

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	Requires improvement	
Accident and emergency	Requires improvement	
Medical care	Requires improvement	
Surgery	Requires improvement	
Critical care	Good	
Maternity and family planning	Requires improvement	
Services for children and young people	Good	
End of life care	Good	
Outpatients	Requires improvement	

Summary of findings

Letter from the Chief Inspector of Hospitals

Royal Sussex County Hospital is an acute hospital for the Brighton and Sussex University Hospitals NHS Trust, which provides acute services to the population of people across the Brighton, Hove and Mid 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 Alexander 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 comprehensive inspection because the Brighton and Sussex University Hospitals NHS Trust was an Aspirant Foundation Trust. The inspection took place between 21 and 23 May 2014. We also carried out unannounced inspections on Tuesday 27 May between 7pm and 11pm and then on Friday 30 May between 3pm and 6pm.

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

Our key findings were as follows:

- We observed staff communicating with and supporting people in a very caring and compassionate way. Patients and their families spoke highly of the care they had received. The overwhelming majority of the feedback given to the team from all sources was positive.
- Staff spoke very positively about the Chief Executive who they said was highly visible, engaged, focused and committed to improvement. Staff across the trust and at every level referred to communication having been "transformed" since his arrival. Nursing staff also spoke positively about the Chief Nurse and the impact that she was having.
- With very few exceptions staff across the trust described their pride in the services they were delivering and the support they received from colleagues and managers. Staff were excited about the recent announcement of the £420m redevelopment of the Royal Sussex Hospital site which was described as a "huge boost".
- The areas of the trust that we visited appeared clean and cleaning was taking place throughout our inspection. The age of some of the buildings made them more difficult to keep clean. The trust's infection rates for C.difficile are within an acceptable range taking account of the size of the trust and the national level of infections. The trust reported five cases of MRSA infections in the last twelve months with the infections occurring in April and October 2013. This is slightly higher than would be expected. The trust has an effective infection control team and we observed good hygiene practices by staff.
- The older buildings and some aspects of the lay out of the Royal Sussex County Hospital campus presented a significant challenge in delivering care, for example patients cannot be moved between buildings during bad weather. Some issues would not be resolved until the planned building programme is complete but in the meantime work had been carried out to make improvements where possible. An example of the latter was the new dementia service, the Emerald Unit in the Barry Building.
- There were issues with the flow of patients into, through and out of hospital. This was having an impact on care and patient experience in the Emergency department, in the medical assessment units, in surgery, in critical care, on the wards and also on the planning and support that people received when they were ready to leave. Some patients were being cared for in wards which were not with their required speciality. The trust needed to achieve 100 discharges a day and at the time of the inspection were achieving between 65 and 70.
- The pressures on the emergency department were significant and connected to the flow issues described above. The department does not have enough physical space to deal with the number of patients that attend. The department is consistently failing to meet the target to admit, transfer or discharge 95% of patients within four hours.

Summary of findings

- The implementation of a centralised booking system (known as “the Hub”) for outpatient and follow up appointments had not gone smoothly and had caused problems for patients and staff alike. The problems included late notice of appointments, cancelled appointments and clinics, delays in dealing with urgent referrals and clinics running without patients booked for them. The trust had a comprehensive action plan in place and improvements were being seen.
- The trust was dealing with a number of significant cultural issues. These included improving engagement with staff, improving and promoting race equality and dealing with some long standing issues in respect of that, addressing the issues that have influenced the staff survey results and improving the take up of appraisals and access to training.
- Staffing levels, particularly in medicine and surgery and the high use of bank or agency staff placed pressure on staff and placed patients at risk of their care needs not being appropriately met. These pressures meant that staff were not always able to attend training as required. Concerns about the quality of food were a recurring theme in patient feedback during the inspection and in patient survey results. Patient records showed that nutritional risk assessments are being carried out using the MUST tool and additionally staff were completing food and nutrition charts for patients who were at risk of weight loss. Fluid charts were also being completed appropriately.

We saw several areas of outstanding practice including:

- We were particularly impressed with how the day case ward met the needs of children going to theatre. There was a ‘one-way’ system that ensured children going into theatre did not see the children that were leaving the theatre. Small children could ride in motorised cars to theatre if they chose to do so. There were booklets available for children to read that explained what they could expect to happen while they were in hospital. These were in the format of a monkey telling a story. Parental feedback about the booklets was exceptionally good.

