthy lifestyles and support on wards. We saw posters and information leaflets throughout the service for patients and relatives to promote a healthy lifestyle. For example, we saw a poster about living well with cancer and posters offering help to stop smoking.

Cancer patients were offered a wellbeing recovery programme after treatment which included exercise, diet and access to a clinical psychologist and a holistic needs assessment. The aim was to support patients to return to a normal life after their treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records in all but one of the notes we reviewed. The clinical outcomes and effectiveness team were developing a trust wide audit of consent forms, documentation and policy but there was no current audit to monitor the standards of obtaining patient consent.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Staff described the correct process for establishing the capacity of patients to make decisions about their care.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. We observed staff seeking verbal consent before taking patient observations or a blood test. Consent for procedures was written and a record of consent was documented in the patient notes.

Staff had access to an up-to-date policy UHSC050 Policy on the Mental Capacity Act and Deprivation of Liberty Safeguards, approved July 2022. The policy included a template for documenting mental capacity assessments. The Safeguarding Adults team provided support to staff and the patient, family as needed with regards to mental capacity assessments and best interest decision making.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and the Mental Capacity Act 2005 and they knew who to contact for advice. Staff described how to access the policy and get advice about the application of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Patients detained under the Mental Health Act who required surgery could access it at this hospital. To support staff caring for them there was a guidance document on the internal internet called Use of Mental Health Act Policy. Staff said

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it was rare to have a patient who was detained under the Mental Health Act. Ward staff said they informed the Mental Health Liaison Service (MHLS) office as soon as any patient was detained under Section 5(2) of the Mental Health Act (MHA) for which a full MHA assessment was required. The MHLS Team coordinated MHA assessment with the MHA Referral Co-ordinator.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Managers had access to information that checked how often Deprivation of Liberty Safeguards were applied for. This was provided through the safeguarding adults divisional surgery report.

Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them, they did so in a respectful and considerate way. Staff were able to answer call bells promptly to meet patient needs. We observed staff introducing themselves and their role to patients and being incredibly kind to patients. Curtains were pulled around the bed areas to provide privacy when needed.

Patients said staff treated them well and with kindness. Patients thought the staff were kind and took time to understand and meet their needs. Other comments from patients included: "staff are outstanding and really friendly". Staff followed the hospital policy to keep patient care and treatment confidential. Efforts were made to keep patient care and treatment confidential by pulling curtains round bed areas while care was being delivered by staff. There was no dedicated space on the surgical wards for patients and family members to receive bad news or have their procedures explained in more detail. However, there was always a room available on the wards for these discussions to take place to provide privacy to patients and family. Ansty Wards had two rooms that could be used. In addition, the hospital chapel was situated next to the surgical ward where family and relatives could have privacy if needed.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We observed holistic assessments of patients which included their physical and mental health. These needs were discussed in a non-judgemental way at ward and board rounds. The trust offered a course in mental health first aid. Mental Health First Aiders in the workplace helped to increase support and encouraged help-seeking, improved knowledge, attitudes and skills, and improved workplace culture. Records showed at the time of the inspection 15 members of staff had completed the course and were qualified Mental Health First Aiders.

Staff always understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We observed close and compassionate interactions between staff and patients in all areas. This extended to staff discussions about care and discharge; for example, patients' individual circumstances were discussed and considered when planning care.

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Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients told us staff had clearly explained their care and treatment and we saw good communication between staff and patients in most areas.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. There were Clinical Nurse Specialists for each cancer tumour group. They had received advanced communication skills training. Patients told us the staff were caring and empathetic when delivering bad news or having difficult communications. The hospital offered staff communication training to support difficult conversations. Newly qualified nurses completed the training as part of their preceptorship course. It is also offered as a stand-alone workshop for staff wanting to develop their communication skills.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. All staff we spoke to clearly understood patient needs in relation to social and emotional wellbeing. Records showed patients emotional and social needs had been assessed fully and care planned considering any issues that had been identified.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients told us staff had clearly explained their care and treatment and we saw clear communication between staff and patients. Records shows that patients taking part in the last National Cancer Patients Survey, 84% stated treated options were explained in a way they understood. This was higher than the national average of 82%.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff had access to translation services, communication aides and used them with patients as needed. The hospital had a learning disability team, provided by the local community trust, who supported staff to communicate fully with their patients.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave mixed feedback about the service. Ward areas undertook monthly audits to assess patient feedback about the service. All areas displayed posters inviting patients and their families to give feedback on their care.

