University Hospitals Sussex NHS Foundation Trust

Worthing Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Worthing Hospital

Requires Improvement 

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

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

Medical care (including older people's care)

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. The service provided mandatory training, but not all staff had completed it.
- Staff did not always assess risks to patients, or act on them, or keep good care records. Documentation of patient records were stored in multiple formats.
- Key services were not always available 7 days a week and information systems were not always reliable.
- Patients sometimes had to wait long periods of time for their call bell to be answered and the environment did not always meet national guidance.
- Staff did not always carry out daily safety checks of specialist equipment, such as resuscitation trolleys. Portable Appliance Testing had not always been carried out. Multiple medical wards had incomplete daily and weekly resuscitation trolley checklists and the service did not always have enough equipment to help them safely care for patients.
- Patient notes trolleys were left open on all medical wards we visited, leaving confidential patient information easily accessible to unauthorised personnel.
- Staff did not always complete medicine records accurately and keep them up-to-date.
- Outcomes for patients were not always positive, consistent and did not meet expectations, such as national standards. Specialist support from speech and language therapists were not always available for patients who needed it.
- The service needed to improve its documentation of capacity assessments and there was inconsistent completion of Deprivation of Liberty Safeguards (DoLS) paperwork which did not always match the patient's needs.
- Staff did not always make sure patients living with mental health problems, received the necessary care to meet all their needs.
- The service needed to improve on the number of times a patient was moved to another ward during their stay.

However:

- The mandatory training was comprehensive and included all subjects within the Core Skills Training Framework for NHS Trusts in England.
- Staff received role-specific training on recognising and reporting abuse and had good compliance rates for staff who attended and completed this training.
- Ward areas were generally clean and had suitable furnishings which were well-maintained, and staff disposed of clinical waste safely.
- Staff used a nationally recognised tool to identify patients and escalated them appropriately.
- Mitigations for patients at risk of falls were seen and the service had 24-hour access to mental health liaison and specialist mental health support.
- The service ensured people's behaviour was not controlled by excessive or inappropriate use of medicines.

Medical care (including older people's care)

- All 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.
- Staff gave patients enough food and drink to meet their needs. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain and supported those unable to communicate using suitable assessment tools.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients and staff gave good practical support and advice to patients to lead healthier lives.
- Staff treated patients with compassion and kindness and respected their privacy and dignity.
- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- People could access the service when they needed it, and it was easy for people to give feedback and raise concerns about care received.
- Leaders had the skills and abilities to run the service and were generally visible and approachable.

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 key skills. However, not all staff had completed it.

Nursing and medical staff did not always keep up-to-date with their mandatory training. The trust set a compliance target of 90% for statutory and mandatory training. Data provided by the trust showed compliance was good for some subjects, such as Equality, Diversity and Human Rights, Health and Safety, Safeguarding level 1 and 2, but required improvement for others. For example, 80% of nursing staff had completed Adult Basic Life Support (BLS), 81% had completed Moving and Handling, and 83% had completed Conflict Management. Similarly, medical staff had low completion rates in some areas, with 76% having completed Adult BLS, 81% had completed Moving and Handling, and 83% had completed Conflict Management. However, it was not possible to identify mandatory training compliance figures for Worthing Hospital. The medical division was across both Worthing Hospital and St Richard's Hospital and the staffing data was not separated into data for each individual hospital.

Although nursing and medical staff were not always up-to-date with their statutory and mandatory training, they were clear about what to do in safety-related situations. For example, staff on the Emergency Floor could explain the deteriorating patient policy, and staff on all wards could tell us about the signs of sepsis and how they would escalate their concerns. Therefore, although staff were not always up-to-date, it did not imply they did not have the right skills for their roles.

The mandatory training was comprehensive and met the needs of patients and staff. The mandatory and statutory training provided to staff included all subjects within the Core Skills Training Framework for NHS Trusts in England. This

included fire safety, infection prevention and control, moving and handling, resuscitation, safeguarding and others. However, despite a legal requirement since July 2022 for all staff to receive training on interacting with people with learning disabilities and autism, only 18 staff had completed the full training by June 2023. Furthermore, only 42% of staff had completed the first section which highlighted limited implementation and oversight.

There were systems in place to monitor mandatory training. However, these were not always effective. Managers monitored mandatory training and alerted staff when they needed to update their training. Each ward used a software system to record compliance and alerted staff when training was due. Supervisors could view compliance for their staff, but on 1 of the 8 wards we visited, the record of allocated staff was incorrect. The manager explained the hospital's Learning and Development team managed this aspect and followed this up.

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 role-specific training on recognising and reporting abuse. Staff had yearly adult and children safeguarding training (level 2), refreshed annually to include updates. Data from the trust confirmed good compliance rates for staff who attended and completed this training. This complied with intercollegiate guidance, which required level 2 training for all staff with regular contact with patients, their families, carers, or the public.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff told us all patients were treated equally, and safeguarding concerns were escalated regardless of their protected characteristics. For example, a nurse escalated concerns about an elderly patient who was admitted with a fall despite being previously known to be bedbound. Staff also explained how they would safeguard patients treated under the Mental Health Act who were at risk of self-harm or suicide by conducting visual environmental risk assessments.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew safeguarding meant protecting people from harm. Staff had access to support from the hospital's safeguarding team and the local authority.

Staff knew how to make safeguarding referrals and whom to inform if they had concerns. For example, one nurse said they would obtain more information from the person and escalate their concerns to the nurse in charge if needed. We spoke with a Healthcare Support Worker (HCSW) who was the designated safeguarding lead for their department and provided support to staff. This helped to provide a point of contact for junior members of staff who may not have had the experience of managing a safeguarding concern or completing a safeguarding referral.

Cleanliness, infection control and hygiene

Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, cleaning records were not always accurate.

Ward areas were generally clean and had suitable furnishings which were well-maintained. We saw good examples of cleanliness on multiple wards. For example, on arrival to Botolphs Ward, domestic staff were cleaning the floors and patient bedspaces were not cluttered. Easy-clean flooring was seen throughout the hospital, meeting infection control guidelines and staff told us they completed daily cleaning checklists. The trust had Infection Prevention and Control (IPC) policies and procedures.

Cleaning records were up-to-date, but not always accurate. For example, we found a jar of mouldy food in the kitchen fridge on Beckett Ward that had no recorded date of opening on it. This could pose a health risk to patients and staff. The nurse in charge was informed and the food was immediately disposed of.

Staff followed infection control principles including the use of personal protective equipment (PPE). All new admissions were screened for MRSA and other communicable infections, as indicated by clinical presentation. Single rooms with closed doors were used for patients with known or suspected infections, and staff wore PPE when entering these rooms. We saw single-use curtains in-between bedspaces which were visibly clean and in date, and laminated posters outside cubicle doors communicating a potential or confirmed infection risk.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We consistently saw "I am clean" stickers used on medical wards. For example, all commodes on Erringham Ward were labelled as clean and ready for use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. However, staff managed clinical waste well.

Patients could reach call bells, but sometimes had to wait for a response. On Botolphs Ward, there was a calm and organised environment. We observed a number of confused patients being continuously monitored and staff could respond quickly to their needs. In other areas, patients said "The call bell is answered pretty quick, most of the time", and "The staff are lovely, but they are hard pressed, if all the buzzers are going at the same time, there is no way they can get to everyone. If I need the toilet and I can see they are busy, I just make myself wait, because I don't want to bother them". We observed most patients had a call bell to hand, and staff told us they increased intentional rounding for patients who could not always be monitored or use their call bell. Intentional rounding means the number of times a member of staff checks on a patient.

The trust did not have a standardised approach to monitoring call bell wait times or intentional rounding. They had not conducted call bell audits, but staff checked for call bell accessibility during intentional rounding and documented it on the intentional rounding form. The trust did not have specific documentation audits for the completion of intentional rounding paperwork, but managers told us they would review it if an incident was being investigated, such as a fall or a hospital-acquired pressure ulcer. Weekly themes were highlighted and fed back to ward managers and staff.

The hospital environment did not always meet national guidance. For example, the heating system on Beckett Ward had been broken since last year, and patients could access dangerous items in the kitchen due to written codes on a laminated poster outside the door. We discussed these concerns with the ward manager, who stated the heating issues had been escalated and were on the risk register. We asked the nurse in charge to remove the written codes on the laminated poster. The concerns with the heating system were highlighted to senior leaders in the trust but we did not see this on the risk register.

Staff did not always carry out daily safety checks of specialist equipment, with inconsistencies across medical wards. We saw some examples of safe practice, such as clearly labelled broken equipment, regular fire extinguisher checks and observation machines up-to-date with servicing requirements. However, equipment issues were found on multiple wards. For example, Beacon Ward had no sharps container on their resuscitation trolley, and Botolphs Ward had expired sterile gloves and unsealed scissors. Multiple wards had incomplete daily and weekly resuscitation trolley checklists. Beckett Ward had clutter around their resuscitation trolley. We saw a hoist on one side and a computer on the other side. This meant the hoist and/or the computer would have to be moved out of the way in an emergency situation for

staff to access the resuscitation trolley. Similarly, on Beckett Ward, there was an overdue hoist servicing, an air conditioning unit in a female bay without a Portable Appliance Testing (PAT) date and 2 fans which had no servicing date. We saw signature sample lists were incomplete across multiple medical wards, which meant supervisors or auditors would not be able to match the member of staff with the initials on the checklists.

Equipment issues, such as the clutter on Beckett Ward and overdue PAT testing, were escalated to the ward manager. The high number of equipment concerns across medical wards suggested there was a lack of oversight in monitoring these risks. As a result, we requested servicing records from the trust, which included 934 pieces of equipment used at Worthing Hospital. Senior leaders told us 20 devices were overdue for their next test and these devices were low risk and did not require any clinical engineering involvement, as per manufacturer's guidelines. However, on closer inspection, we found 73 overdue devices, some of which were high-risk devices such as blood pressure and oxygen monitors, suction units, an ultrasound scanning system, and a defibrillator.

The service did not always have enough suitable equipment to help them to safely care for patients. For example, Beckett Ward, a dementia ward, had only one hoist and no stand-aid or ECG machine, requiring staff to locate equipment from other areas. This took time away from patient care.

Staff disposed of clinical waste safely. We saw waste segregated correctly with the use of different coloured bins, and securely stored whilst awaiting removal from the ward.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient. Staff did not always remove or minimise 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) is a tool used to identify deteriorating patients and included observations such as blood pressure, pulse, pain, and temperature. This information was recorded and stored electronically, and it calculates a NEWS2 score. The higher the score, the more unwell the patient is. Its purpose is to identify acutely unwell patients, including those with sepsis. We saw nurses conducting and uploading observations to the electronic system, which included timeframes for when the next set of observations were due and visual reminders using coloured clocks. For example, on the Emergency Floor, there were no 'red clocks', indicating that no patients required immediate observations. When asked, the matron confirmed there were no unwell patients on the unit, except for one patient who required an urgent pacemaker and was being monitored in a high observational area. Nursing staff were aware of the patient's medical treatment plan. All nurses we spoke to said they would not rely on NEWS2 scores alone but would assess patients visually and escalate their concerns. Three nurses on the Emergency Floor knew the sepsis management policy and where to find it. One nurse had a sepsis card on their uniform with algorithms to follow.

The trust had a policy called "Policy for Vital Signs Monitoring and use of the National Early Warning Score in Adult inpatient areas" that guided staff on how to use the NEWS2 track and trigger system. Senior leaders told us all wards had laminated copies of the NEWS2 chart and protocol, as well as paper versions in case of a power cut. However, managers told us they did not audit sepsis compliance which meant they did not have oversight of the quality of care given to patients who had sepsis.

We spoke to doctors on the Emergency Floor, who said they felt sepsis was managed promptly and that they had 24 hour, 7 days a week access to the outreach team for support. The hospital's outreach team could also access the

electronic system with NEWS2 scores, giving them oversight of the location of unwell patients. We reviewed a patient's notes who was septic on admission and found the sepsis 6 care bundle was delivered within 1 hour and actions and treatment plans were clearly documented. This aligned with the National Institute for Clinical Excellence (NICE) guidelines who made recommendations for healthcare in England.