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

Importantly, the trust must:

- Ensure that the environment is suitable for patient investigations, treatment and care and that hazards related to the storage of equipment that impact on staff, are minimised.
- Ensure that electrical equipment, used directly for patient treatment or care needs, is suitably checked and serviced, to ensure that it is safe and fit for use.
- Ensure that planning and delivery of care on the obstetrics and gynaecology (O&G) units meets patients’ individual needs.
- Ensure the appropriate use of beds spaces which are suitable by their position, design and layout within wards including the Stroke Unit, Grant ward and Baily Ward.
- Ensure that the values, principles and overall culture in the organisation, supports staff to work in an environment where the risk of harassment and bullying is assessed and minimised and where the staff feel supported when it comes to raising their concerns without any fear of recrimination.
- Ensure that relationships and behaviours between staff groups irrespective of race and ethnicity is addressed to promote safety, prevent potential harm to patients and promote a positive working environment.
- Ensure patients who require access to urgent referrals for treatment through the Hub are supported to do so as a matter of urgency and patient safety.
- Take action to ensure that staff receive mandatory training, in line with trust policy.
- Take action to ensure that staff receive an annual appraisal.
- Evaluate the effectiveness of the current patient flow and escalation policy and implement mechanisms to improve patient flow within the ED and other wards across the trust.
- Review the current cohort protocol to ensure that there are clear lines of clinical accountability and responsibility for patients, which all trust staff and ambulance trust staff are aware of.
- Review the current cohort area within the ED to ensure the privacy and dignity of patients. Ensure that women using the day assessment unit have their privacy and confidentiality maintained.

Summary of findings

- Ensure that staff reporting incidents receive feedback on the action taken and that the learning from incidents is communicated to staff.
- Ensure that there are enough suitably qualified, skilled and experienced staff to meet the needs of all patients. In O&G consultants support must be available at all times.

In addition the trust should:

- Ensure that the functions of the booking Hub are addressed, so that patients who need to be seen post-operatively have access to the correct consultant, at the correct time.
- Medical staff should ensure that patients have the opportunity to ask questions within the doctor's round, so that they are fully informed.
- Make improvements to the efficiency around the discharging of patients from postoperative wards.
- Ensure that staff at all levels feel confident about reporting incidents so that learning and improvements to practice can take place.
- Critical care staff should ensure that patient information is secure and confidential at all times and that it cannot be viewed by anyone who is not authorised to do so.
- Ensure same sex breaches are being managed in acute areas such as AMU (Acute medical unit).
- Continue the work to introduce more midwife-led pathways to help normalise birth and reduce the rates of caesarean sections.
- Ensure IT connectivity across all clinical bases is at a level where all community midwives can review essential information.
- Ensure that cover is in place for specialist services as part of the workforce planning.
- Ensure that there are robust governance systems in place to enable more effective management of the outpatient services at the Royal Sussex County Hospital.
- Ensure good communication between outpatient services and the medical records department.
- Ensure that staff understand their role in the event of a major incident, as appropriate to their designation.
- Ensure parity across wards/units regarding access to training, education and study leave.
- Ensure that there are effective human resources and processes to assist patient flow.
- Ensure that information on how to complain is available in languages other than English.
- Ensure that there are effective working arrangements between all staff groups.
- Review the current NHS Friends and Family Test response rate and methodology to ensure they are consistent with national return rate.
- Ensure end of life strategy is given appropriate consideration at board level.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Accident and emergency

Requires improvement

Rating



Why have we given this rating?

The emergency department (ED) was challenged with capacity issues both within the department and trust-wide. There was poor patient flow across the trust which impacted on the ability of the ED to perform to its actual ability. The ED was consistently failing to meet the four-hour national target and patients were experiencing delays in being transferred to inpatient beds, with some delays exceeding 18 hours.

The ED had a process of 'cohorting' patients within the majors cubicle area. It was not clear who assumed overall clinical responsibility for these patients. While there was a local policy in place, there was no formal governance structure regarding the cohort process. Patients were observed waiting on trolleys and chairs in the cohort area for periods of two hours during an unannounced inspection. In response to the capacity issues, the trust had been undertaking work internally and externally with key stakeholders such as the ambulance trust, to try and resolve the patient flow issues. This work included a review of the emergency and unscheduled care pathways.

Immediately after the inspection the trust reviewed progress with these work streams and escalated their actions, in particular the management of the co-hort area. The trust has been working further with the key stakeholders and has shared these actions and their plans to ensure the effective management of these concerns with us. We are pleased to note the trusts response and will be monitoring and reviewing the impact of these actions.

The cleaning contractor was not able to fully meet the needs of the service to ensure patients were cared for in a clean and hygienic environment. Staff were seen to be caring and attentive to people's needs. However, the perception was that when staff were working under pressure, they may not always demonstrate a caring attitude, as they were more concerned with delivering emergency nursing and medical care.

Summary of findings

The children's ED was noted to be of a particularly high standard by the inspection team.