Records showed that patients taking part in the last National Cancer Patients Survey were very positive about their care at the trust. Data was not broken down into the four hospitals but included patients having care at the Princess Royal Hospital. Using a scale of 0 – 10 with 0 being poor and 10 being very good the cancer care was rated 8.8.

Patients who would recommend the inpatient area at the Princess Royal Hospital was between 94.2% and 95.8%. Only 2.1% and 3.5% would not recommend it. The average response rate for the friends and family test was 20% in the 3 months before the inspection.

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Staff supported patients to make advanced decisions about their care. The trust had an end-of-life team who specialised in palliative and end of life care. This team supported both patients and staff to make advanced decisions about care. There were good relationships between this team, the local hospice and community services which aided realising the decisions patients had made.

Staff supported patients to make informed decisions about their care. All areas had leaflets explaining procedures and medical conditions which informed patients about their care. The hospital had a policy called Policy for Accessible Information which set the organisations role in ensuring patient had information in a format which they needed. For example, in easy-to-read format, pictorial aides or in a language used by the patient and their family.

Staff had access to specialist teams who supported patients. For example, cancer, diabetes, stroke and mental health specialist teams visited the wards regularly.

Is the service responsive?

Inadequate ● ↓↓

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

Access and flow

People could not access the service when they needed it and had long waits to receive the right care. Waiting times from referral to treatment and arrangements to admit and treat patients were not in line with national standards. Waiting times for treatment were getting longer (worse). Potential harm to patients from delayed surgery and patients' clinical needs were not always considered when planning surgical lists.

Patients could not access services when needed and did not receive treatment within agreed timeframes and national targets. Following the patient's consultation, patients who needed surgical treatment were added to the waiting list for their surgery. The clinician gave the patient a potential waiting time for the date of the operation. This was based on a numerical priority system of 1 to 4 with priority 1 being very urgent and 4 routine. Managers had regular meetings to monitor referral to treatment times for all patients; these meetings also monitored the waiting time of patients that had been cancelled. When a clinician requested that a patient was listed for surgery, the clinician assigned a priority code to the patient, using the Royal College of Surgeons (RCS) criteria:

- Priority level 2 (P2): Surgery that can be deferred for up to 4 weeks
- Priority level 3 (P3): Surgery that can be delayed for up to 3 months
- Priority level 4 (P4): Surgery that can be delayed for more than 3 months

Priority 1 (P1) was for patients who required emergency treatment within 24-72 hours. It was therefore not a category used when listing patients electively. The P-Code was included on the waiting list card sent to the waiting list department. All patients on the waiting list were clinically prioritised by a clinician. Starting with the longest waiting patients, grouped together by number of weeks waiting, and working down the waiting list. Speciality teams decided the best way for this to be undertaken. This process did not consider the clinical need of patients, it increased the risk of harm to patients due to waiting for surgical treatment.

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The operating theatre scheduling used a 6-4-2 process (introduced into the NHS in 2019, the 6-4-2 model is an improvement process, by which surgical staff: – declare their annual leave six weeks in advance of their surgery schedule – arrange their surgical lists four weeks before for sign off and – review their plans two weeks ahead of the surgery lists being ‘locked down’) to book each theatre list.

Each day the operating theatre team held an operational meeting at 8.45 am. This was an opportunity for staff to raise issues and discuss any reasons why the surgical list could not progress as planned. Any patients at risk of being cancelled were reviewed with the lead clinician and a plan was developed to try and mitigate any issues. The main reasons that patients were cancelled from the theatre list were ward capacity, number of theatre staff and availability of high dependency unit beds.

Patients requiring emergency surgery did not always receive it in a timely manner. Patients who needed emergency surgery were allocated to an emergency theatre list. These lists ran continually, and patients were allocated a space depending on risk. This resulted in patients being cancelled at short notice if a patient with a greater need presented to the hospital.

