

Brighton and Sussex University Hospitals NHS Trust

Royal Sussex County Hospital

Quality Report

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

Ratings

Overall rating for this hospital

Urgent and emergency services

Inadequate



Summary of findings

Letter from the Chief Inspector of Hospitals

Royal Sussex County Hospital (RSCH) is an acute hospital for the Brighton and Sussex University Hospitals NHS Trust (BSUH), providing acute services to the population of people across the Brighton, Hove, Mid Sussex and parts of East Sussex. The hospital provides maternity services, a special care baby unit, outpatient services and medical care. The hospital is the centre for emergency tertiary care with specialised and tertiary services including neurosciences, vascular surgery, neonatal, paediatric services based at The Royal Alexandra Children's Hospital, the Sussex Eye Hospital, cardiac, cancer, renal, infectious diseases and HIV medicine. The trust is also the major trauma centre for Sussex and the South East.

We carried out this focused unannounced inspection following information received and as a result of our regular visits to the hospital during which we had concerns about the safety and experience of patients requiring unscheduled care using emergency pathways.

We focused our inspection on the Urgent and Emergency Services and Acute Medical Admissions Unit provided at The Royal Sussex County Hospital only. We did not inspect other core services during this inspection.

At the time of our inspection the concerns about the trust emergency department were being managed and supported by a multi-stakeholder risk summit process that included NHS England, Trust Development Authority, local commissioning groups and Healthwatch.

Our key findings were as follows:

- Compassionate and good clinical care was provided to patients by staff.
- Physical capacity and staffing numbers and skill mix did not support the timely assessment of patients arriving at the department.
- Patients were not cared for in the most appropriate environment due to overcrowding in the emergency department and poor patient flow into the main hospital.
- Lack of management capacity and effective board challenge and support had resulted in a lack of progress in addressing issues over the last 18 months

Due to the multi-agency risk summit structure that was in place to support and manage improvements in the emergency pathway we have not initiated any regulatory action as a result of this inspection. The trust will however regularly report, in a single and standard approach, the improvements in quality to all stakeholders through the risk summit process.

Importantly, the trust must:

- Reduce the numbers of patients cared for in the cohort area within the emergency department (and the regularity with which congestion occurs in this area) and ensure timely assessment of patients arriving in the department.
- Ensure that appropriate staffing levels and skill mix is in place to meet the needs of the patients within the department and support the process of improvement.
- Enhance board level effectiveness to ensure progress with the emergency department improvement plans.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Rating

Inadequate



Why have we given this rating?

Throughout our inspection, we observed staff treating patients with compassion, dignity and respect. Despite intense operational pressure staff had a caring and compassionate attitude towards patients. Our inspection identified the delivery of good clinical care at the point of delivery.

However, during our inspection the Emergency Department (ED) did not at times have the capacity to ensure the safe accommodation of the number of patients present in the department. Performance data and our interviews with staff indicated that this was a frequent occurrence.

Patient safety was compromised because the initial assessment of patients was not done in a timely way. There was not always a sufficient number and skill mix of nurses on duty in the ED over each 24-hour period to care for patients safely given the acuity of patients and the layout of the department.

The department had allocated cleaning staff, however due to high patient turnover, we observed that cubicles were not consistently cleaned and checked between patients.

The levels of documented safeguarding training among senior medical ED staff required improvement to protect patients from abuse. 100% of junior medical staff had received training.

The ED did not have specific mortality and morbidity (M&M) meeting to discuss deaths in the department, but weekly consultant meetings had a clinical governance (CG) element. We asked the trust to provide minutes of governance meetings in the last three months. This was a reference to a review of one death in the ED in the minutes for January 2015.

The trust maintained a system of scorecards for monitoring targets; for example, national performance targets, patient experience and clinical quality. These were accessible for staff reference.

Overcrowding in the cohort area of the ED meant the privacy and dignity needs of patients were not consistently met, despite the best efforts of the staff. Patient flow from the ED into hospital beds was poor with a high number of patients awaiting admission to wards. This meant a delay in patients being cared for in

Summary of findings

the most appropriate environment for their particular health need. Although issues for external partners have contributed to patient flow problems (a high number of medically fit patients awaiting discharge) the trust could, by implementing recommendations from previous reports, alleviate the pressure.

The trust has not comprehensively addressed either the recommendations of a report by the Emergency Care Intensive Support Team (ECIST) or a compliance action issued by CQC following the inspection in May 2014.

Whilst there is now clear engagement within the sector there is concern that interim management and lack of executive capacity, notably in the Chief Operating Officer role, to manage change has contributed to the lack of progress to date. A Chief Operating Officer has been appointed since our inspection and is now in post and is taking forward the work with senior clinical and managerial colleagues.

There was evidence that the new management structure is committed to delivering necessary changes in the ED. However the board has not recognised the nature and regularity of risk afforded by the ED at RSCH and not effectively sought further assurance following presentations by clinical teams that detailed patient safety and experience risks notably with relation to the cohort area. This has not brought the improvement required and we believe that more could be done by the Board on this matter.

Royal Sussex County Hospital

Detailed findings

Services we looked at

Urgent and emergency services

Detailed findings

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Detailed findings from this inspection

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Background to Royal Sussex County Hospital

Royal Sussex County Hospital (RSCH) is an acute hospital for the Brighton and Sussex University Hospitals NHS Trust (BSUH), providing acute services to the population of people across the Brighton, Hove, Mid Sussex and parts of East Sussex. The hospital provides maternity services, a special care baby unit, outpatient services and medical care. The hospital is the centre for emergency

tertiary care with specialised and tertiary services including neurosciences, vascular surgery, neonatal, paediatric services based at The Royal Alexandra Children's Hospital, the Sussex Eye Hospital, cardiac, cancer, renal, infectious diseases and HIV medicine. The trust is also the major trauma centre for Sussex and the South East.