Medical care

Requires improvement



Medical care services were delivered by caring and compassionate staff who were dedicated to providing the highest possible standards of care under some difficult circumstances. An ongoing inability to staff some wards to the identified safe levels and with the correct skills mix at all times, meant that staff felt care and treatment was not always safe and placed patients at risk. The management of patients not on the correct ward due to capacity issues was not clear and may have placed patients at risk. While staff reported concerns and incidents, very limited feedback was evident to take in learning and make positive changes. Improvements were needed in the management of the environment, which was poor in places. Generally, the wards/departments were well-led, although there was limited connection between the staff providing hands-on care and the executive team.

Surgery

Requires improvement



The surgical care teams were highly motivated, committed and compassionate about the services they provided to patients. Staff were caring and supported to deliver high standards of care with strong and effective leadership. People who were receiving care and their relatives reported a high level of satisfaction with the quality of care and their experience of using the hospital. We spoke with patients, who confirmed staff treated them with dignity and respect. Pain was said to be managed well and patients said they were given enough information to help them make decisions about their treatment and care. Feedback we heard and read was positive about the care and treatment from all staff. Some patients said that the care at the Royal Sussex County Hospital had been “absolutely fantastic” and that it had been a “very good experience”. Another patient said, “Care has been fabulous.” Nursing staffing levels were improving, but there was a high use of bank staff to cover vacancies and unplanned absence. Mandatory training was provided to staff. However, attendance rates were low in some areas and action was taking place to improve the completion of training.

Summary of findings

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

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

Bed occupancy, discharge and flow meant that there were times when patients waited for beds on a surgical ward or were nursed in inappropriate areas. Staff understood their responsibilities to ensure that patient care was delivered safely and effectively.

There were arrangements in place for staff to report adverse events and to learn from these. Clinical effectiveness was continuously monitored and governance was taken seriously, with monitored patient outcomes at ward and department level.

There were numerous items of electrical equipment used for patient care which had not been routinely tested to ensure the items were safe to use. The clinical environment was not always appropriate for certain tests that were being carried out and equipment storage in some areas presented a hazard to staff and additional challenges to cleaning standards.

Critical care

Good



Care and treatment delivered in critical care was safe and effective. The teams leading the units were dedicated and committed to patients, their families and their staff. Patients spoke highly of their care and feedback was overwhelmingly positive.

There were shortages of nursing staff in the general units, a situation that was improving, but the department still had to make use of temporary staff on a regular basis. This had led to some temporary bed closures to add to issues with patient flow in the rest of the hospital, which meant that not enough patients were able to get into the general critical care unit at the optimal time. Poor patient flow meant that some patients were not being

Summary of findings

Maternity and family planning

Requires improvement



discharged when they were ready, as there was no available bed elsewhere. Some patients were discharged earlier than was optimal to free up bed space, some patients were transferred to other hospitals, and some patients were being discharged at suboptimal times, such as after 10pm. The units at this hospital did not currently contribute to the Intensive Care National Audit and Research Centre (ICNARC) data, and although it measured its own data, it was not able to show readily how outcomes compared with other similar units in England. It was currently implementing the processes required to recommence submission of data to ICNARC.

This department has serious on going cultural issues which has affected patient safety and staff sickness. There was a lack of leadership amongst a small group of consultant staff, for example consultants not willing to hold a pager and not attending key meetings. There was a high level of grievances. Senior managers have struggled to address these issues but the trust now has the services of an external agency to help address this. Difficult working relationships amongst and between medical, nursing and midwifery staff were cited during the inspection. Some staff reported that there was an increased potential risk to patients, due to the fear of reporting incidents and poor working relationships. Instrumental and caesarean section rates were higher than expected. The trust recognised this and had strategies in place to help reduce the rate. Midwifery staffing levels were sufficient to provide a safe service throughout the obstetrics and gynaecology (O&G) departments. We spent time observing and talking to staff on all of the units. We also joined a doctors round on the labour ward. We found that care and support offered to women and their families was compassionate, kind and informative. Nursing and midwifery staff were committed to improving the services they offered and promoting continued professional development.

Summary of findings

Services for children and young people

Good



We found children's services to be generally safe. However, we had concerns about nursing and medical staffing levels and the low number of staff that had completed their mandatory training. The reporting of incidents was satisfactory and the feedback following the investigation of the incidents had improved. The wards and units we visited were clean and staff followed the trust's infection prevention and control policy. The equipment and environment was satisfactory in all areas and had been regularly checked and maintained. The management of medicines was satisfactory and improvement actions had been put in place to reduce the risks associated with the patient's own locker being used to store their medicines. Records were comprehensive and person-centred. People had risk assessments appropriate to their needs. Procedures were in place to safeguard children and consent was obtained before any medical or nursing interventions were delivered. There were effective procedures in place to manage the deteriorating patient. Not all of the staff were aware of their role in the event of a major incident. Therefore, improvements were needed. Children's services were effective. The hospital used evidence-based care and treatment, and maintained a clinical audit programme. There was evidence of multidisciplinary working. However, there were occasional delays in holding multidisciplinary team meetings. There were procedures in place to ensure competent staff. However, there was conflicting data concerning the number of staff that had received an appraisal within the last 12 months. Both the undertaking of appraisals and data input concerning appraisals requires improvement. We found services were responsive to the needs of the patients and their families. We noted some outstanding practice in some of the areas we visited. This included the surgical day case ward that had an effective system in place to reduce children's distress before they went to theatre. The hospital needed to improve some of its access and patient flow processes. We noted that there were delays in transferring children from one ward/unit to another.