In May 2023, there were 35 patients who had their emergency surgery cancelled. Seven of these patients had 2 or more cancellations before their operation took place. Reasons included not fit for surgery, theatre list overrun, more urgent cases added to the list, unavailability of doctors and previous case taking longer than planned.

In June 2023, there were 42 patients who had their emergency surgery cancelled. Four of these patients had 2 or more cancellations before their operation took place. Reasons included not fit for surgery, theatre list overrun, more urgent cases added to the list, unavailability of doctors and previous case taking longer than planned.

In July 2023, there were 35 patients who had their emergency surgery cancelled. Five of these patients had 2 or more cancellations before their operation took place. Reasons included being not fit for surgery, theatre list overrun, more urgent cases added to the list, unavailability of doctors and previous case taking longer than planned.

Rescheduling of cancelled operations did not always meet national targets and guidance. When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible, however this was not within national targets and guidance. Patients on the trauma list for each day were discussed at the planning meeting every morning at 07:45. Trauma co-ordinators liaised with clinicians and operating theatre teams and the operating lists were collated in conjunction with clinicians, trauma coordinators and theatre teams.

The service could not be assured they had an accurate picture of harms to patients caused by delayed surgery. It was the responsibility of the clinicians’ booking cases to monitor any risk of harm where patients had their surgery delayed. Trauma co-ordinators and trauma surgeons escalated significant delays to the divisional management team on a regular basis. If a delay resulted in harm to a patient staff completed an incident report. However, as there was an identified under reporting of incidents, it could not be assured that all delays that resulted in harm were reported. There was a dedicated all day orthopaedic trauma list every day and a fractured neck of femur list ran 7 days a week at Princess Royal Hospital.

Surgeons said they were concerned about the number of patients cancelled, the number of times each patient was cancelled, and the length of time patients waited for their operation. They had reported these as incidents and felt the leadership team had not taken the action needed to prevent harm from coming to patients.

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Potential harm to patients from delayed surgery was not always considered. The Specialist Division had recently started to report each cancellation on the day via the electronic incident system. However, they did not have formal clinical harm review groups in place. They had a plan to establish clinical harm review groups to review all reports of harm coming to a patient through their operation being cancelled.

Non-trauma patients were assessed in the emergency department by a senior surgeon who made the decision to admit and operate. The emergency surgery list was coordinated by the emergency theatre coordinator. It was the responsibility of the clinicians' booking cases to monitor any risk of harm where patients had their surgery delayed. An emergency surgery list was available 24 hours a day, 7 days a week and a second emergency list was available 2-3 days per week. Where demand outstripped capacity the divisional leadership considered prioritisation of emergency surgery over elective activity.

Data demonstrated that trust wide the time for people to receive their treatment from time of initial referral was getting longer. National data showed the trust was starting more patients' month on month than in 2019 for first definitive treatment. First Definitive Treatment (FDT) is the first clinical intervention intended to manage their disease, condition or injury and avoid further treatment. However, the trust performed second worst in the southeast of England region for FDT within 31 days, 84.8% compared to 95% in the region. This was against a national target of 96%. This data was at trust level and not at hospital level.

The trust performed second worst in the southeast of England region for two week waits (2WW). The 2WW referral system allows a patient with symptoms that may indicate an underlying cancer to be seen as quickly as possible. National cancer waiting time data for 2WW for cancer was 66.14% in July 2023 against a national target of 93%. This put the trust in the lowest 25% of NHS acute trusts in the southeast. This was much lower than the 81% regional average and lower than the national average of 77%. This data was at trust level and not at hospital level.

The trust was the second lowest for the proportion of patients that were treated within 62 days of an urgent GP referral at 57%. It should be noted that there were no regions that were meeting the national target of 85%. The regional average was 67% and the national average was 62%. This data was at trust level and not at hospital level.

Trust wide, there was a deterioration in the percentage of patients receiving their surgery within the national target of 18 weeks. In October 2022 54% of patients had their surgery within 18 weeks, in June 2023 this had reduced to 46% of patients received their surgery within 18 weeks.