Our inspection team

Our inspection team included the Head of Hospital Inspection, two inspection managers, one inspector, three specialist advisors and an expert by experience.

How we carried out this inspection

We carried out this focused unannounced inspection because we had concerns about the safety and experience of patients requiring unscheduled care using emergency pathways.

We focused our inspection on the Urgent and Emergency Services and Acute Medical Admissions Unit provided at The Royal Sussex County Hospital only. We did not inspect other core services during this inspection.

During this focused inspection we assessed the service provided for adults, focussing on the safe and well led domains, following intelligence gathered during our engagement process with the trust and information from

other health economy stakeholders. We have also commented on but not rated caring, effective and responsive domains. We did not inspect the emergency provision for children.

We observed care and treatment and looked at 60 sets of patient records. We spoke with 26 members of staff, including nurses, consultants, doctors, receptionists, managers, support staff and ambulance crews. We also spoke with 30 patients and relatives who were using the service at the time of our inspection. We also used information provided by the organisation and information we requested.

Detailed findings

The inspection took place over two days between 22 and 23 June 2015.

Facts and data about Royal Sussex County Hospital

The main adult Emergency Department at the Royal Sussex County Hospital is the dedicated regional major trauma centre for the South East Coast, serving a population of approximately 1.75 million people, covering an extensive area, spanning from Chichester in






the West, to Hastings in the East, as well as serving parts of Kent. Across the trust there are approximately 150,000 patients emergency department admissions per year of which around 85,000 patients attend at RSCH.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Not rated	Not rated	Not rated	Inadequate	Inadequate
Overall	Inadequate	N/A	N/A	N/A	N/A	N/A

Urgent and emergency services

Safe	Inadequate	
Effective	Not sufficient evidence to rate	
Caring	Not sufficient evidence to rate	
Responsive	Not sufficient evidence to rate	
Well-led	Inadequate	
Overall	Inadequate	

Information about the service

The Brighton and Sussex University Hospitals NHS Trust provides accident and emergency services through the main Emergency Department (ED) and the Urgent Care Centre (UCC) at the Royal Sussex County Hospital and the Children's Accident and Emergency Department which is located within the Royal Alexandra Children's Hospital. The trust also provides accident and emergency services at Princess Royal Hospital, Haywards Heath and Sussex Eye Hospital.

Patients arriving at the ED by ambulance are taken into the department via the ambulance entrance where they are assessed and allocated to the appropriate area of the ED.

The adult emergency department has a five-bay resuscitation area (Zone 1), 12 spaces for treating major cases (Zone 2a), a two-bay patient assessment triage area, a "cohort" area and 10 lower acuity treatment bays (Zone 2b). In addition, there are two areas utilised as a Clinical Decisions Unit (a 6-bed unit named 'short stay ward' and a 6-bed unit named 'clinical decision unit'.

Patients who self-present in the ED are booked in by a receptionist and directed to the Urgent Care Centre (UCC)/'minors' area of the department where they are assessed by a nurse and allocated to an appropriate area in the department.

We observed care and treatment and looked at 60 sets of patient records. We spoke with 26 members of staff, including nurses, consultants, doctors, receptionists, managers, support staff and ambulance crews. We also

spoke with 30 patients and relatives who were using the service at the time of our inspection. We also used information provided by the organisation and information we requested.

We carried out this focused unannounced inspection because we had concerns about the safety and experience of patients requiring unscheduled care using emergency pathways.

We focused our inspection on the Urgent and Emergency Services for adults and Acute Medical Admissions Unit provided at The Royal Sussex County Hospital only. We did not inspect the emergency provision for children within the Royal Alexandra Children's Hospital.

Urgent and emergency services

Summary of findings

Throughout our inspection, we observed staff treating patients with compassion, dignity and respect. Despite intense operational pressure staff had a caring and compassionate attitude towards patients. Our inspection identified the delivery of good clinical care at the point of delivery.

However, during our inspection the Emergency Department (ED) did not at times have the capacity to ensure the safe accommodation of the number of patients present in the department. Performance data and our interviews with staff indicated that this was a frequent occurrence.

Patient safety was compromised because the initial assessment of patients was not done in a timely way.

There was not always a sufficient number and skill mix of nurses on duty in the ED over each 24-hour period to care for patients safely given the acuity of patients and the layout of the department.

The department had allocated cleaning staff, however due to high patient turnover, we observed that cubicles were not consistently cleaned and checked between patients.

The levels of documented safeguarding training among senior medical ED staff required improvement to protect patients from abuse. 100% of junior medical staff had received training.

The ED did not have specific mortality and morbidity (M&M) meeting to discuss deaths in the department, but weekly consultant meetings had a clinical governance (CG) element. We asked the trust to provide minutes of governance meetings in the last three months. This was a reference to a review of one death in the ED in the minutes for January 2015.

The trust maintained a system of scorecards for monitoring targets; for example, national performance targets, patient experience and clinical quality. These were accessible for staff reference.

Overcrowding in the cohort area of the ED meant the privacy and dignity needs of patients were not consistently met, despite the best efforts of the staff

Patient flow from the ED into hospital beds was poor with a high number of patients awaiting admission to wards. This meant a delay in patients being cared for in the most appropriate environment for their particular health need. Although issues for external partners have contributed to patient flow problems (a high number of medically fit patients awaiting discharge) the trust could, by implementing recommendations from previous reports, alleviate the pressure.