Summary of findings

Complaints were appropriately managed and actions were undertaken to improve the service or level of care in accordance. We noted that information about how to complain was only available in English.

The service was caring. Parents gave positive feedback about the kindness and compassion shown by the staff. Parents were involved in making decisions about the care and treatment of their child and were offered emotional support.

We found the children's services to be well-led at a local level. Some of the staff we spoke with were aware of the trust's 'values and behaviours', but many were not.

There were regular patient safety and governance meetings, and these were attended by the appropriate staff groups and all of the specialities. Staff were very positive about the culture at a local level and felt that it facilitated good working relations and team work.

End of life care

Good



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

We noted that the SPC team supported and provided evidence-based advice to other health and social care professionals, and we were told by ward staff that they were highly regarded across the trust. We saw evidence that urgent referrals were seen on the same day. In the last year (2013/14) the SPC team had received 1,621 patient referrals across the trust.

While visiting the ward areas, we randomly checked nine medical records containing 'do not attempt cardio- pulmonary resuscitation' (DNA CPR) forms. We saw that all decisions were recorded on a standard form with a red border. The DNA CPR forms were at the front of the notes we checked, allowing easy access in an emergency and being compliant with the trust 'Resuscitation Policy.'

Summary of findings

The end of life care facilitator was actively involved in running end of life training courses for staff across the trust. We saw evidence that end of life training was available to all staff groups. Sessions that were due to take place in June and July.

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

Leadership of the SPC team was good, with good team working, although there were varying views regarding the importance of end of life care at board-level.

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

An end of life steering group was in place, but we found that non-palliative care staff exhibited a lack of engagement across the trust.

Outpatients

Requires improvement



All staff had received infection control training and infection control expertise was available in the unit. We saw that all staff had received training about safeguarding vulnerable adults and knew the steps to take if they suspected abuse. We noted reception staff had not received training in safeguarding.

We observed that the seating arrangements for patients in the main outpatient department had been reviewed across the outpatient department to help improve patient flow and to make it easier for patients to find their way around. Patients told us they liked the chairs and the new seating arrangements were a great improvement. It was clear that navigating around the department was now much easier.

On the day of our inspection, we noted two clinics had been cancelled, as consultants had not been allocated to them. Consultants were required to advise the Hub six weeks in advance of their annual leave requirements. Patients had been booked into clinics by the Hub when consultants were on leave. There was a lack of clarity and understanding in the outpatient department concerning information about patient outcomes. The nurse manager did not

Summary of findings

receive feedback on meetings about the referral to treatment times (RTT) and the 'did not attend' (DNA) rates and progress with the booking Hub. We were unable to identify if there were delays relating to specific clinics, but were told there were long waits in neurology and rheumatology.

The minutes of the Executive Quality and Safety Committee for April 2014 clarified the actions being taken to address the ongoing concerns surrounding the efficiency and safety of the Hub.

We saw all support staff had a level 3 diploma in health and social care. Staff had annual appraisals and we saw evidence of this. The appraisal rate was 100%.

We found clinics functioned in isolation of each other and there was no overarching governance framework in place for outpatient services.

Requires improvement 

Royal Sussex County Hospital

Detailed findings

Services we looked at

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

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Detailed findings

Background to Royal Sussex County Hospital

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

The trust employs a diverse workforce of around 7,136 with 896 beds and provides district general hospital services to the local population of some 460,000 across Brighton, Hove and Mid Sussex. It also provides a range of specialist services, including: cancer services, neurosciences, cardiac surgery, renal services and intensive care for adults, children and new-born babies to a population of approximately 1,000,000. There are approximately 856 beds in the trust with 600 of these provided at Royal Sussex County Hospital.

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

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

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Mary Cridge, CQC

The team of 35 included: CQC inspectors and analysts, a consultant cardiologist, junior doctors, a consultant

obstetrician, a consultant in critical care, a consultant paediatrician, a consultant orthopaedic surgeon, an A&E consultant, lead nurses, a matron for A&E, a student nurse, experts by experience and a non-executive director.

How we carried out this inspection

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

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

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning

group (CCG), the Trust Development Authority (TDA), NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch.

We held a listening event in Hove on 20 May 2014, where 15 people shared their views and experiences of the Royal Sussex County Hospital. As some people were unable to attend the listening events, they shared their experiences via email or telephone.