Trust wide there were increasing numbers of patients waiting over 65 weeks for surgery. In October 2022 there were 3282 patients waiting over 65 weeks. In September 2023 there were 5664 patients waiting over 65 weeks for surgery.

Trust wide there were increasing numbers of patients waiting over 78 weeks for surgery and the trust had not met their target of no patients waiting over 78 weeks for surgery by March 2023. In March 2023 there were 257 patients waiting more than 78 weeks for surgery. In June 2023 there were 331 patients waiting more than 78 weeks for their surgery.

We were not able to assess the performance of Princess Royal Hospital as there was no data specific to Princess Royal Hospital.

We were not provided with a recovery plan for people waiting for surgery at Princess Royal Hospital or for those waiting for surgery across the trust.

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Service delivery to meet the needs of local people

The service planned and provided care in a way to meet the needs of local people and the communities served. It worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. The service had systems and processes in place to support the delivery of care to patients in need of additional support. Staff we spoke with could describe the demographic of their local population. The hospital had access to an emergency theatre 24 hours a day 7 days a week, which had the ability to expand where needed. The team used an on-call system to increase capacity and each speciality had consultants on call 24 hours a day 7 days a week. Anaesthetics had three anaesthetists on site out of hours and four on call consultants.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. We were unable to confirm whether and how many mixed sex breaches the surgical services at Princess Royal had as we did not ask for that information. However, nationally available data showed that across all services at Princess Royal Hospital there were no reported mixed sex accommodation breaches in July 2023, there were 23 reported mixed sex accommodation breaches in June 2023 and 32 reported mixed sex accommodation breaches in May 2023.

Facilities and premises were appropriate for the services being delivered. The hospital was fully accessible for patients with additional physical and mental health needs. Staff told us that, apart from the pre-assessment unit, they had enough room for patients, staff rest and teaching areas and to store their equipment. The pre-assessment unit was in a cramped area with seating for patients in a corridor. The area was shared with other departments and too small for the large volume of patients needing this service. Staff told us they made all efforts to be mindful of the privacy and dignity of patients. Leaders were aware of the issues and were considering if a more suitable area could be found.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. The local mental health trust provided a mental health liaison service which staff accessed via a pager 24 hours a day. Staff were aware of the mental health liaison team and knew how to contact them for support. Staff said they had a good relationship with the mental health liaison team, who were very responsive. The older patient and dementia mental health liaison team were available during normal working hours. The people of working age mental health liaison team were available for support 24 hours a day 7 days a week.

The service had systems to help care for patients in need of additional support or specialist intervention. Patients in need of additional support and support or specialist intervention were flagged on the trust's computer system so all staff were aware of their needs in advance. Staff in the preassessment unit told us this enabled them to prepare for patients who needed additional support during their admission for surgery.

The service tried to relieve pressure on other departments when they could treat patients in a day. For example, SDEC (Same Day Emergency Care) and Ambulatory care which provided a same day service to patients; however, these areas were incredibly busy, and staff told us patients had significant waits to be treated. Patients could wait to be collected in a discharge lounge which helped with patient flow by enabling a patient to be admitted.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Medical staff explored mental health with patients and sought to understand patients'

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individual needs outside of their immediate physical health condition. The service had access to the mental health and learning disability liaison teams who supported them when caring for patients living with mental health problems, learning disabilities and dementia. Staff we spoke with could describe how they would care for patients living with mental health problems, learning disabilities and dementia. Staff were all aware of the dementia liaison team and their contact details and reported a good collaboration with them and each ward had a minimum of 1 dementia champion to support daily care on the wards. Wards had information boards about dementia for staff to use as an information resource. On Twineham Ward, which had a high proportion of patients with a dementia diagnosis, one of the ward sisters had 14 hours a week of protected time to support patients with dementia and staff who were caring for them.

Staff told us patients with a dementia diagnosis had equal access to surgical services and were supported by the dementia liaison team where required. Details of this service were available on the external web pages and could be used as a resource for dementia patients and their family. Surgical consultants liaised with the dementia liaison team for support caring for a person with a diagnosis of dementia and ensured they were monitored well for delirium after the operation.