The trust has not comprehensively addressed either the recommendations of a report by the Emergency Care Intensive Support Team (ECIST) or a compliance action issued by CQC following the inspection in May 2014.

Whilst there is now clear engagement within the sector there is concern that interim management and lack of executive capacity, notably in the Chief Operating Officer role, to manage change has contributed to the lack of progress to date. A Chief Operating Officer has been appointed since our inspection and is now in post and is taking forward the work with senior clinical and managerial colleagues.

There was evidence that the new management structure is committed to delivering necessary changes in the ED. However the board has not recognised the nature and regularity of risk afforded by the ED at RSCH and not effectively sought further assurance following presentations by clinical teams that detailed patient safety and experience risks notably with relation to the cohort area. This has not brought the improvement required and we believe that more could be done by the Board on this matter.

Urgent and emergency services

Are urgent and emergency services safe?

Inadequate



During our inspection the Emergency Department (ED) did not have the capacity to safely accommodate the number of patients present in the department and performance data and our interviews with staff suggested that this was a frequent occurrence.

Patient safety was compromised because the initial assessment of patients was not done in a timely way.

There was not always a sufficient number and skill mix of nurses on duty in the ED over each 24-hour period to care for patients safely given the acuity of patients and the geographical layout of the department.

The department had allocated cleaning staff, however due to high patient turnover, we observed that cubicles were not consistently cleaned and checked between patients.

The levels of documented safeguarding training among senior medical ED staff required improvement to protect patients from abuse. 100% of junior medical staff had received training.

The ED did not have specific mortality and morbidity (M&M) meeting to discuss deaths in the department, but weekly consultant meetings had a clinical governance (CG) element. When we looked at minutes of governance meetings in the last three months; there was a reference to a review of one death in the ED in the minutes for January 2015.

Incidents

- The trust used an electronic reporting system called Datix. This allowed for management overview of incident reporting and an ability to analyse any emerging themes or trends.
- We spoke with medical, nursing and allied health professionals who told us they knew how to report incidents and 'near misses' using the Datix system. Staff said they were encouraged to report incidents, but reporting was sometimes not done because staff were too busy in clinical areas.
- Information provided by the trust showed 670 incidents were reported by staff in the ED (A&E, Urgent Care, CDU) in the last 12 months. Information provided included

action taken in response to the incidents. Incidents were graded by the severity of harm caused. Of 670 incidents reported, one was categorised as severe (delay / failure to monitor), 12 were categorised as moderate and 104 were classed as low. The majority of incidents (520) were categorised as 'No Harm: Impact not Prevented'.

- There were 15 Serious Incidents (SI). Thirteen of these related to 12 hour breaches in A&E.
- The trust held weekly patients' safety incident review (SIRM) meetings led by the trust's Chief of Safety and Quality. Incidents reported as 'moderate' or above were reviewed at this meeting. We looked at the minutes of the SI meetings held between 7 April and 23 June 2015.
- Staff told us learning from incidents was shared with them through emails and team meetings.
- There were no "Never Events" in the ED in the last 12 months. (Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented).
- We asked the trust to send us copies of mortality and morbidity (M&M) meetings held in the last three months for the ED. M&M meetings to review deaths as part of clinical professional learning provide assurance that patients are not dying as a consequence of unsafe clinical practices. We were provided with evidence of a mortality meeting reviewing eight deaths in January and February 2014 in the medicine division; however, none were specific to ED. The clinical lead for ED confirmed the ED does not have a specific M&M meeting to discuss deaths in the department, specifically; but told us weekly consultant meetings had a clinical governance (CG) element. We asked the trust to provide minutes of governance meetings in the last three months. There was a reference to a review of one death in the ED in the minutes of a clinical governance meeting in January 2015.
- Summaries of actions taken by the trust included sending 'Duty of Candour' letters to tell the relevant person that a notifiable safety incident has occurred and provide support to them in relation to the incident.
- On 15 April 2015 the trust notified us of a SI concerning 12 hour breaches from decision to admit (DTA). The trust told us they "experienced sustained and significant pressure across Saturday 28th to Tuesday 31st March. This resulted in major challenges regarding patient flow and a mismatch between discharges and admissions. As a consequence, there were delays in certain patient

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transfers which resulted in 8 breaches of the standard requiring a patient to be admitted to a ward within 12 hours of the decision for admission being made". We noted this SI was first discussed at SIRM on 28 April and has been discussed weekly since then. The investigation had not concluded at the time of our inspection.

- The ambulance service told us about a SI they had initiated. During the Easter weekend 2015 there were significant handover delays at RSCH which breached the national standard for handover within 15 minutes. In particular on Easter Sunday, 5th April 2015 there were 80 handovers which were in excess of 15 minutes. There was no reference to these events in the minutes of the SIRM meetings between 28 April and 23 June 2015.