We carried out the announced inspection visit between 20 and 23 May 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including

Detailed findings

nurses and midwives, junior doctors, consultants, physiotherapists, occupational therapists and the Black and ethnic minority (BME) network. We also spoke with staff individually, as requested.

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

Facts and data about Royal Sussex County Hospital

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

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

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

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

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

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

The trust reported five cases of MRSA and 48 cases of Clostridium difficile (C. diff) against a target of 34 for the year 2013/14.

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

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

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Requires improvement	Not rated	Good	Inadequate	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and family planning	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and emergency and Outpatients.

Accident and emergency

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

Information about the service

The Royal Sussex County Hospital provides Accident and emergency services through the main emergency department (ED), the Children's Accident and Emergency Department, which is located within the Royal Alexandra Children's Hospital and the Urgent Care Centre (UCC). The main adult ED is the dedicated regional major trauma centre for the South East Coast, serving a population of approximately 1.75 million people, covering a vast geography, spanning from Chichester in the West, to Hastings in the East, as well as serving parts of Kent. The department sees approximately 150,000 patients each year.

The adult emergency department has a five-bay resuscitation area (Zone 1), 12 spaces for treating major cases (Zone 2), a two-bay patient assessment triage area, a five-trolley "cohort" area and 10 lower acuity treatment bays (Zone 3). In addition, there is a 6-bed short stay ward and a 6-bed clinical decision unit. The department is further supported by a walk-in Urgent Care Centre where patients are seen by either emergency nurse practitioners or by a GP.

Last year, the children's emergency department at the Royal Alexandra Children's Hospital saw 24,000 patients. The emergency department was originally built as an assessment centre. The department had a triage area, consulting rooms for children presenting with minor conditions, a 'Majors' area for children presenting with more urgent needs and an assessment room for children presenting with mental health problems. There was a two-bed resuscitation room. The resuscitation room also supported neonates. Any children presenting with major

trauma were managed in the resuscitation room in the adult emergency department. This was located on the Royal Sussex County Hospital site, and paediatric staff from the children's emergency department attended the adult's resuscitation area to facilitate the management of children. This was accessed by a linking corridor between the two hospitals.

During our inspection, we spoke with 47 members of staff from both the main adult ED and staff working at the Royal Alexandra Children's Hospital ED. We spoke with staff and six families, including parents and children who were present at the Royal Alexandra Children's Hospital ED and also with 18 patients who were present in the main adult ED.

Accident and emergency

Summary of findings

The main adult ED was challenged with capacity issues both within the department and trust-wide. There was poor patient flow across the trust, which impacted on the ability of the department to perform to its actual ability. The main adult ED was consistently failing to meet the four-hour national target and patients were experiencing delays in being transferred to inpatient beds, with some delays exceeding 18 hours.

The main adult ED had a process of 'cohorting' patients within the Majors area. It was not clear who assumed overall clinical responsibility for these patients. While there was a local policy in place, there was no formal governance structure regarding the cohort process. Patients were observed waiting on trolleys and chairs in the cohort area for periods of two hours during an unannounced inspection.

In response to the capacity issues, the trust had been undertaking work internally and externally with key stakeholders such as the ambulance trust, to try and resolve the patient flow issues. This work included a review of the emergency and unscheduled care pathways.

Immediately after the inspection the trust reviewed progress with these work streams and escalated their actions, in particular the management of the cohort area. The trust has been working further with the key stakeholders and has shared these actions and their plans to ensure the effective management of these concerns with us. We are pleased to note the trusts response and will be monitoring and reviewing the impact of these actions.

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

Staff were seen to be caring and attentive to people's needs. However, the perception was that when staff were working under pressure, they may not always demonstrate a caring attitude as they were more concerned with delivering emergency nursing and medical care.

The children's ED was noted to be of a particularly high standard by the inspection team.

Accident and emergency

Are accident and emergency services safe?

Requires improvement



The Emergency Department at Royal Sussex County Hospital was not sufficiently safe. The environment was recognised as not being of sufficient size to meet the needs of the increasing number of patients who visited the ED.

There was evidence that the department reported incidents. However, we were concerned that lessons learnt were not always fully embedded into practice, especially regarding the management of patients who presented to the ED with mental health issues.

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

Equipment was readily available and was seen to be maintained, although there was evidence that staff were not always fully decontaminating equipment between uses.

At times, the department was very busy and patients were "cohorted" within the Majors area. There was no clear line of responsibility for patient care within this area and patients were waiting prolonged times for treatment.

There was a good mix of nursing and medical staff available across the 24-hour period. The nursing establishment had been increased to meet the ever-expanding demands of the service and, as such, there was a reliance on bank and agency staff to back-fill vacant posts.

Completion of mandatory training was seen to be poor. This was attributed to the demands of the service, whereby training was cancelled when the acuity and occupancy of the ED called for additional staff to support the department.