The trust was implementing CAIT (communication and interaction training) course. The CAIT approach highlighted that good communication skills were vital when supporting a person who is living with dementia. Currently only clinical nurse specialists had been on this training, and it was hoped to offer it out to all staff in the division who cared for patients living with dementia.

Wards were designed to meet the needs of patients living with dementia. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff had access to "this is me" or "about me" patient passports which provided information about patients living with dementia, who were not able to communicate their preferences verbally. Staff wrote some patient details on a whiteboard behind each patient's bed. This included the patient's preferred name and most of the time, staff used the preferred name.

Directional signage was dementia friendly as was the signage on toilet and bathroom doors. The friends and family of patients with a dementia diagnosis had open visiting times to them to engage in a supportive way for the patient and their own wellbeing.

Patient-Led Assessments of the Care Environment (PLACE) Programme had recommenced following the COVID pandemic. PLACE assessments are an annual appraisal of the non-clinical aspects of NHS and independent/private healthcare settings, undertaken by teams made up of staff and members of the public (known as patient assessors). In the most recently published PLACE assessment of Princess Royal Hospital (2022), the hospital scored 67% for the environment being dementia friendly.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff told us the policy could be found on the intranet, and the service had access to information in large print, easy read, and braille format. This allowed staff to provide information and communicate with patients in a way that was accessible and understandable.

The service had information leaflets available in languages spoken by the patients and local community. Staff told us they could obtain leaflets in multiple languages for patients and their families as needed.

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Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us they could book face to face interpreters and a telephone language line as needed. They did not use family or friends to translate confidential information but found them helpful when building up a relationship with the patient. Staff had access to the Interpreting & Translation Policy. This included flowcharts explaining to users which resources/ services would be most appropriate for interpreting and translation.

Interpreting, translation, and communication support services for disabled people were procured via a Sussex-wide framework contract and defined preferred providers to support quality and continuity for patients and users with linguistic and communication needs across health and social care services. The following British Sign Language (BSL) provision was available to patients: in-person BSL interpreting – both elective and urgent, video relay interpreting (VRI) – for virtual appointments or online consultations and digital flashcards about health for patients with pre-recorded BSL content written by clinicians.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff gave us examples of supporting patients with specific dietary requirements. We looked at the menus used, which were varied and included suitable alternatives for a range of religious or cultural needs.

Staff had access to communication aids to help patients become partners in their care and treatment. Staff had access to communication aids to help patients become partners in their care and treatment. Reception areas had hearing loops to communicate with patients and their carers or family. Staff had access to an equipment library to support patients with learning disabilities, and patients who communicated in ways other than speaking. Staff showed us the materials and explained how they used them. Staff gave other examples of supporting patients with communication difficulties.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Patients told us they knew how to make a complaint or who to speak to if they had a concern. Staff understood the policy on complaints and knew how to handle them. Staff were able to explain the complaints process, and give examples of when a complaint was received, how it was handled and the outcome. At the time of the inspection there were 41 open complaints being dealt with. There was a delay in responding to and resolving complaints and only 33.3% of complaints were closed within the 25-day deadline.

The service clearly displayed information about how to raise a concern in patient areas. We saw posters detailing the complaints process on all ward areas. There were patient feedback leaflets on all the wards. Staff told us how the duty of candour was met, including recording of the process and the involvement of patients and families. Records showed that duty of candour was used on each occasion it was needed in the 12 months before the inspection.

Staff understood the policy on complaints and knew how to handle them. Staff told us they had access to a guidance policy on patient complaints. Managers told us they would attempt to resolve the complaint if possible. Complainants were signposted to the formal complaints process as needed.

Managers investigated complaints and identified themes. Feedback from complaints was shared with staff in daily safety huddles, on ward rounds and in team meetings. Serious incidents which were at the origin of complaints were

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discussed with staff and escalated. Staff gave examples of using patient feedback to improve daily practice. For example, the development of the urology investigation unit which was due to be opened on 16 October 2023. It was developed following feedback from patients who feedback they would prefer just one visit to the hospital to get their diagnostic tests and results in one visit.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The service had a team of investigators to investigate complaints and provide feedback for staff and patients.