The trust had a pathway for the treatment of neutropenic patients that aligned with NICE guidelines. People with neutropenia may be more likely to get infections due to a reduced immune system. Therefore, neutropenic patients with clinical signs of sepsis, should receive intravenous antibiotics within 1 hour of presentation to hospital. To facilitate this, the trust employed a Patient Group Direction (PGD), empowering nurses to administer timely medicines to these patients. A PGD is a written set of instructions allowing for the administration of certain medicines to specific groups of patients, without the need for a prescription from a doctor. However, senior leaders told us the PGD was out of date and training was not occurring, which limited staff's ability to follow the pathway.

Staff conducted an audit of neutropenic sepsis patients in 2022. Of 19 patients, 11 received antibiotics within 1 hour, with an average 'door to needle' time of 1 hour and 50 minutes for confirmed cases. Senior leaders recognised that improvements were needed and recommended updating the neutropenic sepsis policy, holding monthly meetings to review why patients were not treated within 1 hour, and to create a trust-wide dashboard to track the reasons for delays.

Staff did not always complete risk assessments for each patient on arrival to the ward or reviewed this regularly. We looked at data in relation to the type of risk assessments used for new patients on arrival to medical wards. This included relevant assessments, such as, moving and handling, capacity, falls, pressure, nutrition and so on. We noted elderly care nursing documentation differed from other medical wards, and the team wanted to standardise this. On inspection, we found inconsistencies in the completion of patient risk assessments and regular reviews were not always undertaken for patients. For example, on Beckett Ward, a patient receiving compassionate care had intermittent documentation of mouthcare and skin assessments, and no documentation of a pressure area check for 1 week. Staff stated the patient's skin had been checked but not always documented and did not know the current status of their skin integrity. We asked staff to immediately check the patient due to these concerns.

Similarly, the Pressure Ulcer Risk Primary or Secondary Evaluation Tool (PURPOSE-T) had not been completed for 5 days for this patient. The PURPOSE-T is a tool used to assess a person's risk of developing pressure ulcers. The European Pressure Ulcer Advisory Panel (EPUAP) indicates the PURPOSE-T should be completed frequently for patients who are at risk and would inform staff how often to check patients' skin or turn them. This patient was in a high-risk category and their skin integrity had not been assessed for 5 hours at the time of inspection.

However, we saw examples of good care in relation to patient risk assessments. On Botolphs Ward and the Emergency Floor, falls assessments were completed on admission, and patients at risk of falls had extra mitigations in place after regular reviews and falls incidents. For example, Botolphs Ward used falls magnets on the patient journey whiteboard to indicate patients at risk of falling. Falls mats were used for confused patients, and "bay buddying" was used for high-risk falls patients or those who had already had a fall, which meant these patients were observed by staff at all times. Similarly, the 'Acute Stroke Unit Admission Pathway' booklet included specific risk assessments for stroke patients, such as assessing their ability to swallow.

Due to these inconsistencies, we asked managers how they gained assurance or monitored the quality of nursing and medical documentation. Senior leaders informed us the trust had no formal divisional nursing or medical

documentation audit process in place. Senior leaders told us they would be introducing a level of documentation monitoring via a software system already used, in October 2023. However, it was unclear how this would be conducted without a formal auditing process. Senior leaders told us the Emergency Floor had undertaken some documentation audits in response to incidents, but these audits were not proactive or standardised across the rest of the hospital.

Staff were aware of specific risk issues but did not always manage them effectively. We reviewed patient notes on 4 medical wards and spoke with staff on all wards about specific risk issues. Staff on all 4 wards could identify their high-risk patients, such as those with pressure damage, falls risk, or enhanced care needs. Overall, our findings suggested risks were generally well-managed, with staff mitigating risks through additional care planning and escalations. However, on Beckett Ward, 9 Malnutrition Universal Screening Tool (MUST) scores were overdue. The MUST is a tool used to identify patients who are malnourished or at risk of malnutrition. It informs next steps for patients depending on the MUST result. If MUST scores are not up to date, it means patients with changing nutritional needs may not have their needs met or escalated to other teams, such as dieticians or the nutritional team.

The service had 24-hour access to mental health liaison and specialist mental health support. The hospital had access to a mental health liaison team provided by a mental health NHS trust who provided a range of services, including assessment, treatment, and support for patients with mental health conditions. Staff were able to refer patients to the mental health team if needed.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff told us if a patient's mental health was a concern, the mental health team would be contacted, and a risk assessment would be conducted. We checked a patient's notes who had suicidal ideation and found they had been reviewed by the mental health team in a timely manner.

We asked staff about environmental risks for patients with suicidal ideation, such as call bells and oxygen tubing. Staff said they conducted visual checks to assess this risk and documented it in the daily nursing notes. Managers told us there was no structured ligature risk assessment in place, which posed a risk as less experienced staff may not always know to conduct this assessment. However, we did not see any patient harm as a result of this, and all mental health patients we reviewed, their need for enhanced care was risk-assessed, escalated and in place. After discussion, it was explained a Standard Operating Procedure (SOP) would be considered for structured guidance on ligature risk assessments.

Shift changes and handovers included all necessary key information to keep patients safe. We observed good professional interactions and care planning during a morning handover on the Emergency Floor. Information was communicated verbally and updated on the patient journey whiteboard. Magnets were also used indicating different patient needs, such as a heart for cardiac monitoring, a butterfly for end-of-life care and a watch for Parkinson's medicines.

Nurse staffing

The service did not always have 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 staffing levels but could not always adjust this to meet the needs of patients.

The service did not always have enough nurses, healthcare assistants, and allied health professionals to keep patients safe. On day 1 of inspection, we attended an operational site meeting where any potential risks were identified and discussed, including staffing levels. It was indicated Occupational Therapists (OTs) were working at 53%, Physiotherapists at 64%, Dietetics at 44%, and Speech and Language Therapy Team (SALT) at 80% of their capacity. Staff

on Erringham Ward and Beckett Ward told us staffing was a challenge, especially when managing patients who were detoxing or had challenging behaviour. We spoke to a HCSW on Beckett Ward, who stated staffing was always a challenge and they were regularly asked to move to other areas, leaving their ward short-staffed. Staff felt patients' needs could not always be met. Managers on most medical wards told us staffing levels were a concern and escalated, but wards did not always get the necessary numbers.

As a result, we reviewed staffing gaps on Beckett Ward, Erringham Ward, and the Emergency Floor. It was found all 3 areas had fewer nurses than expected, and 2 out of 3 wards had fewer HCSWs than expected. Ward Managers told us reduced staffing levels were not always backfilled with bank or agency staff, but posts were out to advert, and the trust were doing all they could to recruit to these vacancies.

The OT and Physiotherapy teams had senior staffing shortages. This meant junior staff operated the service in most cases. The OT team had an open Band 7 position, and the Physiotherapy team had issues recruiting Band 6 therapists, which meant they had to rely more on Band 5 therapists.

SALT staff reported retention challenges due to a lack of leadership and Allied Health Professional (AHP) lead restructuring. They struggled to cover all areas within the hospital, with 4 SALT team members, including medical wards, Special Care Baby Unit (SCBU), neonatal, and intensive care. Furthermore, Botolphs Ward staff, which is a stroke ward requiring regular SALT team input, highlighted delays in care for stroke patients, such as swallowing assessments.

Staff on Botolphs Ward reported potential overuse of nasogastric (NG) tubes to ensure patients who were not taking food or drinks and awaiting a SALT review could receive nutrition. Staff told us this did not happen regularly, and we did not note any incidents of the inappropriate use of NG tubes. However, we did raise this concern with the senior leadership team, who were unaware of any incidents or issues, but stated they would investigate this further. There had been no datix (Datix is the incident reporting system used by the trust) incidents relating to SALT in the previous 3 months.

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. Ward Managers were responsible for creating the rota. The rota was created in line with national guidance, which specified the number and grade of staff needed for each shift.

The ward manager could not always adjust staffing levels daily according to the needs of patients. The Emergency Floor had a coordinator to monitor staffing levels against risk and patient acuity. Managers on Erringham Ward told us they often had patients with challenging behaviours, and doctors felt nurses often needed more staff. Sometimes patients needed enhanced care but did not always get additional staff to provide this. The Safer Nursing Care Tool (SNCT) was used, which was an evidence-based tool used in the NHS to determine staffing levels based on patient acuity and dependency. However, there were examples of planned versus actual staffing levels not being met. Nursing staff and managers we spoke with expressed concerns at their inability to complete assessments and provide the quality of care they wanted. This was attributed to a lack of staff and high activity rates throughout the year.

The number of nurses, healthcare assistants and allied health professionals did not always match the planned numbers. On the day of inspection, Beckett Ward had 3 nurses and 3 HCSWs, when they should have had 4 nurses and 4 HCSWs. Similarly, staff on Beacon Ward told us it was rare for actual staffing levels to meet planned levels. We observed a patient on Botolphs Ward, under DoLS who required enhanced observation but did not receive it due to a lack of staff. SALT staffing met planned numbers for 1 week from 1 May 2023 to 31 July 2023, and ranged from 30% to 90% cover outside of that time.

Medical care (including older people's care)

The nursing workforce had variable vacancy, turnover, and sickness rates in July 2023 (14.49%, 8.06%, and 4.44%, respectively). These statistics reflected the nursing workforce as a whole, and not just the medical division. Senior leaders reported common themes of sickness were flu, stress, or burnout due to the cost-of-living crisis.

The service had high rates of bank and agency nurses and healthcare support workers on the wards. In July 2023, bank healthcare support workers (HCSW) worked 906 hours, bank nurses worked 1037 hours, and agency mental health nurses worked 409 hours. Senior leaders told us they were running an international recruitment campaign to reduce HCSW and nursing vacancies.

Medical staffing

The service did not always have 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. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service did not always have enough medical staff to keep patients safe, especially consultants in elderly care. Doctors on Erringham Ward reported having enough staff 95% of the time and the trust's medical rota identified 95.3% of shifts were fully staffed from May to July 2023. However, medical staff informed us there were significant consultant staffing gaps in elderly care, with only 2.5 geriatricians in post. Doctors told us they should have 10. Of these, they covered the Emergency Floor on a weekend rota of 1 out of 7. Due to the shortage of elderly care consultants, this meant 4 weekends out of the 7 were covered by locums. The front door frailty service helped to ensure everyone received a comprehensive geriatric assessment on admission, as per best practice.

We could not be assured the service had low and/or reducing vacancy rates, had low and/or reducing turnover rates, and sickness rates were low and/or reducing for medical staff as we did not receive this information.

The service had high rates of bank and locum staff. There were 910 shifts covered by locums on Worthing wards and 96 shifts covered on the Emergency Floor from June to August 2023. Senior leaders were aware of the high usage of locum doctors and linked in with the Royal Sussex County Hospital and the Princess Royal Hospital to improve access to junior doctor circulation lists.

Managers could access locums when they needed additional medical staff. We spoke to doctors on the Emergency Floor who stated that medical staffing was generally okay. When they were short-staffed, locum shifts would tend to get covered as doctors enjoyed working on the unit and had good consultant support.

Managers made sure locums had a full induction to the service before they started work. We saw a locum pack that included information on how to activate their locum card, cancer prescribing, shift patterns, bleep numbers, hospital map, and the location of trust policies. We also saw a general induction checklist for agency staff that included IPC information, location of fire exits, and how to report incidents.

The service always had a consultant on call during evenings and weekends. On the Emergency Floor, junior doctors covered specific bays, including medical frailty and surgical patients. Registrars covered all patients, and consultants covered each area. There was a frailty consultant, an acute medicine consultant, and a surgical consultant, who saw their respective patients. Consultants could come to each bay to do a run-through of the patients in that area after the ward round. All doctors interviewed were ware of who to hand over to out of hours and felt the system was robust.

Also on the Emergency Floor, consultant cover was provided by 1 to 3 frailty consultants and 3 to 5 acute medicine consultants. They worked shifts so staggered hours across the day (8am – 4pm, 10am – 6pm, and 12pm – 8pm), and there was consultant cover from 8am to 8pm. There were fewer consultants on the weekend, but at least 1 for frailty and 1 for acute medicine.