Cleanliness, infection control and hygiene

- A labelling system was in use to indicate that an item had been cleaned and was ready for use.
- The treatment areas had adequate hand-washing facilities. We observed staff washing their hands between seeing each patient and using hand sanitising gel. The 'bare below the elbows' policy was observed by all staff.
- We observed that staff complied with the trust policies for infection prevention and control. This included wearing the correct personal protective equipment, such as gloves and aprons.
- Side rooms were available for patients presenting with a possible cross-infection risk.
- Despite positive evidence from Trust environmental audits, we observed the cubicles were not consistently cleaned and checked between patients. This was corroborated by staff who told us patient turnover was sometimes so fast, there was not time to clean and restock the bed space or cubicle.
- The congestion and close proximity of trolleys in the cohort area constituted an infection control risk because they could be touching each other which increased the risk of skin to skin contact between patients in the cohort area.
- The hand hygiene audit score for the A&E at RSCH was 84% in April 2015 and 79% in May 2015 compared to the Acute Directorate's average scores of 89% (April) and 90% (May).
- 74% of nursing staff in the ED had current infection control training.
- The ED did not have the capacity to safely accommodate the number of patients presenting to the department at all times.
- The ED was often overcrowded with insufficient cubicle spaces to accommodate patients. When cubicles were full, additional patients were lined up on trolleys, wheelchairs or chairs in the cohort area. The cohort area was identified as a risk during our comprehensive inspection of the trust in May 2014 and we issued a compliance action instructing the trust to ensure service users are protected against the risks associated with unsafe or unsuitable premises. The actions taken by the trust since our last inspection have not been sufficient to mitigate the risk.
- The trust's Ambulance Handover and Cohort Standard Operating Procedure stated, 'Four is the maximum number of patients that BSUH staff, without South East Coast Ambulance Service (SECAMB) Hospital Ambulance Liaison Officer (HALO) support, will be responsible for in the cohort/assessment area.' Staff told us there were often more than four patients in the cohort area. We observed during our inspection that patients continued to be at risk due to overcrowding in this area. For example, at 15.20hrs during our unannounced inspection on 22 June there were nine patients on trolleys in the cohort area. There was one trust trained nurse overseeing the area.
- There were 146 incident reports in the last 12 months relating to concerns about patient safety in the cohort area.
- Overcrowding in the cohort area increased the risk of lack of clinical oversight. Several nurses and doctors told us they were concerned about this risk.
- Nursing staff told us when is highly congested cohort area, at times, there was insufficient monitoring equipment for the number of patients in the area.
- The waiting area within the urgent care centre did not allow the triage nurse direct line of sight to patients who were waiting to be seen by a healthcare professional. Medical and nursing staff we spoke to raised this as a risk. We observed staff looking at patients on a frequent basis.
- Nursing and medical staff working in the UCC/minors area told us there were not always enough rooms in the area to carry out their work effectively, which meant patient waiting times, were increased. The trust has a plan to improve this as part of its overall improvement work.

Environment and equipment

Urgent and emergency services

Medicines

- Medicines management was largely safe and secure.
- Locks were installed on storerooms, cupboards and fridges containing medicines and intravenous fluids. Keys were held by nursing staff. In some areas of the department, such as the resuscitation area, cupboards and fridges were appropriately left open to facilitate access to medicines in emergencies. Risk assessments were undertaken for these.
- We found that controlled drugs (CD) were checked daily by staff working in the department. We audited the contents of the CD cupboard in the CDU area against the CD registers and found they were correct.

Records

- A paper record was generated by reception staff registering the patient's arrival in the department to record the patient's personal details, initial assessment and treatment. All healthcare professionals recorded care and treatment using the same document.
- An electronic patient system ('Symphony') ran alongside paper records and allowed staff to track patients' movement through the department and to highlight any delays.
- We found poor record keeping in the emergency department. Our audit of sixty patient records identified omissions in completion of the records in 41 sets of records, including one case where care was documented after the recorded time of death. In another case the time and type of overdose was not recorded on ambulance or triage sheet.
- On 31 October 2014 the coroner issued a Regulation 28: Report to prevent future deaths. This included concerns about incomplete documentation in A&E. In responding the trust accepted shortcomings in record keeping and have indicated that changes relating to use of early warning scores at handover have been made, consultants have been reminded of requirement for completion of records and the role of locum staff in assessment and a planned reduction in handovers over a 24 hour period. The difficulties agency staff face in both locating equipment and completing documentation were acknowledged. The trust has provided evidence of subsequent audit of documentation which indicates improvement and the planning of further audits

Safeguarding

- There were appropriate systems and processes in place for safeguarding patients from abuse. Staff spoken with was aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns.
- Overcrowding meant vulnerable patients could be at risk from harm from other patients in agitated or anxious states, particularly if under the influence of alcohol and or drugs. We observed two such incidents during our inspection. One agitated male patient was on a trolley adjacent to an elderly female. Another agitated male patient was observed walking in and out of other patients cubicles.
- Although junior doctors attained 100% compliance with on line training, the number of ED staff who were trained in safeguarding required improvement. Information from the trust showed:
 1. 58% of ED nursing staff had up to date training in safeguarding vulnerable adults.
 2. 15% of ED medical staff had up to date training in safeguarding vulnerable adults.
 3. 67% of ED nursing staff had up to date training in training in safeguarding children at level three.
 4. 15% of ED medical staff had up to date training in training in safeguarding children at level three.
- During our inspection we observed an incident of good practice in the management of potential domestic violence.

Mandatory training

- The nursing staff duty rota scheduled one day per month for staff to attend training. This enabled staff to keep up to date with statutory and mandatory training. The rate of mandatory training was variable. For example, 33% of ED nursing staff had up to date fire safety training and 67% nursing staff had up to date training in health and safety and manual handling.
- 76% of ED nursing staff had up to date training in basic life support (BLS), 14% held intermediate life support certificates (ILS) and 20% held advanced life support (ALS) certificates. Four of these staff were instructors. 48% of ED medical staff had up to date training in BLS.

Assessing and responding to patient risk

- Patient safety was compromised because the initial assessment of patients was not done in a timely way.