Managers shared feedback from complaints with staff and learning was used to improve the service. The team meetings and staff huddles were used to share feedback and learning from complaints. Records showed this was minuted and shared with staff who were off duty.

Staff could give examples of how they used patient feedback to improve daily practice. Staff gave us an example of a patient who had their procedure cancelled on the day because their allergies had not been checked before the procedure. The process had changed to ask this question when booking the investigation to prevent future patients being cancelled.

Is the service well-led?

Requires Improvement ● ↓

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

Leadership

Local leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Leaders at a ward level had the skills and ability to run the service. Staff we spoke with felt that local level leadership was excellent, and they felt did their best for the service. We heard examples of how teams and leaders had come together to work through challenging times and incidents. Other staff we spoke with said they had felt supported and recognised by the senior leadership team. Ward managers told us that the director of nursing held high expectations about uniform, behaviour and nursing care. This empowered them to mirror the same behaviours and hold staff to account as needed.

Hospital services at the trust were grouped into eight clinician-led divisions. The divisions were separated into 2 areas: Unscheduled Care and Planned Care, each led by a Managing Director. Every division was led by a Chief of Service, Divisional Director of Operations and Divisional Director of Nursing. For the purpose of this report, the surgical core service we inspected covered more than one of the trust divisions. The divisions we inspected covered the Royal Sussex County Hospital in Brighton and The Princess Royal Hospital in Haywards Heath.

However, not all staff felt that the trust senior leadership and executive team were visible or approachable. There was variability amongst staff opinions of how visible the trust senior leadership and executive team were. Some staff

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expressed disappointment that they had never seen senior management in their department, and we heard this in several ward areas across the site. Some staff felt they would not be able to recognise executive team leaders if they were to come onto their ward or department, even though we observed posters with their photos and job titles around the hospital.

Vision and Strategy

The surgical division did not have a specific vision or strategy but referred to the trust wide vision and strategy. The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

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

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

During the inspection we saw laminated posters of the local values and behaviours strategy in all areas we visited and all staff we observed embodied these values and behaviours. Not all staff could tell us the trust vision and values but could direct us to posters and pages on the internal intranet which had information about the vision and values.

Culture

Most staff felt respected, supported and valued. Patient facing staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development within theatres and the wards. Locally there was an open culture where staff could raise concerns without fear at most levels.

Ward staff and those who worked in the operating theatre, of all levels told us they felt respected, supported and valued by their senior staff. We observed positive conversations between teams of staff. Staff were clear on their role in providing high quality patient care. Staff described how they felt able to bring their real selves to work and felt there were many opportunities for career development within the surgical services.

The hospital had a number of ways for staff to raise concerns. There were toolkits available on the internal intranet to support staff raising concerns that set out the speaking up pathways available at the Princess Royal Hospital. Guidance in the toolkits included information on holding difficult conversations, mental health and wellbeing guidance and raising and responding to concerns. Virtual 1 hour question and answer sessions were scheduled in June and July to help with successful use of the toolkit for both managers and staff. The trust had recently appointed a freedom to speak up guardian and we saw that this was the topic of the week in the improvement huddles on the wards.

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The hospital had arranged for an internationally trained nurse, who was a senior lecturer in international and adult nursing to speak about internationally trained nurses and the associated culture shock. Staff told us they could join network groups such as the lesbian, gay, bisexual, transgender and queer (LGBTQI+) network, staff disability network and SOAR network for staff from ethnic minority groups and their allies.

Ward staff up to matron level told us they were happy to raise concerns without fear. Medical staff told us that up to speciality clinical leadership they were able to raise concerns without fear. However, senior clinicians remained concerned about raising concerns with the triumvirate and executive leadership teams. Some felt their concerns were not listened to or acknowledged by trust senior leadership teams and some feared reprisals from raising concern with senior leaders.

Locally staff wellbeing was considered. Staff were offered one to one pastoral care and there was an open-door policy with all staff in the team. It was possible to refer staff onto services that could support them such as occupational health and a staff support service.