Incidents

- There were no Never Events in the emergency department between December 2012 and January 2014.
- The trust reported seven serious incidents (SI) to the Strategic Executive Information System (STEIS) relating to the main ED between December 2012 and January 2014.
- In addition, the trust provided us with the ED incident listing reports from September to February 2014, which were logged on the hospital incident reporting system, Datix. In total, 353 incidents were reported. One report was linked to the death of a patient and 22 reports were categorised as 'moderate', as there was no harm caused to a patient.
- We were provided with the root cause analysis for one serious incident, which involved the ED and more specifically, the Short Stay Ward (SSW) in 2013. We reviewed the Serious Incident investigation into this event. One outcome from this investigation was that all patients who required a referral to the mental health liaison team would undergo a mental health risk assessment by a member of the ED Team. This action was further reiterated in a clinical governance meeting that took place on 18 September 2013. The ED carried out an audit of notes for patients who were referred for mental health input between 17 February 2014 and 3 March 2014. 114 case notes were reviewed, of which, only 39 patients had a completed mental health risk assessment form.
- As a result of this audit, the mental health risk assessment form was reviewed and simplified in April 2014 to help improve completion. A random review of 50 ED Central Alerting System (CAS) cards demonstrated that the revised risk assessment was being used, but of the five that had been used, there was information missing from each form, such as descriptions of patients not being recorded. This information would be of use to the police and security teams, should a person abscond from the department after having presented with suicidal tendencies or other behaviours that may have placed them at risk of harm.
- We asked staff directly if they reported incidents. We received a varied response depending on the grade and profession of staff we spoke with. Some senior nursing staff said that the frequency with which they reported incidents had reduced due to them receiving little or no feedback, with no evident changes in practice. Junior staff said that they reported incidents, but again, did not always receive feedback to the incidents they reported.
- The number of clinical incidents reported per 100 admissions (or in the case of the ED, the number of visits), ranged from 1.9 reports per 100 in June 2013, to as high as 8.8 reports per 100 visits in January 2013.
- Between July 2013 and January 2014, the number of clinical incidents reported per 100 visits averaged at 5.8

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reported clinical incidents with July seeing 5.1 reports at the lowest end and August 2013 at the higher end, with 6.4 reports per 100 visits. The average number of clinical incidents reported across the trust over a 12 month period dating from February 2013 to January 2014, was 7.7 incidents per 100 admissions/visits. This demonstrated that although staff told us that they had not reported incidents, the average number of reports had remained reasonably consistent during a seven month period, although the overall number of clinical incidents reported within the ED was below the trust average.

- Minutes from an ED staff meeting held on 28 March 2014, which was attended by 14 members of staff, including the head of nursing and the ED clinical lead, reported that the head of nursing was developing a newsletter as a means of providing feedback on Datix incidents and safety incidents.
- Staff working in the Royal Alexandra Children's Hospital emergency department told us that they felt confident to complete incident reports and raise any concerns they had.
- Incidents within the children's ED were discussed at the clinical quality and safety meeting on a monthly basis. There was evidence that lessons from incidents were learned and action plans put in place to reduce the risk of further occurrence. An example of this was the introduction of a 'wheezer pathway' for children presenting with a wheeze. This followed the mismanagement of a previous patient with a wheeze from the previous year.
- We saw evidence that the children's departmental manager fed back the outcomes from incidents to the staff during their staff meetings.

Cleanliness, infection control and hygiene

- The department had a range of equipment, which was, for the most part, seen to be clean and well-maintained. Labels were in use to indicate when items of equipment had been cleaned. However, we noted that two commodes were heavily stained on the underside of the seat. One commode had a green label stating that it had been cleaned.
- Daily cleaning checklists were in place for Zone 2 (Majors). However, it was noted that there were repeated gaps in the checklist.
- A note was made in the staff meeting of 28 March 2014 that a mock inspection had been carried out in the ED in

which: "The department was dirtier, faeces found on the floor and there were dusty trolleys." Staff told us that there had been concerns about the standard of cleaning from the cleaning company. We discussed this with the manager and they told us that it was being addressed, and actions implemented to ensure a good standard of cleanliness.

- The ED and children's ED were both identified as areas of high risk, and as such, compliance with environmental audits was required to be 98% or above. An audit carried out in November 2013 resulted in an audit compliance score of 92% for the main ED and 97% for the children's ED.
- 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.
- We observed staff appropriately decontaminate patient's skin, in line with the trust policy, prior to the insertion of venous and/or arterial catheters.
- Staff washed their hands between each patient and we noted good usage of the hand sanitising gel.
- 'Bare below the elbow' policies were seen to be observed by all staff.
- The ED scorecard provided to us by the trust prior to our inspection (dated November 2013) demonstrated that there was, overall, inconsistent compliance from ED staff regarding the 'clean your hands' audit. The overall RAG rating (in which red/amber/green ratings are assigned to outcomes and priorities) for this area of audit was red, with 95% compliance being achieved in October 2013. Additional information provided by the trust following the inspection indicated that the ED had attained 100% compliance in February and March 2014. Compliance was reported as being as low as 50% during the September 2013 audit.
- A hand hygiene audit was routinely carried out in the children's ED. 100% hand hygiene compliance was attained each month between October 2013 and February 2014. However, it was noted that a drop in compliance had been noted for March 2014 when the department attained 78% compliance.