On Fridays, the frailty team identified patients who needed a weekend review by a consultant, registrar, or junior doctor. They also made sure that blood tests were requested. There was good frailty registrar support over the weekend to help the consultant.

Records

Staff kept detailed records of patients' care and treatment. However, records were not always clear, up-to-date, stored securely or easily available to all staff providing care.

Patient notes were comprehensive, but staff had difficulty accessing them and locating specific information. Notes included relevant information, such as scanned medical records from previous admissions, nursing risk assessment tools, and electronic prompts to evaluate information. Staff could access imaging and blood results on their electronic system. However, we found patient records were stored in different places and formats, including proformas, multiple electronic records, medical folders, nursing folders, Allied Health Professional (AHP) folders, and end of bed notes. This disjointed approach made it difficult to review patient records, especially for junior doctors who had to keep up with many different forms that changed frequently. Staff also reported having difficulty accessing patient information due to server issues and outages.

The daily nursing handover sheet was printed from one of the electronic record systems, which included diagnosis, comorbidities, weight, frailty and other relevant information. However, junior doctors and AHP's added daily entries to separate folders, and pain assessments were recorded both electronically and on paper. Multiple staff members told us this made it difficult to locate information. Senior leaders told us they were aware of the challenges and were working to improve the system, as the trust was not yet digitally mature and different paperwork was used in different locations.

When patients transferred to a new team, there were delays in staff accessing their records. Staff told us they did not have access to some patient information, such as mental health records and assessments. Additionally, we found some documentation was unclear and conflicting. For example, we reviewed a patient's notes on Erringham Ward where a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form indicated a patient lacked capacity, but the medical notes stated they had been involved in the decision-making process around resuscitation. This further highlighted the issues with records and the need for clear and non-conflicting documentation of capacity and resuscitation decisions, which should be easily accessible to all staff involved in a patient's care.

Patient notes trolleys were open on all medical wards we visited, leaving confidential patient information easily accessible to unauthorised personnel.

Medicines

The service had systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. The trust had an electronic and administration (EPMA) system for medicines which had inbuilt safeguards and reports were run routinely to ensure safe prescribing. All allergy boxes were completed on the prescriptions we reviewed.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Pharmacy staff told us they conducted regular medicine reviews, and we observed nursing staff informing patients about their medicines. When a patient was due to be discharged, they would receive a copy of their discharge summary. On their discharge summary, there would be a list of medicines indicating the dose and frequency. Nursing staff told us this medicine list would be explained to patients and their carers on discharge.

Staff did not always complete medicines records accurately and keep them up-to-date. We observed empty boxes on prescription charts, and in one case, an exclamation mark with no code to indicate why a medicine was omitted. This made it unclear whether medicines had been given or omitted, and if omitted, the reason why. However, we did not see any incidents as a result.

Staff stored and managed all medicines and prescribing documents safely. All medical wards we visited had drug preparation rooms with locked storage, accessible only with a keycode. Computers with patient prescription charts were logged out when not in use, and patients own medicines were stored in locked cupboards next to their beds. Controlled drugs were stored securely, and we saw checks of these were completed daily. If patients brought their own controlled medicines with them, these were recorded in a separate register. Medicines that required to be stored in a fridge were kept in a locked fridge and we saw temperatures recorded daily and were within the correct range.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Doctors on the Emergency Floor highlighted very strict sedation policies, and nurses stated it was only used as a last resort. One ward sister stated covert medicine administration was rare and required Mental Capacity Act paperwork and trust policy compliance.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

All 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. Staff at all levels told us they were encouraged to do this, and they used an electronic software system to do so. Of the incidents we reviewed, we found staff had reported them, managers had conducted investigations, and learning had been shared correctly.

However, the trust's incident reporting rate was lower than that of comparable trusts, as evidenced by a national data review spanning from October 2022 to October 2023. This low incident reporting rate was acknowledged by the trust in the Patient and Quality Committee report for August, September, and October 2023.

The service have had no never events on any medical wards in the last 12 months.

There was evidence that changes had been made as a result of feedback. Our review of 4 safety-specific incidents found changes had been made in response to feedback. For example, a serious incident prompted a consultant on the Emergency Floor to develop a ward round patient review checklist for medical teams. This was as a result of a suspended antibiotic for 48 hours. This checklist was circulated trust-wide. Similarly, the hospital implemented 'modesty pants' for patients with incontinence problems and moisture sores, to improve their dignity and comfort and prevent the deterioration of moisture sores.

Medical care (including older people's care)

Managers investigated incidents thoroughly, staff understood the duty of candour, and staff received feedback from investigation of incidents. Managers told us they conducted weekly meetings to review any new moderate harm and above incidents and assigned them to the most appropriate manager for further investigation. At these meetings, senior leaders reviewed adherence to duty of candour. The trust used a 'Learning Tracker' which recorded the status of all open incidents and shared learning with staff. Staff we spoke with said they had received feedback and associated learning had been shared.

Staff met to discuss the feedback and look at improvements to patient care and managers debriefed and supported staff after any serious incident. The trust used an 'After Action Review' (AAR) tool to understand the incident and identify areas for improvement. The AAR involved gathering the team, reviewing the incident, noting findings, such as what went wrong, what should have happened, and potential reasons for the discrepancy. Associated actions were identified.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The trust aligned their practice and policies with NICE guidelines. It had a clear governance structure to oversee and monitor the implementation of relevant NICE guidance. Reporting showed the status and risks, allowing for discussion and challenge. The Clinical Outcomes and Effectiveness Group (COEG) provided assurance that arrangements were in place for continuous improvement of clinical outcomes across the organisation in line with best practice. They interpreted national strategy into local strategy and produced trust policies. There were currently 10 Quality Standards published relevant to medical care and the trust had assurance of compliance with 4 of these so far and were working on the other 6.

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 made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We saw kitchen staff regularly conduct tea rounds, offering patients hot drinks and biscuits. All patients we observed had jugs of fresh water within reach, regularly topped up by staff. Patients were offered 3 hot meals a day. Those who required assistance with eating were placed on a 'red tray' system, indicating to staff that they needed help at mealtimes. On Botolphs Ward and Beckett Ward, we saw a patient nutritional whiteboard that informed which patients required a red tray and their MUST score. On multiple medical wards, we saw a purple 'Knowing Me' form detailing patients food likes and dislikes.

Medical care (including older people's care)

Staff fully and accurately completed patients' fluid and nutrition charts where needed. All records we reviewed for patients requiring their food and fluids to be monitored, had their intake and output recorded. This was either in their end of bed notes or on a software system. This allowed staff to keep up-to-date on patients whose nutritional intake and fluid balance were being monitored.

Staff used the nationally recognised MUST score to monitor all patients for malnutrition risk. On most wards, patients were weighed weekly unless there was a clinical reason to do so more often. The software system used to input this data would remind staff to review patients MUST scores. Most food charts we reviewed were completed for patients at risk of malnutrition.

Specialist support from staff such as dietitians and speech and language therapists were not always available for patients who needed it. Dietician referrals were triggered by a MUST score of 2 or more. Patients could also be referred by telephoning the dietician or SALT team. However, we found it was not always clear from patient records whether referrals had been made. For example, staff on Beckett Ward told us they had 3 patients with a MUST score of 4 who had been referred to a dietician. However, when we asked to see documentation of the referrals, it took staff 15 minutes to locate entries from the dietician team. This suggested staff did not have a clear system in place for tracking dietician referrals. After a discussion with staff, it was decided they would add a column to their patient nutritional whiteboard to track when a dietician referral had been made.

Similarly, on Botolphs Ward, we spoke to staff about SALT referrals. One consultant said they needed to check if a patient under their care had a swallow assessment from the SALT team but could not find the referral or documentation of their input. Staff also said there were delays in assessments for patients awaiting a SALT review. This was consistent with the issue of staffing shortages within the SALT team.

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. Pain was recorded in an electronic system using the standard 0 to 4 pain scale. For non-verbal or patients who were unable to communicate their needs, staff used a nationally recognised pain assessment tool, which considered cues such as facial expression, body language, and physiological changes. Staff told us referrals were done online and the pain team were easily contactable.

Patients received pain relief soon after requesting it. All patients we spoke to during inspection said they were very happy with the care they received. One patient who was unwell said they felt cared for and not in any pain. They were asked about pain relief regularly, although they did not need it.

Staff prescribed, administered and recorded pain relief accurately. However, the electronic system did not allow staff to alter medicine changes if a patient changed their mind about taking it. This resulted in a number of blank entries and uncertainty about whether or not a medicine had been given. For example, if a patient declined pain relief and then requested it 10 minutes later, medical staff would have to re-prescribe it in a different way, such as a one-off dose.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements. However, they did not always achieve good outcomes for patients.

Medical care (including older people's care)

The service participated in 12 national clinical audits throughout 2023/24 and managers used the results to improve patients' outcomes. The Clinical Outcomes and Effectiveness Division oversaw the audits, and this was monitored on a monthly basis. Some of which included Adult Respiratory Support, COPD Secondary Care, and the National Lung Cancer audit.

Outcomes for patients were not always positive, consistent and met expectations, such as national standards. The trust submitted their data for the care of stroke patients to the Sentinel Stroke National Audit Programme (SSNAP). This is a clinical audit that benchmarks evidence-based care for stroke patients. It indicates national targets for the thrombolysis and the time it took for a patient to be admitted to a stroke unit as well as the time it took to be reviewed by a consultant. Key indicators were used to reflect performance across 10 areas within stroke care and an overall score was given (A to E, with A meaning the hospital was performing well, and E meaning the hospital was not performing well).

The trust's SSNAP score for timely admission to a stroke unit and review by SALT was 'E', and it had remained at 'E' for timely admission to a stroke unit since April 2022. The hospital scored 'D' for patients receiving thrombolysis on time, physiotherapy, and MDT working, from April to June 2023. Overall, the hospital rating for stroke care delivery was 'D'.

During the inspection, SALT staff told us they sometimes had to prioritise one patient over another. The average time it took for SALT to review a confirmed stroke patient was more than 20 hours. Some patients required 45 minutes of SALT input per day for their recovery, but this did not always happen. Staff told us patients had been sent home before seeing SALT, although SSNAP guidelines required patients to be seen by SALT before discharge.

Staff told us the suitability of patients for NGT (Naso-gastric tube) insertion was not a concern, as nurses had clear guidelines to follow. However, there was a concern for other patient groups such as those who required daily physiotherapy with a language problem. If the SALT team were short-staffed, they would prioritise patients who were nil by mouth (NBM) as they were not receiving nutrition. This meant patients with an ongoing language problem were not always reviewed, as per SSNAP guidelines, to aid their recovery.

Senior leaders recognised that access to therapies was compromised, and staff were unable to provide the same amount of time to patients. Actions for improvement included protecting stroke beds to allow quicker flow to stroke wards when needed and conducting a complete review of therapies at Worthing Hospital. The hospital had an action tracker with monthly governance meetings focusing on different improvement projects, such as improving the 4-hour to ward target.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. For example, the medicine division participated in audits such as the National Core Diabetes Audit and the National Asthma and COPD Audit Programme. This allowed managers to identify trends and areas for improvement.

Managers shared and made sure staff understood information from the audits. Records showed audit meeting minutes 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.

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.

Medical care (including older people's care)

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role. Staff told us they had their induction training and felt confident they knew what to do when caring for patients. We observed staff being attentive to patients' needs and saw organised, calm ward environments. Ward managers told us they would allocate senior nurses to care for more unwell patients with higher acuity needs.

The trust induction lasted 1 week, with 4 weeks of supernumery time working on the ward. New staff worked day shifts for the first 3 months and had 2 mentors to support them. Competencies were recorded and required sign off. Ward managers aimed to manage the rota so there was only 1 newly qualified or junior nurse on shift at any one time.

Managers supported staff development through yearly appraisals, but they were not always up-to-date. The trust's compliance target rate for appraisals was 90%, but medical staff had a compliance of 71.43% and nursing staff had a compliance of 87.11%. Staff said they felt supported by their managers and had the opportunity to discuss and develop their skills and knowledge.

The clinical educators supported the learning and development needs of staff. Managers told us practice educators could develop individualised plans for overseas nurses and provide general support to all staff who required it.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw examples of meeting minutes documented and for staff to read if they could not attend team meetings.