Since March 2023 there had been wellbeing sessions provided for all the staff in the perioperative division, offering a 15-minute slot of a choice of therapy from a back, neck and shoulder massage to reiki. Feedback from staff was positive about these sessions.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a clear governance structure within the surgical division. Each speciality monitored key performance and risk metrics. These were discussed at speciality level and then at divisional level. The division then presented the key performance and risk metric reports to the trust board. The report showed the trust's performance against each of the performance and risk metric and the actions taken to improve and sustain performance. The trust told us they held governance meetings to focus on near miss incidents and aim to ensure staff learn from them as well as incidents with harm.

We spoke to staff at all levels who were able to tell us about how they were involved in hospital governance, whether this was through incident reporting and feedback or attending safety and improvement huddles.

We reviewed the minutes of speciality morbidity and mortality meetings which were held monthly. The topics discussed included referral to treatment times, mortality and morbidity, incidents, workforce issues, quality improvement, serious incidents and audits. The cancer steering group met monthly and fed into a quarterly cancer board. Cancer performance was discussed at this meeting and actions were used to drive improvement within the trust.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Locally leaders and teams used systems to manage performance and risks. The surgical division at Princess Royal Hospital used a quality score card to monitor performance. The areas rated on the score card were clinical outcomes and effectiveness, safety and patient experience. Following the inspection, we reviewed the data on the quality score card

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and saw how leaders used the data to improve performance over time. We noted that patients with suspected sepsis had not received their antibiotics within 60 minutes of arriving in the hospital. This had been noted as a risk and the actions put in by staff showed an improvement in the number of patients with suspected sepsis receiving antibiotics within an hour of diagnosis.

Clinical and non-clinical managers worked well together to identify risks and make improvements. Matrons and ward managers had a good understanding of the issues within their clinical areas. Risks were recorded at ward, department and divisional level. Monthly meetings took place to discuss key risk and performance issues. Meeting minutes showed them to run to a set agenda and clearly recorded. Actions could be tracked, and minutes showed they had been completed. Leaders at all levels could clearly describe the risks in their area of work and the mitigation in place to reduce the risks. Risk registers were updated regularly, with risks added to the register relating to patient care, safety performance and current issues. Monitoring of risks and actions were allocated to named staff who recorded regular updates with the mitigations to reduce the risk.

Records showed that across the surgical division (this included Princess Royal Hospital and Royal Sussex County Hospital) there were 40 approved risks on the divisional risk register and 28 risks awaiting approval. These included long waits for patient treatment, aging anaesthetic machines and lack of ward, theatre and high dependency unit capacity for throughout the surgical division.

Each speciality discussed risks and issues to review, learn and drive improvements. Leaders followed the trust's governance processes to ensure trust senior leadership had oversight of the most serious risks and issues.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The department collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. The trust's website provided safety and quality performance reports and links to other web sites such as NHS Choices. This gave patients and members of the public a range of information about the safety and governance of the hospital.

Each area we visited had several computer terminals and computers on wheels to allow staff to access electronic patient records and test results. All staff had individual log on passwords. In all areas the terminals were locked when not in use which meant confidential information could only be accessed by those with permission.

Records showed that data had been submitted consistently to external organisations.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Senior leaders shared a weekly operational staff update, via email, which contained information about the whole trust. Topics included the trust and individual trust operational pressures escalation level (OPEL). OPEL is an indicator of the operational pressures the organisation is experiencing. Level 1 was the least pressure and level 4 was maximum

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pressure. At the time of the inspection the Princess Royal Hospital was at Level 2. In addition, there was an outline of news topics, up to date information about patient waiting times, a celebration of good practice and hyperlinks to other topics of interest for the staff. Staff told us the weekly update had useful information, but they did not always have time to read it. We saw that printed copies were on the staff notice boards on some of the wards.

Oncology services organised ward-based patient groups, for surgical patients with a cancer diagnosis, run in conjunction with charitable organisations. Patients and their families were given access to support groups and information resources to help them understand and adjust to their treatment.

The management team said any good ideas put forward by staff were discussed at weekly ward and monthly team meetings. Useful suggestions and good ideas were passed on to the clinical and quality boards. Staff felt informed and involved with the day-to-day running of the service.

Staff advised us there were regular staff meetings and that managers arranged these for different times and days to ensure all staff were able to attend regularly.