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- Patients presented at the department by walking into the reception area or arriving by ambulance into a separate entrance.
 - Patients arriving by ambulance as a priority (blue light) or trauma call were transferred immediately through to the resuscitation area, or to an allocated cubicle space. Such calls were phoned through in advance, so that an appropriate team could be alerted and prepared for their arrival.
 - Other patients arriving by ambulance were assessed by a nurse assigned to ambulance triage who took a 'handover' from the ambulance crew. Based on the information received, a decision was made regarding which part of the department the patient should be treated.
 - If a patient arrived on foot, they were registered by reception staff before being seen by a triage nurse.
 - Triage was undertaken in accordance with the Manchester Triage System. This is a tool used widely in A&E departments to detect those patients who require critical care or are ill on arriving at the A&E. Trained triage nurses followed a pathway or algorithm and assigned a colour coding to the patient following initial assessment. Red was the label assigned to those patients who needed to be seen immediately through to orange (very urgent), yellow (urgent), green (standard) and blue (non-urgent).
 - Between June 2014 and January 2015, the trust wide time to initial assessment for patients from the ambulance was between 40 and 125 minutes, which was consistently significantly worse than the England average (20 minutes) and standard of 15 minutes. (Health & Social Care Information Centre HSCIC).
 - RSCH specific data (provided by the trust) showed the average time to initial assessment for patients arriving by other transport or who self-present was 20 minutes between December 2014 and May 2015.
 - NHS England Daily Hospital Situation Report (Sitreps) between 3 November 2014 and 29 March 2015 showed 3541 ambulance handovers (trust wide) were delayed by over 30 minute. This is an average of 35 ambulances daily compared to an England average of 9 ambulances daily.
 - Data provided by the trust showed:
 1. 25.4% ambulances waited over 30 mins for handover between 1 April 2014-31 March 2015 (RSCH only – not trust wide).
 2. 27.1% ambulances waited over 30 mins for handover between 1 April 2015-25 June 2015 (RSCH only – not trust wide).
- This demonstrated an upward trend in ambulance waiting times.
- At 15.05 on 22 June, we observed seven ambulance crews waiting to hand over patients in the ED. Five crews had waited over 30 minutes, one crew had waited 1hr 3mins and another had waited 1hr 13mins. At 15.20hrs there were nine patients on trolleys in the cohort area.
 - The department utilised the national early warning scoring system (NEWS) to detect the deteriorating patient.
 - On 31 October 2014 the coroner issued a Regulation 28: Report to prevent future deaths. This included concerns about the initial assessment of a patient in ED.
 - During our inspection we observed that all majors' patients had NEWS charts in use. The nurse co-ordinator in the area checked that NEWS charts were completed.
 - Nursing and medical staff we spoke with expressed their concerns about maintaining clinical oversight of patients in the department, particularly the cohort area. This was corroborated by our observations during the inspection. For example, At 15.45 we looked at the notes of a patient in the cohort area who arrived in the department at 14.01 following a paracetamol overdose. The time of the overdose was not recorded on either the ambulance records or the ED records. When we spoke with nursing staff allocated to triage and cohort were unaware of what was taken in the overdose, or the time it was taken.
 - From January to March 2015 (Q4), the median time to treatment for patients was between 55 and 59 minutes (trust wide) compared to between 46-56 minutes nationally. The trust performed in line with or better than the England average or standard (60 minutes) for time to treatment in the 12 months to January 2015.
 - The Acute Floor Performance Review for April 2015 indicated that 46% of patients had a time to treatment of less than 60 minutes in week commencing April 2015.
 - Staff reported that patients had been accommodated overnight in the department, including the resuscitation area and ambulatory care area, because there were no bed spaces on wards. A staff member told us they were distressed by an incident when they were told to take a

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patient from the ED to a ward but on arrival there was no bed space to accommodate the patient. The staff member said the safety and dignity of the person was compromised because they were left in the corridor.

Nursing staffing

- There was not always a sufficient number and skill mix of nurses on duty in the ED over each 24-hour period to care for patients safely given the acuity of patients and the geographical layout of the department.
- There were 177.1 Whole Time Equivalent (WTE) nursing posts in the planned establishment for the ED. The nursing vacancy rate was 7.6%.
- The ED operated two shifts, a day and a night shift, in 24 hours. The matron for ED told us the usual planned staff complement for each shift was 17 registered nurses (RN) and five healthcare assistants (HCA). The Trust has further advised us that there are 19 trained nursing staff and 6 HCAs on a day shift and 18 trained staff and 5 HCAs on a night shift. In addition the department employed Emergency Nurse Practitioners (ENP), who worked in the UCC area to treat minors' patients.
- The department was not consistently staffed with the planned numbers. Information requested from the trust showed the ED worked 'short' of planned numbers for 40 shifts in March, 35 shifts in April and 21 shifts in May 2015.
- Our review of the incident reports in the ED at RSCH over the last 12 months showed there were 38 reports made concerning a lack of nursing staff. Two incidents were discussed at SIRM. 34 incidents were categorised as 'no harm'. Action taken included 'on-going recruitment' and 'escalated at the time'.
- There was a high reliance on bank and agency staff leading to skills gaps in some cases. For example, we observed a spell in resuscitation when four patients were in the care of one member of staff who as consequence was under significant pressure. In another example, we were told about an agency nurse who did not have the necessary knowledge and skill to immobilise a patient requiring a CAT scan, which caused diagnostic delay.
- Nurse agency usage for the ED was 24.5% in the last 12 months. We saw evidence of an induction process for agency staff. Staff told us agency nurses often made up 50% of the total of nurses on duty in the ED.
- The sickness rate was 6.9% among nursing staff in the ED in the last 12 months.

- Absence due to leave, sickness or vacancies was covered by staff overtime (2%), bank staff (48%) or agency staff (50%).
- The turnover rate was 16.9 % among nursing staff in the ED in the last 12 months.