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 could be done by informal discussions, or during their appraisal.

Managers made sure staff received any specialist training for their role. For example, nursing staff on Beacon Ward, which often cared for patients with complex wounds, were trained by vascular nurses to change Vacuum-Assisted Closure (VAC) dressings. A VAC dressing is a type of dressing that uses negative pressure wound therapy, to help wounds heal. All band 5 nurses on this ward were trained to do this. Similarly, band 6 nurses on Botolphs Ward, which was a stroke ward, were trained to take direct admissions from the ED and to conduct assessments of stroke patients. The assessing nurse worked alongside a doctor, but the nurse was often the first to arrive in the ED and would therefore commence the initial assessments.

Managers identified poor staff performance promptly and supported staff to improve. Managers told us action plans were put in place for poor performance. The appraisal process ensured staff were given regular feedback on their performance. It also helped to identify any areas where staff needed additional support.

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 (MDT) meetings to discuss patients and improve their care. We observed good MDT meetings on multiple medical wards, often involving matrons, ward managers, discharge coordinators, OT's, physiotherapists, and junior doctors. Consultants conducted their ward rounds separately. At each meeting, the team discussed each patient's medical and social history, identified current interventions needed, made an estimated date of discharge, and discussed discharge pathways. We observed a board round on the Emergency Floor attended by nurses and other MDT colleagues, which meant nurses were aware of patients' treatment plans in real-time and we saw professional interactions with good challenge.

Medical care (including older people's care)

Staff referred patients for mental health assessments when they showed signs of mental ill health. Staff told us the mental health team were easily contactable and they knew when to escalate their concerns regarding a person's mental health.

Patients had their care pathway reviewed by relevant consultants. We saw good working relationships between consultants. For example, patients requiring speciality reviews, such as a cardiology or stroke review. These discussions were documented in patient's notes, which ensured patients were on the correct pathway for their care.

Seven-day services

Key services were not always available 7 days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. The medical rotas team worked with a lead consultant on each site to ensure the consultant on-call rota was covered 24 hours a day, 7 days a week. This was within the consultant contract, whereby they were required to be immediately available if called to come onsite. From 1 January to 30 September 2023, there were no gaps in on-call consultant cover over evenings and weekends. This meant medical staff always had someone to escalate their concerns. Medical staff told us renal reviews were more challenging as the team was not based onsite and came to review patients twice a week. However, they could be contacted by telephone for advice at any time.

Staff could not always call for support from all disciplines, 24 hours a day, 7 days a week. There were gaps in coverage, such as the lack of Allied Health Professionals (Physiotherapists, OT's and SALT) cover over the weekend and the lack of pharmacy staff to cover the Emergency Floor at the weekends. Consultant cover on the gastroenterology ward was limited at weekends as they were not onsite, but they were contactable by telephone. There was also support from Senior Physician Registrars and outreach if needed. The loss of therapy input over weekends meant patients awaiting a SALT review could be kept NBM from Friday to Monday when they did not always need to be.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. We observed information boards on smoking cessation and living a more active lifestyle. Leaflets were available linked to health promotion programmes, such as the smoking cessation project and promotion of a fall's awareness week.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. This included completing a comprehensive assessment, making referrals to other specialist nursing teams, such as the diabetic team, and providing information and resources about healthy living.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Patient records did not always demonstrate staff followed national guidance and legislation about consent. However, they knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limited patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture

and traditions. Staff could clearly describe the correct process for establishing the capacity of patients to make decisions about their care. When patients could not give consent, staff made decisions in their best interest. Records of patients who had been assessed as not having capacity and where staff made care decisions based on the best interests of the patient were completed.

On the Emergency Floor, the nursing proforma had questions to assess mental capacity. If nurses identified concerns, the form would signpost them to seek a formal assessment by a doctor. If a patient was admitted to a ward with concerns about their mental capacity, or if they wished to leave the ward and were found to lack mental capacity and were not formally under a Section under the Mental Health Act, a DoLS application would be made.

Staff gained consent from patients for their care and treatment in line with legislation and guidance, however there were no formal audits on consent. 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 patient notes. For example, we saw good documentation of consent around NGT insertion on Botolphs Ward. We asked senior leaders how they monitored consent, but we were told there was no formal auditing process to monitor this compliance.

Staff did not always clearly record consent in patients' records. We saw inconsistent completion of mental capacity, particularly in relation to Treatment Escalation Plan (TEP) forms which did not always align with what was documented in medical notes. A TEP form is a tool used to reflect the values and preferences should a person deteriorate, and the actions clinicians should take. We also found multiple issues with a lack of mental capacity documentation recorded in multiple places. For example, on Erringham Ward, one patient's DNACPR form stated the patient lacked capacity but there was no capacity assessment seen. Similarly, a review of a patient's notes on Botolphs Ward, their DNACPR indicated they did not have capacity; however, this was not recorded on the TEP form and there was no capacity assessment documentation seen. We spoke to a consultant who felt confident it was happening but acknowledged there were inconsistent methods of documentation.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act (MHA) and the Mental Capacity Act 2005 (MCA) and they knew who to contact for advice. Staff had an awareness of legislation relating to the MHA and the MCA. They told us they could seek advice from medical teams, senior nurses, mental health liaison team, psychiatry and social services if they required further advice.

Managers monitored the use of DoLS and made sure staff knew how to complete them. Staff told us they had a weekly DoLS review sticker to ensure they had oversight of when a DoLS authorisation was expiring and needed to be extended or reviewed. All ward managers we spoke to knew which patients were being treated under DoLS.

Staff could describe and knew how to access policy and get accurate advice on MCA and DoLS. Staff told us they could find relevant policies and information on the hospitals intranet page. Staff told us they would escalate their concerns around MCA or DoLS to medical teams.

Managers monitored how well the service followed the MCA and made changes to practice when necessary, however, the service needed to improve its documentation of capacity assessments. We saw an example of the use of the MCA where an end-of-life patient with capacity had a Respect Form to indicate they did not want any further admissions to hospital after discharge. A Respect Form records a person's wishes about their care and treatment. This was documented in their notes and the palliative care team was involved in planning their care. However, we reviewed 4 TEP forms where capacity decisions should be documented, and they were blank.

Medical care (including older people's care)

Staff did not always implement Deprivation of Liberty Safeguards in line with approved documentation. We saw DoLS paperwork used for patients where their liberty had been deprived, such as the ability to leave the ward. For example, on Botolphs Ward, we saw a patient who was treated under DoLS, which was in date and had been regularly reviewed. An MCA form was also completed to indicate the patient did not have capacity and a decision had been made in their best interest. The patient had mittens on their hands to prevent them from removing their NGT to ensure they could receive nutrition and this decision was documented clearly in their DoLS paperwork.

However, there was inconsistent accurate completion of DoLS paperwork where another patient on Botolphs Ward had mittens on which was not documented. As this was a form of restraint, this decision should have been clearly documented. We initially discussed this with the nurse looking after the patient who stated they had put them on in the morning as the patient had been pulling their catheter. It was further discussed with the ward manager who was unaware the mittens were in situ and admitted this should have been documented. Managers also told us this patient required enhanced observations due to their level of confusion, but the patient was not receiving this due to a lack of staff. The ward manager stated they had requested 1:1 care and this concern had been escalated.

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 did not always follow policy to keep patient care and treatment confidential.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff being courteous, kind, and respectful to patients and visitors. Patient dignity was respected and we witnessed multiple staff members knocking on the doors to single rooms before entering. We also observed a physiotherapist helping a patient to orientate themselves to walk using a stick being caring in their approach. One patient we interviewed said, “Staff tell me what’s going on and my family too, they come in most days. They are ever so respectful”. Another patient reported that they observed how professional and calm staff were with them, and other patients.

Patients said staff treated them well and with kindness. Patients we interviewed spoke highly of the staff, describing them as kind, caring, and respectful. One patient said, “All the staff are kind and caring. I used to be a nurse myself, so I know what I’m talking about. I’m just glad to be here and count myself lucky”. Patients also commented on the cleanliness and comfort of the wards, as well as the artwork and courtyard gardens. Another patient said, “There was a dining table in the middle with flowers, giving it a homely feel and the staff are always smiling and happy, it cheers you up just to look at them”.

Staff did not always follow policy to keep patient care and treatment confidential. For example, on the Emergency Floor, patient treatment plans were discussed in an open area at the central desk.

Medical care (including older people's care)

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 from both mental health teams and general staff when reviewing patient notes with mental health needs. During our observation of a board round, mental health patients were discussed in a respectful and non-judgemental way.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The hospital had multi-faith areas with facilities for Christian worship and Muslim prayer. We saw a private room dedicated to Wudu, which is where a cleansing ritual can take place prior to performing prayer. In the chapel area, there was a memorial tree and a memorial harp for patients to add notes to. The chaplaincy service was available 24 hours a day, and the chaplain told us they spent one day per week visiting wards to focus on staff well-being. We saw artwork throughout the hospital corridors, courtyard and remembrance gardens. Patients commented on this and stated it helped to create a warm and welcoming environment.

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. For example, when a patient deteriorated, doctors discussed the situation with the family and decided to stop treatment. Staff were aware of the patient's strong faith, so they called the chaplain and informed the local church. The palliative care team provided family emotional support and symptom control for the patient.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff told us they used privacy screens for patients who became distressed in open environments. We observed curtains pulled around bedspaces when more than one patient was in a bay, maintaining their privacy and dignity.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff considered patients individual needs and respected their wishes. For example, when a patient was receiving compassionate care, family members expressed a desire for the patient not to be moved into a single room, as it may have caused distress. Staff respected these wishes.

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. Staff spoke with patients, families and carers in a way they could understand, using communication aids where necessary. Most patients we spoke with said they were well informed about their care and treatment. One patient said, "Everything is explained to me. My discharge may be as soon as Friday, but I am having discussions about this with the team". Communication aids were available such as flashcards and picture menus if required.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients were offered the Friends and Family Test to provide feedback and could be signposted to the Patient Advice and Liaison Service (PALS) if they wanted to raise a complaint.

Medical care (including older people's care)

Staff supported patients to make informed decisions about their care. For example, one patient told us 2 Occupational Therapists (OT) accompanied them to their home to help them decide how they would manage once they were discharged. This allowed the patient to be involved in their care and make informed decisions.

Patients gave positive feedback about the service. Friends and Family data showed 95% of patients from February to July 2023 rated their care as good or very good, with the main reason for this being the staff and the quality of care.

Is the service responsive?

Requires Improvement 

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

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

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

Managers planned and organised services, so they met the changing needs of the local population, including those with mental health problems, learning disabilities, and dementia. Staff worked to ensure these patients received the necessary care to meet their needs. The hospital had a learning disability team, a 24 hours a day, 7 days a week mental health service, and dementia teams available to provide specialist support.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Trust data showed there were 10 mixed sex breaches in medicine on the Emergency Floor from August to September 2022. This was due to the high number of COVID-19 positive patients awaiting single rooms. Managers told us patients verbally consented before being placed in a mixed sex area, and these breaches were reported.

Facilities and premises were appropriate for the services being delivered and the service had systems to help care for patients in need of additional support or specialist intervention.

Meeting people's individual needs

The service was inclusive and took account of most patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. However, the service did not always meet the needs of people with mental health illnesses.

Staff did not always make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The hospital had access to specific teams provided by a mental health NHS trust with expertise in mental health, learning disabilities and dementia. We saw good examples of dementia care which included thorough reviews and advice to staff on how best to support people living with dementia. We also saw input from the learning disabilities team for another patient. They had made a district nurse referral and ensured key information was shared for ongoing care needs, such as wound care and there was clear documentation around communication with the patient's next of kin.

However, individual needs were not always met for patients living with mental health problems and were not always inclusive. For example, we observed a lack of environmental ligature risk assessments for patients with suicidal ideation. This meant staff had to rely on their colleague's knowledge and expertise rather than following a standardised risk assessment procedure.

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 who could not always communicate their needs verbally. Staff wrote some details on a whiteboard behind each patient's bed, such as 'tea with milk and 1 sugar' and patients preferred name. This enabled staff to provide personalised care to patients.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to communication aids to help patients become partners in their care and treatment. 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. On Botolphs Ward, we observed 2 physiotherapy staff communicating with a patient using a visual aid card.