All staff were encouraged to participate in the annual NHS Staff Survey. We also saw a poster with a summary of the surgical division's results and details of how to feedback to the divisional triumvirate team regarding their suggestions for improvement actions. The hospital offered a wide range of active staff groups including network groups for LGBTQi+, Disability, Trans, and SOAR for our Black, Asian and ethnic minority colleagues and allies.

Staff were celebrated in a number of ways. For example, there had been an international nurse's day celebration, long service awards, star celebrations and plaudits for excellent practice.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff participated in the patient first improvement system (PFIS) and made improvements for staff and patients alike. Improvement huddles were run twice a week on Tuesdays and Thursdays at 4 pm on all wards in the surgical division at the Princess Royal Hospital. We observed the improvement boards and staff told us what improvements had been made as a result of the discussions.

Staff gave us several examples of service improvement following staff feedback. In the operating theatre it was identified agency staff needed a more comprehensive orientation to the department, so they created an induction pack for agency staff. Secondly the anaesthetic practitioners reported issues with not being able to access their emails, so a morning anaesthetic huddle was started to follow the all-staff huddle which was used to share work critical messages of the day.

Following a near miss event the theatre team revamped the 'count policy algorithm' and made it larger, added colour and changed the language to be more accessible. Posters of the algorithm were laminated and prominently placed in the operating theatre. Finally, following an incident when the on-call team had not been called to a case that they should have attended, the team developed a 'On Call Team' standard operating procedure. It included a flow chart as an aide memoire for the practitioner in charge.

Following a noticeable rise in pressure area damages, the ward team used the Patient First Process to investigate the increase. A questionnaire (devised by the Tissue Viability Team) was sent to every nursing staff member both trained and

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untrained to ascertain where their knowledge gaps were. Once this information was collated, teaching sessions were set up for all staff. Everyone had training on up-to-date assessment and care/prevention of pressure damage. Subsequently, the incidence of pressure damage had fallen. Every new member of staff who began working on Twineham as part of their induction completed the same training.

Areas for improvement

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

Action the trust **MUST** take to improve:

- The trust must ensure appropriate training, in line with guidance, is in place and completed by staff to support patients with learning disabilities, dementia and autism. Regulation 12.
- The trust must ensure that staff complete mandatory training in line with their role and that oversight of targets is effectively monitored. Regulation 12.
- The trust must ensure that medicines are stored according to the manufacturer's instructions. Regulation 12.
- The trust must ensure that all guidance documents relating to medicines management are up to date. Regulation 12.
- The trust must ensure there is enough equipment to safely meet the needs of patients. Regulation 12.
- The trust must ensure that it responds to all patient complaints as per their policy. Regulation 16.
- The trust must ensure all incidents and near misses are reported and acted on. Regulation 12.
- The trust must ensure there are enough nursing staff and medical staff to keep patients safe. This needs to include arrangements for the management of patients operated on by Royal Sussex County Hospital surgeons. Regulation 12.
- The trust must ensure that guidance documents have been reviewed and are up to date. Regulation 17.
- The trust must ensure action is taking to improve their compliance with national waiting list targets. And that performance data for the trust can be separated to show site performance. Regulation 17.
- The trust must ensure that workforce data for the trust can be separated to show individual site performance. Regulation 17.

Action the trust **SHOULD** take to improve:

- The hospital should consider improving engagement with patients and their families to increase the response rate of the friends and family test surveys.
- The hospital should act to reduce the number of mixed sex breaches.
- The hospital should act to improve compliance with the Royal College of Radiologists safety check list.
- The hospital should consider how to improve staff confidence in raising concerns to senior leaders.

Our inspection team

The team that inspected the hospital included 3 CQC inspectors, a CQC national professional advisor for surgery and 3 specialist advisors who had expertise in surgical services. The inspection was overseen by a CQC Deputy Director.

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

We observed ward handovers, daily staffing meetings, safety huddles and the day to day running of the surgical service. We reviewed 10 patient records, drug charts and care plans. We also reviewed information received before the inspection from patients and staff. We reviewed several documents before, during and after the inspection. These included meeting minutes, policies, guidance, staff rotas, training figures, feedback from staff and patients, complaints and investigations.

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