Medical staffing

- We examined the medical staffing rota and spoke with consultants, middle grade and junior doctors.
- Emergency Medicine Consultants were on duty in the department 24 hours a day, seven days a week. The trust met The College of Emergency Medicine (CEM) recommendations.
- The department employed 58.9WTE medical posts against a planned establishment of 70.2. The vacancy rate was 16.1%. Medical staff were employed at the following grades:
 1. 16.9WTE emergency consultants in post against the establishment of 19.3. The vacancy rate was 12.2%.
 2. 6WTE specialty registrars (ST1/2) in post against an establishment of 16. The vacancy rate was 62.5%.
 3. 14.6WTE specialty registrars (ST3 and above) in post against an establishment of 13.9. The vacancy rate was 5.1%.
 4. 5.5WTE specialty doctors in post against an establishment of 4.8. The vacancy rate was 14.6%.
 5. 1.8 WTE associate specialists in post against an establishment of 2.1. The vacancy rate was 13.3%.
 6. 0.1WTE clinical assistants in post against an establishment of 0.2. The vacancy rate was 50%.
 7. 5WTE foundation programme Year 1 (FY1) in post, which was the planned establishment.
 8. 9WTE foundation programme Year 2 (FY2) in post, which was the planned establishment.
- There was a GP rota which provided 2 GPs between 9am and 7pm daily to staff the Urgent Care area of the department.
- There was a sickness rate of 1.6% among medical staff in the ED site in the last 12 months.
- There was turnover rate of 5.1% among ED medical staff in the last 12 months (excluding training grade doctors who leave on a six month rotation).
- Locum usage in the ED was 13.2% in the last 12 months.

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- Our review of the incident reports in the ED at RSCH over the last 12 months showed there were two reports made concerning a lack of medical staff. One incident was categorised as 'No Harm' and the other as 'Unpreventable Adverse Event'.

Major incident awareness and training

- The trust had a major incident plan, which was last reviewed in January 2014. Staff we spoke to had an understanding of their roles and responsibilities with regard to any major incidents.
- Decontamination equipment was available to deal with casualties contaminated with chemical, biological or radiological material, or hazardous materials and items. However, the equipment was not stored in the ED following relocation to create space for cubicles. A new store has since been created directly outside the ED.
- Information from the trust showed 50% of staff had received appropriate training.

Are urgent and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

We did not inspect the effective domain on this inspection.

Are urgent and emergency services caring?

Not sufficient evidence to rate

We did not inspect the full range of the caring domain and have therefore not provided a rating. The following observations and comments do however apply to this domain.

Compassionate care

- We observed staff behaved in caring and compassionate way.

- The Friends and Family Test (FFT) results for the trust for the 12 months up to February 2015 showed between 5% and 85% people were extremely likely or likely to recommend the ED compared to an England average of between 55 and 85%.
- Throughout our inspection of the ED, we observed staff treating patients with compassion, dignity and respect.
- Patients responding to the CQC A&E survey 2014 said they were treated with respect and dignity while they were in the A&E department, which was about the same as other trusts nationally.
- The patients and relatives we spoke with during our inspection were positive about the way staff treated them. Their comments included: "They're very busy, but they try and make sure we don't go without. They're always asking if I want anything."

Understanding and involvement of patients and those close to them

- Patients responding to the CQC A&E survey 2014 said they were given information about their condition or treatment and they felt involved in decisions about their care, which was about the same as other trusts nationally. However, the trust performed worse than other trusts nationally when asked about relatives being given an opportunity to talk to a doctor if they wanted to.
- Patients and relatives we spoke with told us their care and treatment options were explained to them in way they could understand.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Not sufficient evidence to rate

We did not inspect the full range of the responsive domain and have therefore not provided a rating. The following observations and comments do however apply to this domain.

Service planning and delivery to meet the needs of local people

- Overcrowding in the cohort area meant the privacy and dignity needs of patients were not consistently met.

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- During our inspection we observed that screens were not in use for patients in the cohort area. Staff we spoke with told us they were available, but were impractical because of the lack of space to use them. We observed this during our inspection. This meant, for example, elderly female patients in nightwear or hospital gowns were sometimes accommodated in close proximity to male patients during the period of care. We observed the corridor between reception/UCC, which was a thoroughfare for visitors and public, opened into the cohort area and further compromised the privacy and dignity of patients.
- The trust's operating procedure for the cohort area stated patients would be taken into triage bays for investigations; we observed this did not consistently happen during our inspection due to overcrowding. Nursing and medical staff confirmed that some patients were accommodated in the cohort area for their whole episode of care.
- The x-ray department and CT scanning facilities were adjacent to the ED and were easily accessible. However, the magnetic resonance imaging (MRI) scanner was located in a different building on the site and it was necessary for patients to be transferred outside for part of their journey between the ED and the MRI scanner. We have been advised by the trust that since the inspection there is now a new MRI scanner on level 4.
- The signage and navigation around the acute floor constituted a major issue for patients, relatives and carers. It was unclear whether temporary signage was directed at patients, carers or contractors. This had the potential to create delays for walk in attendants and also for relatives wishing to track patients.

Access and flow

- The trust has had significant issues maintaining key performance indicators relating to emergency care. The trust board performance report of April 2015 indicated a deterioration of performance against the four hour standard in the time period April 2014-March 2015 across all the trust ED's. The trust was rated as 239th of 245 trusts nationally.
- The trust board performance report also indicated worsening trust wide positions for ambulance handover delays > 30 < 60 minutes, those > 60 minutes and the number of patients waiting >12 hours post decision to

admit from January 2015 to April 2015. The trust reported an improvement in 7 day re-attendance rates over the same time period. This data is not presented by site in the board report.