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.

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 if needed.

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.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit and treat patients were in line with national standards. However, some patients were discharged out of hours, between 10pm and 8am.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The operational site team coordinated flow within the hospital. We saw good examples of clinical leadership and communication at the trust operational status meeting, with a focus on bed availability and capacity issues. Senior leaders told us they would communicate regularly with external services such as the Integrated Care Board (ICB) where community capacity was challenged. For example, the provision of mental health beds. Ward staff reported hospital escalation policies such as the Operational Pressures Escalation Level (OPEL) status, had a minimal impact on them. Managers told us patients were rarely cared for in corridors which implied patient flow was managed well. The division held weekly performance meetings to discuss and reduce patient wait times. The executive team also monitored this process. One example of an implemented action plan was closer monitoring of booking capacity to improve the usage of outpatient clinics.

Medical care (including older people's care)

Managers and staff worked to make sure patients did not stay longer than they needed to. The hospital had an ambulatory care pathway where patients could receive same-day treatment without admission, such as a blood transfusion. Staff reported the Ambulatory Care Unit could treat 30 to 40 patients per day. Patients could be booked back to the unit for blood results or a medical review a few days later, and all patients were reviewed by a consultant before discharge.

Staff rarely moved patients between wards at night. We reviewed data on out-of-hours bed moves (22:00 to 06:00) for May, June, and July 2023. There were 7 moves in May, 25 moves in June, and 14 moves in July. These moves were typically for critical care step-downs, unwell patients requiring higher dependency care, or to create medical bed capacity for acute patients.

Managers monitored patient moves between wards and services during the day, but they did not always minimise them. They moved patients when medically necessary, in their best interest, or due to capacity pressures. Staff reported patients were rarely moved unnecessarily. Managers monitored patient moves within medicine monthly. In May to July 2023, 6 patients were moved in May, 4 in June, and 4 in July. Most patients admitted to medical wards came via the Emergency Floor pathway, which had medical, surgical, and orthopaedic patients. Bed allocation depended on triage after consultant review and availability. Senior leaders told us most moves were based on clinical need, but some were due to hospital pressures and bed capacity issues. Although the monthly data for bed moves was low, we asked how many times a patient was moved on average during their hospital stay. In May to July 2023, patients were moved 8 times in May, 9 times in June, and 7 times in July.

Managers and staff started planning each patient's discharge as early as possible. However, some discharges occurred out of hours which did not meet best practice guidance. Discharge planning started on admission. Staff asked patients about their home setup and care needs to understand their baseline needs. If a patient's needs changed, staff could forward-plan and implement care more quickly.However, from May to July 2023 there were 208 patients discharged between 10pm and 8am This was not in line with best practice guidance. The trust did not have an out-of-hours discharge policy, so staff did not have clear guidance to follow when discharging patients late at night.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them. The hospital held weekly 'long length of stay' meetings for patients with delayed discharges. Attendees included matrons, therapy representatives, social care, discharge coordinators, and the chief of service for medicine. We visited Buckingham Ward, which had 23 patients medically fit and ready for discharge. The ward's discharge process was well-organised, with patients placed on different pathways depending on their needs. For example, pathway 1 where the patient would go home with a package of care. Staff knew which pathways their patients were on and how long they had been waiting since being declared 'medically ready for discharge'. This enabled oversight and escalation of any delays to staff at the long length of stay meetings.

Managers prioritised early discharge planning and reviewed the causes of delays. For example, they were working on a discharge project to improve the time it took pharmacy services to prepare take-home medicines, which had been a barrier in the past. Doctors and nurses on the stroke ward identified a lack of community beds as a cause of long patient stays, a common challenge faced nationwide. Data from May to July 2023 showed 50 patients were waiting on a care package to be discharged, but remained in hospital medically ready for discharge as this was not readily available.

Staff supported patients when they were referred or transferred between services. We reviewed patients in the Emergency Department (ED) who had been accepted by the medical team and were waiting to be transferred to a

medical bed. On inspection, there were 17 patients in the ED waiting for medical beds. These patients had been reviewed by the medical teams overnight and accepted under their care. Staff told us these patients would be reviewed daily by the medical teams who had overall responsibility even if they remained in the ED. If they became unwell, ED doctors would provide that care and escalate this back to the medical teams.

We identified a potential risk where the ED did not have online prescribing facilities, whereas the wards only used online prescribing. The lack of standardisation meant there was a risk that medicines could be missed (if not checked by ward staff on arrival), or that medicine changes might not be accounted for. Staff informed us this was not a common occurrence, but it had happened in the past and was more likely to happen in the winter when departments were busier.

We reviewed ward-to-ward handover documentation for patients who were transferred or were outliers and they were robust with clear plans in place for receiving staff.

Managers monitored patient transfers and bed availability for all specialities. We attended a bed meeting where discussions of bed availability took place and any divisional risk. This included medicine, ITU, stroke and others. This was necessary because patients sometimes required care outside of their speciality or escalation to other areas. At the bed meeting, the team reported there were 2 available ITU beds, which gave managers clear oversight of what care could be provided.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. We found no medical outliers on inspection, but staff told us they did occur. When patients were outliers, consultants would visit the outlying ward to review them. The hospital held daily medical divisional safety huddles to review where medical cover was needed and to discuss outliers. Nursing teams on these wards also monitored patients who had not been reviewed that day and escalated any concerns to the appropriate teams.

Managers worked to minimise the number of medical patients on non-medical wards. There were 161 medical outliers from May to July 2023. Senior leaders told us the clinical site management team would aim to reconcile any outliers back to their speciality bed as soon as possible. They also informed outlying patients would be the preferred option, rather than opening up escalation areas. Staff on Erringham Ward proactively called down to the Emergency Floor to ensure that patients triaged under Gastroenterology could be assigned a bed. This helped to create further capacity and improve patient flow, which had a positive impact on patients getting to the right speciality bed for their needs.

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. The service clearly displayed information about how to raise a concern in patient areas. None of the patients we spoke with felt the need to complain, but said they would first express their concerns to the nurse looking after them or the ward manager. We saw Patient Advice and Liaison Service (PALS) leaflets displayed on multiple medical wards.

Staff understood the policy on complaints and knew how to handle them. Staff told us they knew where to find the policy on the hospital's intranet page. If a patient complained, the ward manager would first try to resolve the issue. If it could not be resolved at that level, it was escalated to the matron or to PALS.

Medical care (including older people's care)

Managers investigated complaints and identified themes. They looked for patterns in complaints to identify areas for improvement. We reviewed how complaints were managed. Each complaint was assigned an opening date, location, status, and categorised by speciality. This allowed leaders to ensure the complaint was signposted to the correct investigating division. Some complaints were resolved locally, and others were sent to PALS. A clinical governance team monitored risk and investigated concerns. Feedback was shared with staff for learning and service improvement.

Staff could give examples of how they used patient feedback to improve daily practice. For example, after a complaint about mouthcare provision, they created a mouthcare pack to ensure all items needed were in one place. The hospital also implemented weekly contact with the next of kin of all patients.

From January to June 2023, there had been 68 complaints received where identified themes included poor attitude from some nursing and medical staff, lack of communication on discharge, and long physiotherapy waiting lists. We noted actions had been taken to address these concerns and responses were sent to complainants.

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 generally visible and approachable in the service for patients and staff.

We interviewed the Chief of Service and Divisional Director of Nursing to learn about the hospital's leadership and management. We were told there were 3 service leads who rotated between Worthing Hospital and St Richard's Hospital. The medical triumvirate told us they had a visible presence on the sites, met weekly, worked well together, and completed a leadership programme which gave them the skills they needed for their roles. They acknowledged the challenge of working across more than one site and strived to be more visible to staff.

The hospital had a strong nursing leadership team, and staff told us this team was visible and accessible. Senior leaders told us they preferred to communicate in person rather than by email. The medical team had a less well-formed leadership structure, but the hospital was working to address the gap in middle management. The hospital had a guardian of safe working hours who worked with junior doctors to identify and address any concerns.

During our inspection, we observed a safety huddle on the Emergency Floor. Leaders identified potential risks, discussed staffing gaps, and planned discharges. They assigned more experienced staff to more acutely unwell patients and made sure that patient safety would not be compromised when doctors attended training sessions that day. Positive patient feedback was shared, and a project of the week was discussed. The huddle lasted 15 minutes and was efficient and well-run, with clear leadership from the matron. A doctor told us this was a fair representation of how safety huddles normally run, and this happened Monday to Friday.

Similarly, on Byworth Ward, we saw an improvement huddle board with ideas for improvements and an employee of the month award. Staff gave us positive examples of supportive care and professional development. Managers praised their

team's resilience and flexibility in the face of staff shortages and turnover. Staff reported they felt valued locally. However, some staff reported feeling unsupported by senior leaders. For example, nurses and doctors on one ward were grieving the loss of a colleague. A planned visit to offer condolences and check on staff well-being by senior managers was cancelled. This led to staff feeling unsupported and with a reduced morale.

Vision and Strategy

The service did not have a vision for what it wanted to achieve or a strategy to turn it into action.

Local leaders told us the trust had a clinical strategy but no divisional strategy, and they needed to focus on this to drive future improvement. They also acknowledged a lack of interest from medical teams in taking on more senior roles and said they were working to improve the culture to make these roles more appealing.

Medical staff informed us that elderly care wards were short-staffed, which we also found during our inspection. Leaders acknowledged the need to improve staffing levels and create more stable teams with reduced turnover rates. They also mentioned a successful staffing model used at another trust, which they planned to implement at Worthing Hospital.

Senior leaders told us they were committed to reducing harms and planned on conducting a deep dive into their incidents with harm, to identify root causes and potential themes. They acknowledged that the focus had been lost on regular safety audits on the wards, due to the demands and capacity pressures of COVID-19, but a programme to restore this focus will begin in October 2023.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff at Worthing Hospital said they were proud of their work and the hospital culture. The staff survey had a return rate of 67%, and the hospital had been holding listening events to gather feedback and identify areas for improvement. The most recent listening event was in September 2023.

The division held a leadership day and launched a communications campaign, 'You said, we did', to keep staff informed of developments. The Emergency Floor had a culture of Quality Improvement (QI), with a Kaizen board where staff could raise problems and work together to find solutions. A Kaizen board is a visual tool where people can make recommendations for improvement. The matrons and consultants said they felt proud of the QI culture, and there was evidence that many Multidisciplinary Team (MDT) members had raised issues for improvements using this method. Most staff said they felt supported, had a good work-life balance, and appreciated the visibility and accessibility of the management team.

Staff said they enjoyed the social events that were held at the hospital, such as 'Fish and Chips Friday', which staff said was a good way for staff from different specialities to get to know each other.

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.

Medical care (including older people's care)

The hospital had a strong culture of shared learning, with a variety of initiatives to share lessons from datix incidents, patient stories, and safety reviews. The hospital was also committed to training and development, with a focus on Patient Safety Incident Response Framework (PSIRF) and more emphasis on near miss incidents. This framework is an NHS tool used to investigate patient safety incidents. For example, some of the hospital's governance processes included monthly governance meetings to discuss national audit performance and review data, supervision groups for matrons, divisional newsletters and tablets with QR codes to share governance information, theme of the week initiatives, governance half-days and meetings with learning, and ward team days. The division was working on improving communication with staff, especially for those working on busy wards who may not always have had time to check their emails.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They did not always identify or escalate relevant risks and issues and did not always identify 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.

Risks to patient safety and performance were not always identified and managed through the risk register. The hospital had a risk register that was reviewed monthly. The top risks included the provision of mental health care, capacity and flow, and Emergency Department (ED) boarding. However, risks associated with gaps in patient assessment and care delivery, lack of audits, for example, of content and quality of patient records and sepsis compliance were not detailed in the risk register. There was a risk that these gaps would become normalised and tolerated by supervisors in the face of persistent staff shortages and a lack of oversight as these concerns were not audited, putting patient safety at risk.