Environment

- Overall, the ED environment was found to be too small for the number of patients seen on a daily basis. Poor patient flow across the hospital impacted on the suitability and functionality of the ED.

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- During an unannounced inspection on 27 May 2014, we observed the resuscitation area to be full, with five patients. Zone 2 (Majors), was full to capacity. There was one patient receiving treatment in the plaster room and one patient, who was cervical spine immobilised, was waiting on a trolley in the corridor next to the nursing station. There were also nine patients who had been conveyed to the hospital by ambulance who were waiting in the cohort area. One patient was observed to be waiting for two hours before being moved from the cohort area to a cubicle space.
- Each of the 10 cubicles in Zone 3 was also noted to be full.
- One patient had been discharged from the ED and was waiting for ambulance transport. This patient remained on a trolley in the corridor, also next to the Majors nursing station. Upon the arrival of the ambulance crew, the patient experienced a delay of ten minutes, as there was no way for them to be transferred from the hospital trolley to the ambulance trolley while ensuring their privacy and dignity.
- At its busiest time during the unannounced visit there were 72 patients occupying the ED.
- Within the urgent care centre, patients were waiting approximately two hours to see a GP or emergency nurse practitioner.
- It has to be noted that the patients we spoke with during the unannounced inspection were accepting of the environment and spoke positively about the care and treatment they received. In addition, on the day of our unannounced inspection, the ED had received 11 trauma patients earlier in the day, which had caused further congestion within the ED.
- Within the Majors 2a area, a set of fire doors toward the rear of the department were blocked by clinical waste bins.
- We also noted that a lift, which was allocated as a 'fire lift only', was not of sufficient size to allow staff to transfer a patient on a bed or trolley in the event of an emergency within the department.
- We followed a patient who was required to undergo a magnetic resonance imaging (MRI) scan following a road traffic accident. The MRI scanner was situated in the Barry Building. We were required to use three separate lifts during the transfer, which took approximately 15 minutes. The transfer between the main hospital and the Barry Building required the team to escort the patient outside. Although a canopy had been fitted between the two buildings, we noted that a large section of the canopy was missing. On the evening of the transfer it was raining and, overall, the weather was inclement. The patient complained of pain on a number of occasions, due to the various wet floor and road surfaces encountered. Overall, the transfer was considered as a poor patient experience. Staff told us that it was routine for elderly patients to be transferred via the same route when they were admitted to wards in the Barry Building direct from the ED.
- The waiting area within the urgent care centre was not suitably designed so as to allow the triage nurse direct line of sight to patients who were waiting to be seen by a healthcare professional. However, we observed staff looking at patients on a frequent basis. One nurse we spoke with told us that they would scan each patient in the waiting room at the end of each triage. Where they noticed a patient who looked acutely unwell, they would intervene and liaise with the main department coordinator to prioritise the patient.
- The clinical decision unit and short stay ward had been separated into single-sex areas so as to provide privacy and dignity to patients who were admitted to those areas.
- Side rooms were available to patients who presented with a possible cross-infection risk. However, during the unannounced inspection on 27 May 2014, we observed one patient who had presented with nausea and vomiting, waiting with other patients in the cohort area. This patient had not been medically assessed so the cause of the nausea and vomiting was not known. A further Datix report indicated that two patients who had been conveyed to the ED by ambulance with symptoms of diarrhoea and vomiting were both held in the cohort area for periods of 30 minutes or more, before the triage nurse realised the possible risk that both patients presented.
- The parents, whose children were being treated at the Royal Alexandra Children's Hospital, ED told us that the parking facilities were inadequate.
- Within the Royal Alexandra Children's Hospital, there were adequate areas to meet the needs of different age groups. These included play areas for younger children and an area for adolescents. We noted that there was a 'baby waiting' area that included a private environment for women that were breastfeeding.

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Equipment

- There was adequate resuscitation and medical equipment. This was clean, regularly checked and ready for use.
- Portable ventilators were available in the resuscitation area. We found that these had been checked and were ready for use.
- Each bed space within the resuscitation area were designed and configured in exactly the same way. This allowed staff working within that area to be familiar with the bed space, which ultimately led to improved working during trauma and resuscitation events.