- Within that time period performance at the Royal Sussex County Hospital (RSCH) showed a similar trend of deterioration for type 1 (majors) with performance from December 2014 to March 2015 not exceeding 72% for any month. This level of performance was below that of the trust's other ED's.
- The Acute Floor Performance Review for April 2015 reported an overall performance of 65% against the four hour standard at RSCH for the week commencing 11th April 2015.
- Patient flow from the ED into hospital beds was poor with a high number of patients awaiting admission to wards. The Urgent Care Transformation April 2015 board paper cited exit block and unavailability of beds as the major issue driving deterioration in patient time spent in ED at RSCH. Weekly 95th percentile time had moved from under 600 minutes in April 2014 to in excess of 900 minutes in April 2015 against the quality standard of 240 minutes.
- During our unannounced inspection, the 'Symphony' screenshot showed at one point: 10 out of 25 patients in the resuscitation area, Zone 2a and the cohort area had been in the department for more than 4 hours. Six of these patients had a decision to admit (DTA). Four out of ten patients in Zone 2b had been in the department for more than 4 hours. None of these patients had a DTA.
- The Acute Floor Performance Review April 2015 also indicated that for April 2015 19 patients waited greater than 12 hours from decision to admit (DTA) to transfer to a specialty bed and that the average wait for a specialty was between 6.5 and 8.5 hours.
- The percentage of patients who leave the department before being seen is recognised by the Department of Health as potentially being an indicator that patients are dissatisfied with the length of time they have to wait. The trust performed in line or worse than the national average in the 12 months up to January 2015. Between January and March 2015, between 2.8% and 3.5% of patients trust wide left without being seen compared to a national average of between 2.1% and 2.6%.

Are urgent and emergency services well-led?

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Inadequate



The trust and the Emergency Department (ED) leadership have faced sustained pressures to deliver performance and safety standards. This pressure is exacerbated by health economy capacity and departmental physical constraints.

However our inspection indicated that despite a number of transformational plans, management reconfiguration and support from the Emergency Care Intensive Support Team (ECIST) there is a continued deterioration of performance.

The trust has not comprehensively addressed either the recommendations of the initial ECIST visit or the compliance action issued by CQC following the inspection in May 2014.

Whilst there is now clear engagement within the sector there is concern that interim management and lack of executive capacity, notably in the Chief Operating Officer role, to manage change has contributed to the lack of progress to date. A Chief Operating Officer has been appointed since our inspection and is now in post and is taking forward the work with senior clinical and managerial colleagues.

There are clear signs from the new management structure that robust performance management data and greater clinical engagement will provide a foundation for change. However the Board has not recognised the nature and regularity of risk afforded by the ED at RSCH and not effectively sought further assurance following presentations by clinical teams that detailed patient safety and experience risks notably with relation to the cohort area. This has not brought the improvement required and we believe that more could be done by the Board on this matter.

Vision and strategy for this service

- The strategy for improving the performance of the emergency care pathway over the last three years has been based on medium term transformation programmes, management reconfiguration with enhanced performance management data and short term escalation management tactics. The trust has in this time sought support from external agencies and broader stakeholder engagement.

- The trust has a nine year capital development programme – 3T's (teaching, trauma and tertiary care) – and as such is currently subject to major building works.
- In January 2014 Board papers indicated that the trust was implementing Right Care, Right Place, First Time – an executive led transformation strategy that had five work streams – 1. Front loading clinical decision making and handover 2. Streamline processes and pathways 3. Re-organise medical cover 4. Early daily review and decision making for all inpatients 5. Increase rehabilitation options. This programme followed the engagement of the Emergency Care Intensive Support Team (ECIST) in 2013.
- Following the CQC comprehensive inspection in May 2014 the emergency department was rated as requires improvement and was issued a compliance action notice relating to management of the cohort area. The trust reports monthly against the associated action plan.
- During our inspection we were provided with a presentation for the July 2015 System Resilience Group Meeting by the Deputy Chief Executive/Director of Strategy and Change providing highlights of the Urgent Care Recovery Plan for the trust, a further emergency care transformational change programme.
- The governance of the Urgent Care Recovery Plan included reporting to the System Resilience Group (SRG) and was supported by the BSUH internal Urgent Care Programme Board that itself reports to the Trust Executive Change Board.
- This presentation was prepared subsequent to a second ECIST visit in June 2015 and included recommended immediate actions targeting assessment and streaming, rapid handover, introduce ward board rounds to enhance flow, ambulatory care unit process and implementation of an escalation trigger tool with accountability. The recommendations of the second ECIST visit are similar to the first.
- In June 2015 an external management consultancy reported to the SRG their findings on system wide capacity concluding that significant shortfalls exist in both acute and community settings.
- The trust has implemented a new directorate structure that includes the Acute Floor Directorate led by a triumvirate management structure that includes a clinical director, lead nurse and general manager.