There was a lack of oversight of the management of risks associated with caring for patients with mental health conditions. Senior leaders told us the hospital offered a 5-day mental health training course for staff and there had been no safety-related incidents where untrained staff had looked after patients who were sectioned under the Mental Health Act. When we identified and raised the concerns around a lack of ligature risk assessment documentation, senior leaders emphasised it was an acute hospital, rather than a mental health hospital. However, whilst mental health patients resided there, the hospital had overall responsibility for the care of those individuals. Senior leaders told us it was up to ward staff to assess and mitigate this risk, but there were no trust-wide processes to support staff and more work was needed to improve this.

The discharge lounge had been moved to a private ward, and staff were expected to be relocated again during winter pressures. Staff told us they felt disappointed with this move, and temporary signage to the discharge lounge was unclear and difficult to navigate.

Senior leaders told us there was a high number of surgical patients in the ED, which had a direct impact on bed availability for medical patients on the Emergency Floor, which contained both medical and surgical patients. The hospital also did not have an out of hours discharge policy.

Information Management

The service collected reliable data and analysed it. However, staff could not always find the data they needed. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required but patient records were not always stored securely.

Senior leaders told us the mental health liaison team would complete their reports and a copy of the notes would remain on the wards for staff to access and instructions for staff to follow. This did not seem to be a barrier.

We discussed the record-keeping challenges of accessing information stored in multiple locations and formats. Senior leaders acknowledged the need for an improved digital platform and said the board recently approved a new digital system. They realised the lack of standardisation of paperwork used both internally and at different site locations was also a barrier with record-keeping.

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.

The hospital was working to address silo-working between divisions and other locations. For example, they had implemented leadership programmes to help bring people together, and there was cross-working initiatives for dermatology services. The hospital was also working to share good practices between the East and West sites.

The hospital director held a 9am west call system every day to exchange information with the community trust, Integrated Care Board, local Mental Health Trust, and Ambulance service. This helped them gain more oversight of the impact of other services on the hospital.

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.

Senior leaders told us the hospital's nursing team had been particularly resilient and innovative during the COVID-19 pandemic. They maintained a good culture and kept their focus on patient safety, despite the challenges they faced. Senior leaders told us the hospital's governance and incident reporting systems were patient-focused. They would also like to see improved mental health services nationally.

Outstanding practice

We found the following outstanding practice:

- The hospital had multi-faith facilities for Christian and Muslim prayer. We saw a private room dedicated to Wudu, which is where a cleansing ritual can take place prior to performing prayer. In the chapel area, there was a memorial tree and a memorial harp for patients to add notes to.
- The chaplaincy service was available 24 hours a day, and the chaplain told us they spent 1 day per week visiting wards with a focus on staff well-being.
- Artwork seen throughout the hospital corridors, courtyard and remembrance gardens.
- The Emergency Floor has been set up as part of the Royal College of Physicians Future Hospitals Programme. The integrated services ensure that older people get a non-inferior service and good access to all specialities and can switch between medicine and frailty easily. This helps to ensure that older people who were not frail can be admitted to medical wards and elderly care wards were protected for those with high clinical needs and complex frailty. It was based on clinical need; rather than age and a cross cover of junior doctors meant they learnt on both frailty and acute medicine/surgical case.

Medical care (including older people's care)

Areas for improvement

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

Action the trust MUST take to improve:

- The trust must ensure that all patients on medical wards receive regular risk assessments upon admission and throughout their stay and take all reasonable steps to mitigate any identified risks. This includes mouthcare, skin and nutritional assessments as well as ligature risk assessments for patients with suicidal ideation for staff to use. Regulation 12.
- The trust must ensure that equipment including heating systems are suitable for purpose and properly maintained. Regulation 12.
- The trust must ensure equipment in ward environments is moved and stored in a suitable location and avoids emergency exits being blocked. Regulation 12.
- The trust must ensure the proper and safe management of medicine including prescribing systems. Regulation 12.
- The trust must ensure the Patient Group Directive treatment of neutropenic patients is reviewed in a timely manner. Regulation 12.
- The trust must ensure appropriate training, in line with guidance, is in place and completed by staff to support patients with learning disabilities, dementia and autism. Regulation 12.
- The trust must ensure that patient record documents and systems are reviewed to ensure staff have access to patient information that is accessible, accurate and up to date across all electronic or paper-based records. Regulation 17.
- The trust must review its audit monitoring systems to effectively improve the quality and safety of the services. Regulation 17.
- The trust must ensure they take measures to restrict unauthorised access patient record documents. Regulation 17.
- The trust should ensure the consistent completion of DoLS paperwork that matches patient's needs. Regulation 17.
- The trust must ensure there are sufficient numbers of suitably qualified staff to keep patients safe. Regulation 12.
- The trust must ensure that workforce data for the trust can be separated to show individual site performance. Regulation 17.
- The trust must ensure they have an out of hours discharge policy to reduce risks relating to patients when discharged out of hours. Regulation 17.

Action the trust SHOULD take to improve:

- The trust should have updated signature sample lists across all medical wards.
- The trust should work towards reducing the number of times a patient is moved during their hospital stay.

Surgery

Requires Improvement

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

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

However:

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

Is the service safe?

Requires Improvement

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

Mandatory training

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

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

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

Leaders told us all theatres staff had Immediate Life Support training, however we were not provided with any details regarding compliance so are unable to be assured about the percentage of staff who have completed it.

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

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

The mandatory training available only met the needs of some patients and staff. For example, there was no dedicated training on recognising and responding to patients with mental health needs and dementia. The trust had also not fully implemented dedicated training on recognising and responding to patients with learning disabilities and autism. There was also no training available for all staff in sepsis management or recognition, this was instead a training done by some staff in additional modules they completed depending on their role.

Safeguarding

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

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

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

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

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

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

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

Cleanliness, infection control and hygiene

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

Theatre areas were clean and had suitable furnishings which were clean and well-maintained. Most ward areas were visibly clean, however entrance doors to wards were damaged due to constantly being hit by beds and trolleys when being moved in and out of the wards. This made them difficult to clean effectively. We were told this had been reported to estates but there was no evidence of a plan to rectify the damage.

We saw chairs in use in the Day Case/Surgical admissions ward that had damaged covers making them difficult to clean effectively.

On Clapham ward, a surgical patient identified and demonstrated how the clinical sink in their room/cubicle created a backflow into the bowl when used. This brought dirty water, containing debris into the sink. The sink would also not drain away effectively. The patient, and anyone else using the room, would not be able to wash their hands effectively. The flooring in the room was damaged meaning it could not be cleaned effectively. The patient said they had reported this to the ward staff but was unsure if there was a plan to resolve the issue.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed some staff using 'I am clean' stickers on equipment and domestic staff followed daily work sheets to complete cleaning activities. We saw cleaning checklists were completed daily by staff and had been for the month prior to inspection.

Staff in theatre recovery areas told us they completed cleaning at the start of the day but this was often delayed due to patients being held in this area late into the evening and night due to lack of bed availability on wards. We also saw some emergency equipment for theatres had 'I am clean' stickers that were not recent and this included the difficult airway trolley with a date of June 2023, and a laparoscopy trolley dated November 2022. The emergency ears nose and throat trolley also had a sign on it stating it must be cleaned weekly but this was last dated as being done on 18th July 2023, which was 2 weeks prior to our inspection.

Following our inspection, we requested Infection prevention and control (IPC) audit data for surgical wards and theatres at Worthing Hospital. We identified a lack of consistency in the completion of these audits between surgical areas. The trust told us staff recorded all IPC audits on a system that meant monthly reports could be generated to monitor compliance. The overview report generated for February to July 2023 showed theatres at Worthing recording a compliance of 0%. The trust also supplied other data which showed erratic recording of weekly audit compliance for surgical wards including Chiltington, Clapham and Coombes such as weeks missing data completely.

For example, Chiltington ward had only 3 out of 17 boxes showing a compliance score, and Coombes ward showed only 5 weeks of data in a period of 17 weeks. Despite this, Coombes ward was recorded as having 100% compliance, this seemed to be based on only completed audits and not those that had not been recorded therefore the figure was incorrect. The trust also stated compliance was 99.7% for Chanctonbury ward despite there being only 13 out of 17 audits completed which would produce a compliance of 67%. When we spoke to senior leaders they told us these audits were completed so it was not clear how they were recorded or monitored.

We also requested hand hygiene audit scores for the period between February 2023 to August 2023. The trust provided some hand hygiene audits; however these were incomplete or erratic in detail. Chiltington ward was recorded as not completed for 5 out of 7 months, only scores of 100% from July and August 2023 were given. The data stated an incorrect compliance of 40% for Clapham Ward, when calculated by us based on 6 out of 7 audits being completed the accurate figure was 14%. Despite audits being incomplete, areas were recorded as having 100% compliance, this seemed to be based solely on completed audits and not those that had not been recorded so it was unclear how this score was generated. There were no compliance scores supplied for Downlands Suite. It was unclear how IPC monitoring for any of these areas was monitored for compliance and improvement at ward or a higher governance level.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). PPE was available in all areas and most staff used PPE such as disposable gloves and aprons correctly. However, we saw nursing staff carrying soiled bed linen through a ward without using PPE. We noted a doctor visiting a patient on the ward wearing scrubs and they were not bare below the elbow. These occurrences did not follow trust policy regarding effective IPC guidelines.

However, whilst hand sanitiser dispensers were available they did not always contain sanitiser. This meant staff and visitors could not always sanitise their hands when required.

Within theatres we saw how staff wore designated scrubs to ensure sterility of this area was maintained, there were also visual reminders to not enter non-surgical areas in these. However, we saw that surgical scrubs were not always readily available for staff. We spoke to staff who told us they frequently arrived for work in theatres and were unable to change. This led to delays on starting surgical procedures. They told us this was frustrating as the sterility of theatres meant these items were essential and necessary. We spoke with leaders who told us these shortages were regularly escalated but not resolved. We heard how a staff member had completed a quality assurance project to determine improvement areas but this had not resolved the issue.

Staff worked to prevent, identify, and treat surgical site infections (SSIs). Staff used records to identify how well the service prevented infections. The theatre ventilation systems were recorded on the service risk register as being old and requiring replacement. The service had investigated if the ventilation system was a contributory factor in the increased number of SSIs, however this proved inconclusive.

Environment and equipment

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

In main theatres and the treatment centre we saw large amounts of equipment such as Xray equipment, and specialist surgical equipment stored in corridors as there was no secure areas for these to be stored in.

In ward areas there was a general lack of storage. Equipment, including some large items, were stored in ward corridors and day rooms. This meant equipment and corridors were difficult to access for cleaning. It also made it challenging to move patients and equipment around the wards.

On Chiltington Ward there was an unlocked cabinet in the ward day room that contained various completed ward admission and controlled drug books. These contained patient identifiable information and therefore breached confidentiality. In the same room, there was a shopping trolley and boxes containing Christmas decorations stored in a corner. This day room was used as an escalation area for patients who required a bed.

Surgery

On Chiltington Ward the corridor leading to the Enhanced Surgical Care Unit (ESCU) contained various large items of equipment, including the ward resuscitation trolley, two patient hoists, commodes, and linen trolleys. This meant it would be challenging to move a patient out of ESCU in an emergency given the lack of space. We were not assured the risk had been identified or mitigated in any way.

On Clapham ward the external window in one of the patient rooms/cubicles had been permanently screwed closed as the frame was damaged. The patient in the room told us this meant the room could become very warm and could not be ventilated. In the same room, a previous patient had damaged an internal observation window. The damaged cavity had been boarded up with untreated/covered wood which, while effectively covered up the damage, meant it could not be cleaned. There were also exposed screwheads protruding from the wall within the room which could cause injury.

Senior leaders told us environmental spot checks were undertaken to monitor compliance with guidance such as cleaning of equipment and access to hazardous chemicals. However, in main theatres we saw hazardous chemicals were not stored in line with guidance as these were kept in an unlocked and open cupboard. The area was also unlocked with the door propped open by boxes.

The service had enough suitable equipment to help them to safely care for patients. However, staff did not always carry out daily safety checks of specialist equipment. In theatres we saw daily checking for emergency equipment had not been completed in line with policy. For example, in the emergency theatre we saw the emergency equipment trolley had not been completed on 5 occasions in June and 6 occasions in July 2023. The gaps in these checks occurred most often on weekdays when normal theatre activity would be occurring. The Paediatric emergency airway trolley had no paper records to demonstrate checking beyond 2019. Staff advised us this was to save paper and these were now recorded on a wipe clean sheet, this however had not been signed since May 2022. The removal of paper checklists also meant any monitoring and oversight of compliance with checking this equipment would not exist beyond the last day it was checked.

In addition to this, the trolley containing emergency equipment for paediatrics had only been completed 4 times in July and 5 times in June 2023. There were also incomplete checks on the paediatric emergency equipment. This was not in line with policy that stated this should be checked daily. We were not provided with detail of any internal monitoring processes to oversee compliance of emergency equipment checks. This meant that resuscitation equipment may not be available and fit for purpose and was not checked in line with professional guidance.

There was expired clinical equipment on the difficult airway intubation trolley, for example an intubation catheter that had expired in July 2021, writing next to this stated no new stock was available but this was not dated so it was not clear when this was documented. There was also a flexible endoscope with an expiry date of April 2023. We asked staff if they knew about replacement of the expired items, but they did not know if it had been checked to see if a replacement for these items was now available or whether a risk assessment had been completed to use the expired items.

Anaesthetic machine safety checking log books had not been completed on multiple occasions where there has been activity within theatres. In theatre 6 there were 8 occurrences where no safety checks had been recorded but activity had occurred. This was not in line with Association of Anaesthetists of Great Britain and Ireland (2019) recommendations. The trust told us anaesthetic machines were checked daily and this was recorded electronically on the equipment. However, all clinical staff we spoke with told us this should always be recorded in the log book as this was best practice. This was also not in line with MHRA guidelines which state accurate and complete copies of records in paper or electronic form are required to be made available for future inspection, review and copying e.g. for CQC, internal audits, traceability, and investigations. This meant that anaesthetic equipment may not be available and fit for purpose and was not checked in line with professional guidance.

Staff disposed of clinical waste safely. There were appropriate facilities for storage and disposal of household and clinical waste, including sharps. A sharps bin is a container that can be filled with used medical needles and all categories of sharps waste, before being disposed of safely. All sharps bins we observed were appropriately labelled and stored correctly and not overfilled.

We noted some equipment had out of date servicing stickers, this included a cell saver machine and a monitor on the emergency trolley in the emergency theatre, both with next service dates of June 2023. We were told by managers servicing was monitored by an internal spreadsheet, we requested this from the trust following inspection but it was not provided.

The design of most environments followed national guidance.

Patients in ward beds could reach call bells and patients we spoke with told us staff were responsive when they called for support. However, the service did not always have suitable facilities to meet the needs of patients and their families. For example, day rooms on wards were being used as escalation areas for additional beds spaces. On Chiltington Ward a day room was used as an additional bed space. This room had no call-bell, piped oxygen, or suction. Patients were given a hand-bell to ring to summon assistance. This room was originally a staff lounge and could be accessed from the main corridor. This meant staff often walked in not knowing a patient was bedded in there and this was upsetting for both staff and patients.

The trust also used the surgical day case/admission ward to accommodate overnight stays because of bed shortages. There was a specific criteria for the type of patient who could be bedded overnight, based on clinical risk. However, the ward was not designed for overnight stays and had limited facilities for patients. For example, there was no piped oxygen or suction available and, at the time of the inspection, no working catering facilities. To mitigate this the ward used portable oxygen cylinders and portable suction equipment.

Ward staff created additional bed spaces within existing bays. However, these additional spaces had limited room, were often situated in the corner of the bay and had no dedicated oxygen, suction or call bell facilities.

Examination rooms in the day case/pre admission ward were small and had limited space. Each room had an examination couch, however it would be challenging to manoeuvre should a patient become unwell and require a team of staff to support them. We discussed this with staff at the time and they confirmed they had not had an emergency that had required multiple staff to attend. However, they had not considered carrying out a simulation exercise to understand any issues.

We also noted the examination rooms did not have any privacy curtains. Should a patient need to undress to be examined, there was no privacy within the rooms. The department and rooms were small, so should a door be opened whilst a patient was being examined they would potentially be able to be seen by staff and other patients.

Assessing and responding to patient risk

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

All patients attended a nurse-led face-to-face surgical pre-assessment clinic appropriate to the surgery or procedure they were having. Where required, patients would also attend a dedicated anaesthetic clinic to determine their suitability for surgery.

Surgery

Staff completed an initial assessment for each patient upon admission and prior to their surgery, using a series of systematic question and answer stages to determine the frequency of subsequent assessments. The individual assessments then flagged as a colour, with red indicating patients who were at particular high risk such as falls. Staff told us they completed these assessments for each patient and included pressure ulcer risk assessments and venous thromboembolism assessments where appropriate. Senior ward staff told us they had oversight of these assessments and demonstrated the ward overview screens on the electronic recording systems.

Risk within theatres should be recorded as part of the World Health Organisation (WHO) surgical safety checklist. It is mandatory and compliance should be monitored in all services where surgery is performed. Staff told us these checklists were regularly audited. We reviewed the completion of surgical safety checklists in all of the theatres we visited. These showed between May and July 2023 the average compliance with WHO checklists was 97%.

However, staff told us due to a new IT system in theatres this meant they were unable to complete the checklists for surgical 'briefs' and 'debrief' effectively. The brief/debrief is not mandatory. Briefing facilitates delivery of clear messages and ensures all staff are aware of their roles and the surgical list. Debriefing is carried out at the end of the surgical list. All the members of the surgical team discuss the work of the day stating the positive and potential negative issues. These parts of the checklists are sometimes overlooked during a list due to time constraints, interruptions, and other distractions. However, when training is limited due to staffing it ensures learning and training is structured and positive. When we reviewed compliance for these it showed average compliance for surgical briefs between May – July 2023 was 60%. For the same period compliance for debriefs was 30%, this was significantly below the trust target. This meant that the hospital was not ensuring compliance with the 5 steps to safer surgery guidelines set out by the National Institute of Health. This is also advocated as good practice by the National Patient Safety Agency (NPSA) for all patients in England and Wales undergoing surgical procedures.

The service had identified an increased risk of falls of patients resulting in harm. To mitigate the risk, the service located a member of staff in each bay to provide enhanced monitoring and observation. Wards had placed temporary desks and chairs in each bay to allow staff to complete documentation whilst maintaining oversight of patients. However, each desk we saw had been placed in front of fire exit doors therefore restricting access to fire safety routes. We were not assured this mitigation had been appropriately risk assessed and this was highlighted to nurse leaders for review during the inspection.

Staffing

The service did not have enough nursing, allied health professionals and support staff to keep patients safe from avoidable harm and to provide the right care and treatment. On all wards we visited, we saw actual nurse staffing was consistently below planned establishment.

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

Following the inspection, we requested 'Safer Staffing' data. The trust provided information that stated on night shifts the nurse to patient ratio across a 24 hour period was usually less or equal to 1 Registered Nurse (RN) to 8 patients. However, there were instances where this was not met and data showed Clapham ward had a ratio of 1 RN to 10 patients overnight. The data showed Chiltington and Coombes wards, and the Enhanced Surgical care unit had enough staff, however due to the limited information we did not have assurance of staffing on other surgical wards or time periods.

Surgery

The trust wide vacancy rate for band 5 nursing staff had increased from 8% in January 2022 to 19% in May 2023. The vacancy rate for band 2 staff was 11% in May 2023. The trust was aware of these issues and a workforce steering group had been implemented to reduce these to 8%. Leaders and ward staff told us recruitment was ongoing and there had been several allied health professional and nursing appointments, which they had found encouraging. None of the wards we visited had a full complement of staff at the time of inspection.

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

Medical staffing

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

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

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

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

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

Records

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

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

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

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

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

We observed confidential waste bins were not secure. Although these were kept in staff areas this meant records could be easily removed by anyone working in the area and the safe disposal of these by the intended recipient was not assured. Staff told us these bins often fell apart as they were cardboard and we saw bins which had been taped together in several areas.

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

Medicines

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

Staff followed some systems and processes when safely prescribing, administering, recording, and storing medicines. The trust had an electronic prescribing and administration (EPMA) system for medicines which had inbuilt safeguards and reports were run routinely to ensure safe prescribing. There had been some issues which had been identified by staff and were addressed via the previous upgrade and were being implemented via the current round of clinician training.

In theatres, staff stored and managed all medicines safely. However, we saw every theatre log book used to record administration of controlled drugs (CDs) were not completed in line trust policy and best practice guidance. For example, it was recorded the medicines that had been drawn up by staff, but not the amount given to patients. This meant there was no assurance as to amounts that were disposed of or who did this.

We also saw when CDs were received from pharmacy this did not follow policy which stated entries should be witnessed and signed by a registered practitioner, we saw 3 instances where the signature of the witness or responsible person was not completed. We also saw controlled drug stock checks were not completed twice daily in line with guidance.

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

In main theatres we saw instances where medicines had been left out on a worktop which were left unattended by staff. The medicines were for patients on an upcoming theatre list during the day of the inspection. This was not in line with best practice or trust policy. This posed a safety risk as no one was supervising or accountable for the medicines to ensure they were not accessed by people who were unauthorised to access them.

Staff in theatres stored and managed medicines in line with the provider's policy. Medicine fridges and store room temperatures were monitored in line with trust policy. There was a clear escalation process if the temperatures were outside of tolerable range. All fridge temperature records we reviewed were completed in line with policy.

Fluids stored inside intravenous (IV) fluid warming cabinets were correctly labelled with the date when they needed to be removed from the cabinet. This was in line with guidance which states IV fluid should be marked with permanent marker to identify the date they were put in the warming cabinet, and the date they need to be removed. This step also ensures IV fluids should not be subsequently returned to the warming cabinet once removed. However, the records used for monitoring the temperatures of these were not always completed, and we saw this had not been recorded on 7 instances in July and 5 in June 2023.

Staff on the wards generally stored and managed medicines in line with the provider's policy. However, on one ward in a treatment room we found medicines had been prepared by staff, ready to be administered to patients, but they had been left unattended. This was not in line with trust policy regarding the safe management of medications. We immediately highlighted this to nurse leaders who rectified the situation and destroyed the medication that had been left unattended. The nurse leaders attributed this lapse in process to staff shortages on the ward on that day.

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

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

Incidents

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

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

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

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

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

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

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

Surgery

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The trust was in the process of standardising policies, guidance, and documents across the trust. However, the standardisation process was delayed due to the COVID-19 pandemic, meaning some guidance was past their review date. We saw folders in theatres that contained policies that were out of date and this included the trust business continuity plan dated 2020.

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

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

At handover meetings, staff routinely referred to 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. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. However, after surgery patients sometimes went for extended periods of time without being able to have hot food.

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

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

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

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

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

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

The trust utilised the surgical day case/admissions area as additional overnight beds, however there were no operational catering facilities available at the time of our inspection. Patients would be provided with sandwiches if they needed to eat.

Pain relief

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

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

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

On wards, staff prescribed, administered, and recorded pain relief accurately. Patients told us although staff were busy, they generally responded to requests for pain relief in a timely manner.

Patient outcomes

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

Due to the pandemic there had been delays to the publication of some national audits. Data in the latest publications were at least 2 years old or data was not available at trust level. Examples of this included The National Bowel Cancer Audit last reported in 2020 with incomplete data showing for the trust.

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

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

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

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

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

Competent staff

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

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

Managers gave all new staff a full induction tailored to their role before they started work. We saw induction booklets were tailored to the staff specific role to ensure training was appropriate. In theatres staff said they were supernumerary while they worked through their inductions and were well supported by all staff. We saw student nurses working on wards. While they described good working environments, some told us they received limited training and initial support.

Clinical educators supported the learning and development needs of staff. However, staff told us there were not enough clinical educators. Senior ward staff told us newly qualified nurses were provided with ongoing support through their preceptorship period. Staff we spoke with told us the support received was invaluable.

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

Managers did not always support staff to develop through yearly, constructive appraisals of their work. Nurse leaders said they often struggled to find time for their managerial responsibilities, which included scheduling time for staff appraisals.

The provider submitted divisional staff appraisal data. We saw the overall appraisal compliance figures for surgery division were 82%, which was lower than the trust target of 90%.