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- Senior staff described the escalation policy for the department. On 22 June, the first day of our inspection, the department was escalated to level RED, which should initiate the following actions:
 1. COO informs CCG's and SECAMB
 2. Medical Rep to inform GP's, Hermes and Harmony
 3. Chief's to cascade to all consultants
- These actions were implemented by a series of email communications however, the bed management meeting at 15:00 hrs. was attended by directorate nurse leads only. The meeting provided no indication of enhanced engagement with clinicians as a result of escalation.
- The hospital had several policies which referred to escalation for overcrowding, but the policies did not reference each other and it was difficult for us to evidence how the policies worked together. For example, the trust has an escalation policy. In addition it has a Full Capacity Protocol. It was not clear at inspection how the two protocols interrelate operationally.
- The Full Capacity Protocol is initiated when escalation is red, ED full with no immediate discharges, six patients are in the cohort area and all escalation areas are open. It was not clear during the inspection, despite these factors being met, whether the Full Capacity Protocol had been initiated.
- It was not possible to determine trend analysis of departmental escalation status over the last three months.
- The deputy medical director (safety) provided a copy of an overarching five year Safety, Quality and Patient Experience strategy – Acting with kindness and compassion – Improving adapting innovating – Working Together. This comprehensive document was due for board presentation in July. We now understand that this was approved by the Board in July.
- The departmental risk register reflected what individuals raised as their key concerns for the service. Staff were clear on the risks and areas in the department that needed improvements.
- The trust performance reports (April 2015) provided trend analysis using the following indicators: - attendance to emergency admission ratio, greater than 12hr waits from DTA, ambulance delays greater than 30 mins and greater than 60 mins, percentage of patients less than 4hrs and A/E re-attendance rates.
- Ambulance delay data was not confirmed as being either 'on target' or 'of concern'.
- The board received monthly papers on both urgent care transformation and performance however the board did not appear to be sighted of trends in delays in time to first treatment and escalation status (i.e. how often red or black) of the emergency department.
- The acute floor participated in detailed performance reviews meeting chaired by executive leads. Comprehensive reports were tabled by the acute floor management triumvirate and discussed.
- Performance meetings were further supported by operational, safety and quality meetings chaired the directorate lead clinician. Risks were identified and documented.
- We have discussed extensively with the trust the reporting of ED issues and risks to the board. Dashboard reports and performance narrative, along with direct clinical team reports, should have left the Board with a clear understanding of the severity of the situation and the scale of challenge. In response the Board requested a deep dive into the 4 hour and 12 hour standards. They did not seek further assurance on co-horting.
- The trust has failed to comply with the breaches of regulation identified during the inspection in May 2014.

Leadership and culture within the service

Governance, risk management and quality measurement

- The trust maintained a system of scorecards for monitoring targets; for example, national performance targets, patient experience and clinical quality. These were accessible for staff reference.
- The trust received regular reports and updates relating to both the operation and transformation of the acute floor.
- The trust had a nominated non-executive (the trust Chair) for the acute floor who visited the department. Other non-executives have also visited the department. Although their experiences enriched discussions at Board meetings, there was no formal mechanism for documenting the visit.
- The trust had no substantive Chief Operating Officer (COO), although an appointment was expected to be made in July, or Executive Director of Workforce

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(although there is an operational director of HR who reports to the Deputy Chief Executive/Director of Strategy and Change). The ED Director of Operations was an interim at the time of inspection.

- In the extended absence of a substantive Chief Operating Officer (COO) the role was effectively being delivered by the Deputy Chief Executive/Director of Strategy and Change
- The Chief Executive Officer (CEO) was visible and engaged with the acute floor on a frequent and regular basis.
- The triumvirate departmental management structure was evolving with the clinical director having clear sight of improvements required and the necessity for detailed performance management data. However, the team needs significant support in its development and this is acknowledged by the clinical director. To enable this, the trust is implementing a leadership development programme.

Staff engagement

- Staff spoke with a sense of pride about their local team and the work they did, but expressed frustration about their ability to do their best for patients because of the pressures they worked under. As reported earlier staff were likely to report clinical incidents but not staffing or escalation incidents. Our interactions suggested that staff morale in the department was variable.
- The relentless pressure on the department was leading to disengagement, particularly of the consultant body, some of whom reported that they are no longer raising issues to the directorate and senior management.
- One senior clinician told us, "The four hour target has gone out of the window here; it's all about the 12 hour target, that's the one we aim to avoid breaching." Several other nursing and medical staff offered similar comments during our conversations with them.
- Clinicians told us the support from specialties within the hospital needed to improve in reviewing patients in the ED to make decisions to discharge or admit as well as facilitate discharges on hospital wards to free up beds.

Innovation, improvement and sustainability

- The trust has established a Change Board, People Board and People Management Board. The Unscheduled Care Board reports to the Change Board where it is held account to for delivery.

- The trust does not have a dedicated programme management office (PMO) for the management of change and has recently agreed support with commissioners from a system wide PMO which will support the unscheduled care programme (system wide master plan).
- Despite a short period of recovery the trust has had a sustained challenge in maintaining access standards within the emergency department.
- ECIST have now been into the trust on two occasions in the last twelve months, most recently in June 2015. During inspection we were presented with a report prepared the week prior to our visit, indicating 'immediate actions' as a result of the last visit detailing cessation of triage, rapid ambulance handover, initial streaming, daily ward board rounds, Ambulatory Care Unit process and escalation trigger tool with accountability at the bed meeting.
- In the board report of January 2014 the work streams described for the emergency pathway included frontloading clinical decision making and handover, streamlining processes, early inpatient review and increased rehabilitation at home.
- A recent external management consultant capacity review identified considerable shortfalls in capacity for acute and intermediate care and this is being progressed across the local health economy.
- The trust has invested significantly in a well-crafted organisational development plan aimed at maximising the management and clinical engagement opportunities afforded by the recent organisation restructure.
- Work lead by the clinical director for the acute floor and Lightfoot has developed a system that will provide greatly enhanced data and intelligence for the emergency pathway that has potential to support transformation of the pathway.
- It is difficult to ascertain the level of change that the department has made over the last year on the basis of one day in the department. However, evidencing improved patient care and experience alongside reduced patient risk is difficult to discern from the trust data. The newly appointed Chief Operating Officer will be leading this work.