Medical staff appraisal rates were submitted separately and showed only 67% of these staff had completed an appraisal with 19% of staff not having an appraisal booked at all. This data also showed 28 staff required a medical appraisal and there were no staff allocated to complete this.

The trust had also not fully implemented training for staff on how to interact appropriately with people with a learning disability and autistic people, at a level appropriate to their role. This is statutory training required by the Health and Social Act 2022 and must be completed by all staff. At the time of inspection there was only e-learning for both clinical and non-clinical staff, this training had been implemented in June 2023. Only 18 staff across the trust had completed this training and no staff we spoke with had heard about the training. There was no face to face learning. This meant staff may not have the skills, knowledge and experience to identify and manage issues arising from this vulnerable group of patients.

Staff working in pre-assessment clinics undertook specific training and completed pre-assessment competencies. Staff described good support from their nurse and theatres leadership team. Staff told us if they wanted to develop their skills local leaders were always supportive of this.

Multidisciplinary working

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

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

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

In theatres the morning huddle covered key areas such as bed numbers, surgical lists, stock shortages and staffing. These meetings were held daily and run by the daily coordinator. However, theatre huddle notes were not recorded so staff who had not been able to attend could not review previous meetings and may not be up to date with relevant issues.

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

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

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

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

Seven-day services

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

Surgery

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

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

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

Health promotion

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

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

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

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

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

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

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

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

Surgery

Is the service caring?

Good ↓

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

Compassionate care

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

Feedback from the trust wide Friends and Family Test (FFT) for January to July 2023 was positive. Response rates for FFT were above national average of 15%, for example Clapham ward was 29% and Enhanced Surgical Care unit was 37%.

Staff told us they understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. We saw and heard nurses asking patients about their preferences.

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

Most staff were discreet and responsive when caring for patients. We saw staff take time to interact with patients and those close to them in a respectful and considerate way. We saw staff caring for patients in a warm and compassionate way, ensuring they were attended to and cared for. We saw them introducing themselves to patients and explaining the care they were going to be giving. We saw staff drawing privacy curtains and softly inquiring if they had finished with bedpans or urinal bottles.

Most staff we interacted with had a good sense of the patients on their ward and their individual needs. However, we did see 2 instances of staff having conversations about patients and using inappropriate language when not within earshot of the patient.

We noted the lack of curtains in the examination rooms in pre-admission. There was a risk if a patient was in a state of undress and the door was opened, they could be seen by other staff or patients in the department.

Staff also told us in theatre recovery it was difficult to maintain dignity and privacy if patients wanted to mobilise in this area. Theatre recovery areas are usually only for patients staying a short length of time and in bed. In Worthing, patients often stayed for several hours, staff told us it was difficult to maintain other patients' privacy and dignity and was a concern for staff.

Emotional support

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

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

Surgery

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. We saw examples where, for patients who had additional needs, staff had detailed discussions with the patient's family about treatment options to support decision making. These discussions were recorded in the patients' medical records.

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

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We observed staff on wards communicating with patients in a clear verbal style ensuring they understood all the information regarding their care. In theatres we observed all staff took time to reassure patients before they entered for their surgery and had time to ask questions they may have.

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

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

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

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

Is the service responsive?

Inadequate 

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

Service delivery to meet the needs of local people

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

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

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

Surgery

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. We asked several staff if their wards had any mixed sex breaches in the last 6 months and none told us they had. On the Enhanced Surgical Care Unit (ESCU), located on Chiltington ward, staff told us there were often both male and female patients who were deemed as 'ward fit'. This meant they should be reported as mixed sex breaches, however staff confirmed they did not report any such occurrences.

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

Managers monitored and took action to minimise missed surgical appointments. We heard how all efforts were made to fill surgical spaces where surgeries were cancelled, this included doing shorter surgeries to ensure time was not lost. The trust monitored hospital and patient prompted cancellation rates at board level.

Managers ensured patients who did not attend appointments were contacted. We reviewed the beds management process and saw patients who were safe to be transferred were moved regularly to accommodate elective surgical patients.

Facilities and premises were not always appropriate for the services being delivered. There was a lack of surgical beds within the hospital. Patients were sometimes recovered from anaesthesia in the operating theatre because the recovery bays were full of patients waiting to be discharged home or to a ward. We saw this happened 6 times between May and June 2023. In addition recovery areas were frequently used to accommodate lengthy delays because of the bed shortages. Staff told us they were often unable to move patients from recovery to wards due to bed availability. This meant patients were kept in this area for longer periods of time than they should. The recovery area did not have any toilet facilities for patients and was also unable to supply hot food. This meant patients would need to use bedpans for toileting facilities. The department had sourced a small fridge so a limited food selection could be provided. Patients who had been nil by mouth were unable to eat anything warm and sometimes had only sandwiches as nutrition for a long period of time.

The demands on beds and staffing levels meant some patient operations were delayed or cancelled on the same day. Surgery was sometimes delayed because there were often no beds for them to be admitted to. The pressures on beds in the hospital meant there were times when non-surgical patients were admitted to surgical beds and specialist surgical patients were admitted to general surgical beds.

Meeting people's individual needs

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

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

Staff made sure patients living with mental health needs, learning disabilities and dementia received the necessary care to meet all their needs. Staff could access emergency mental health support 24 hours a day 7 days a week for patients living with mental health problems.

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

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

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

Access and flow

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

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

In theatres, we heard how operating lists had been cancelled due to staffing levels. This was frustrating for all involved and local leaders and staff told us this was always a last resort.

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

Staff told us there were instances where patients had remained in theatres and had to be recovered there. The trust told us that between May and July 2023 there were six occasions where patients were recovered in a theatre and this was recorded in the Recovery Patient Register. For these patients only 3 had a clear rationale documented. For those that did have a rationale this included simple procedures not requiring recovery or infection control risk.

Staff submitted weekly incident reports when patients had been unable to leave the recovery area or were kept there overnight. We saw they had reported this 34 times in 4 months. On the day of inspection we heard patients were kept in recovery until midnight due to bed space. Staff told us they did not like keeping patients in recovery for long periods of time as it meant the system was gridlocked. Recovery staff finished work at 6pm and after this time the on call surgical team were required to care for patients in recovery. We were not provided with assurance the trust was acting in response to these concerns or there was sufficient planning in place in response to demand. These concerns were also raised in a previous inspection of the hospital.

Surgery

The winter planning document for the trust did not feature any detail that considered the current demand on services within theatres and recovery. Clinical staff and those in management roles in theatres told us they were rarely consulted with regards to winter planning.

Managers monitored patient transfers and followed national standards. We observed patients transferred to other wards and escalation areas where it was deemed safe and appropriate to do so, to free up capacity for elective surgical patients or urgent admissions. The trust did not provide data specific to Worthing Hospital theatre utilisation.

There was a process for monitoring patients awaiting surgical procedures and staff reviewed waiting lists regularly, monitored waiting times and reported these to the trust board. Each division had a waiting list and each patient on that waiting list was discussed weekly to identify what was needed to admit the patient for their planned procedure. The service reported waiting times and plans to reduce them to the trust board.

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

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

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

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

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

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

We were told bed capacity, a decrease in theatre utilisation and workforce challenges greatly impacted on the services ability to meet demands.

We heard from leaders that lower risk patients could be offered surgery at another site within the trust that was able to treat these patients. However, due to consultant resistance around historic concerns of escalation of unwell patients this had not been done. There were no strategic plans in place or work being done to alleviate these staff concerns which meant patients waited longer to be treated.

Staff told us they were unable to treat private patients as an ongoing dispute with regard to staff pay at this site meant they were not being renumerated in line with colleagues doing the same role at other trust sites.

Learning from complaints and concerns

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

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

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

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

Managers investigated complaints and identified themes and shared feedback from complaints with staff and learning was used to improve the service.

Is the service well-led?

Requires Improvement 

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

Leadership

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

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

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

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

Surgery

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

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

Most staff told us senior leaders were not visible, and engagement was limited. They told us they did not understand the leadership model or 'who was in charge'. They did not feel supported or listened to when raising concerns with executive members of staff. In theatres staff told us they didn't see some executive leaders at all.

Vision and Strategy

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

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

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

During inspection senior leaders mentioned this strategy. Although no onsite staff we spoke to could describe the vision for the service, all staff described the motivation for their work as being 'giving the best care for the patient'. However, there was no specific vision or values for the surgical division regarding how they were achieving this or to ensure they linked in to the trust wide vision and strategy.

Culture

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

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

Surgery

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

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

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

Governance

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

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

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

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

Some services were yet to be joined up in their approach, for example infection prevention control was still monitored differently at the east and west sites and leads were keen to pull out best practice and align how this is delivered trust wide.

Management of risk, issues, and performance

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

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

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

Surgery

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

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

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

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

Despite the current pressures on waiting lists and theatre backlogs, the issues with patients in recovery for long period of time had not been addressed and no investment made to increase capacity to ensure patients were cared for in more appropriate areas. There were no plans to utilise existing alternative surgical sites that had capacity. In addition to this staff told us they were willing to work weekends or out of hours to clear waiting lists but these offers had not been responded to.

Staff had raised concerns for several years about renumeration when working on call and treating private patients. This was because staff at other trust sites were receiving more favourable pay rates for the same roles. Despite this being referred to as ‘an easy problem to solve’ by several leaders, no action had been taken and staff were frustrated by this.

Information Management

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

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

Some of the trust’s systems and processes for recording and monitoring clinical information were recently changed so they were consistent across the trust. This had led to some issues from staff who found they were having to use multiple systems to look up records.

Engagement

The service engaged with patients to gain feedback to plan and manage services. However, some leaders told us they could not always find the data they needed to understand performance, make decisions and improvements.

Surgery

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

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

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

Learning, continuous improvement and innovation

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

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

Staff understood quality improvement methods and the skills to use them to make changes. We were given examples of staff using quality improvement methods to make changes.

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

Areas for improvement

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

Action the trust MUST take to improve:

- The trust must ensure that medicines are used once opened in line with manufacturers guidance. Regulation 12.
- The trust must ensure that staff complete mandatory training in line with their role and that oversight of targets is effectively monitored. Regulation 12.
- The trust must ensure appropriate training, in line with guidance, is in place and completed by staff to support patients with learning disabilities, dementia and autism. Regulation 12.
- The trust must ensure there are enough nursing staff to keep patients safe. Regulation 12.
- The trust must ensure that all staff receive timely appraisals in line with provider policy. Regulation 12.
- The trust must ensure that controlled drug records and the oversight of these are in line with national guidance. Regulation 12.

Surgery

- The trust must ensure the monitoring of anaesthetic machine checks is recorded and aligns with best practice guidance. Regulation 12.
- The trust must ensure that the systems used to monitor WHO checklist compliance, including brief and debrief, are effective in demonstrating compliance and able to show areas for improvement effectively in line with NPSA guidance. Regulation 12.
- The trust must review its existing IPC audit monitoring systems to identify any shortfalls in infection prevention and control so action can be taken to make improvements when needed. Regulation 12.
- The trust must ensure equipment in ward and theatre environments is moved or stored in a suitable location and avoids emergency exits being blocked. Regulation 12.
- The trust must ensure action is taken to improve their compliance with national waiting list targets and that performance data for the trust can be separated to show site performance. Regulation 17.
- The trust must ensure that workforce data for the trust can be separated to show individual site performance. Regulation 17.
- The trust must ensure that patient record documents and systems are reviewed to ensure staff have access to patient information that is accessible, accurate and up to date across all electronic or paper-based records. Regulation 17.
- The trust must ensure organisational wide learning is shared within the trust to reduce the risk of repeated incidents. Regulation 17.
- The trust must ensure that guidance documents have been reviewed and are up to date. Regulation 17.

Our inspection team

The team that inspected the hospital included 4 CQC inspectors, 2 CQC operational managers, a CQC clinical fellow, 5 specialist advisors who between them had expertise in medical and surgical services and 1 expert by experience. The inspection was overseen by a CQC Deputy Director.

During the inspection we visited medical and surgical wards, the discharge lounge, 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 services. We reviewed patient records, drug charts and care plans. We also reviewed information received before the inspection from patients and staff. We reviewed several documents before, during and after the inspection. These included meeting minutes, policies, guidance, staff rotas, training figures, feedback from staff and patients, complaints and investigations.

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