Medicines

- On two out of the three days we visited the department, both fridges (containing controlled drugs) were found unlocked within the resuscitation area and in Majors 2b.
- There was no evidence that the temperature of the fridge within Majors 2b was being recorded on a routine basis. However, there were daily temperature checks being carried out on the medication fridge within the resuscitation area.
- We were informed by the department matron that there had been significant issues with controlled drugs being unaccounted for. There were a total of four Datix reports, which directly related to missing controlled drugs between January and April 2014. A formal investigation was being conducted by the head of nursing and the issue was logged on the trust's risk register.
- Staff were observed carrying out the checks of controlled drugs between shift handovers.
- Within the Royal Alexandra Children's Hospital medicines were stored correctly in locked cupboards or fridges. We found that controlled drugs and fridge temperatures were regularly checked by staff working in the Royal Alexandra Children's Hospital.

Records

- We looked at over 50 set of notes during our inspection (some were current, others were provided by the trust from the previous week).
- A nursing document had been introduced into the main ED approximately two weeks prior to our inspection. This document included a range of categories, including skin assessment tools, social history assessments, falls risk assessments, trolley rail risk assessments, comfort rounds and space for nursing staff to record continuing care notes.

- We reviewed 10 nursing care booklets and found that in each booklet, various sections were incomplete. But what was of particular note, was that staff were not always recording comfort rounds, especially for those patients who had been in the department for eight hours or more.
- There were no nursing documentation booklets for patients who were seen in the department on 20 May 2014, as the department had run out of stock.
- We considered that the use of the nursing documentation would demonstrate best practice, but accepted that the booklets had not been fully embedded into the nursing practices of the department at the time.
- An audit of records was carried out by the matron on a monthly basis. The content of the audit included, whether the following information had been recorded: a full patient history, social history, previous medical history, a record of current medications the patient was taking, any allergies the patient suffered from and a list of property the patient arrived into the department with. Furthermore, a review was carried out by the matron to determine whether appropriate risk assessments were routinely carried out including, patient vital sign observations, Waterlow assessments (for monitoring possible skin pressure damage), a falls risk assessment, pain assessments, urinary catheter care bundles, intravenous line care bundles and nutrition screening tools.
- 100% compliance was attained for ensuring that appropriate observations were carried out on seven patients during April 2014. This included a full set of observations being recorded within 15 minutes of admission to the department, and an appropriate national early warning score (NEWS) was recorded and correctly calculated.
- During April 2014, it was noted that there was poor compliance with the completion of intravenous catheter insertion bundles being used, with only 25% of care bundles that were audited being completed in April 2014. Year to date (May 2013 – April 2014) data demonstrated an overall compliance rate with regards to the completion of intravenous catheter care bundle completion being 54.5%.
- There was poor compliance, with staff recording reassessed pain scores after analgesia had been administered to patients and only 25% of the audited patients being reassessed in April 2014.

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- We found that patients presenting with asthma-like symptoms routinely had their peak flow assessed on arrival. However, repeat peak flows were not routinely being recorded following the administration of medications to treat symptoms. The non-assessment of peak flows had been identified by the department and were recorded as an action in the March team meeting, because an asthmatic patient had been in the ED for approximately one hour and staff had not performed a peak flow on the patient.
- We saw that patient records within the Royal Alexandra Children's Hospital ED were completed appropriately, including risk assessments in accordance with what the patient presented with.
- The trust had a computer system that showed how long people had been waiting for and what investigations they had received. The system was seen to be updated regularly.
- Staff working in the children's emergency department had received level 3 safeguarding training.
- There was a named consultant and nurse for safeguarding within the department. The consultant told us that there were weekly peer reviews of all non-accidental injuries.
- 32 staff working with the main adult ED had attended either level 2 or 3 safeguarding children training but this had been rated as red by the trust, meaning they were in need of an update.
- 51% of staff working in the ED had received an update in safeguarding vulnerable children at level 3 within the previous 12 months.
- 46% of staff working with the main adult ED had received an update in safeguarding vulnerable adults during the previous 3 years.
- Staff raised concerns about the children's social work department being moved from on-site to an off-site location. They told us that they felt this would cause delays in a child being seen.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent forms were available for people with parental responsibility to consent on behalf of children who were not Gillick competent.
- We observed that consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent.
- The staff we spoke with had sound knowledge about consent and mental capacity.
- Training records demonstrated that 57% of clinical staff working within the ED had received training on the Mental Capacity Act 2005.
- Where people lacked the capacity to make decisions for themselves, such as those patients who had arrived into the resuscitation department unconscious, we observed staff making decisions which were considered to be in the best interest of the patient. We found that any decisions made were appropriately recorded within the patient care notes.

Safeguarding

- There were effective systems in place for the reporting of safeguarding incidents so that they could be appropriately investigated by the multi-agency safeguarding team. This included a double-check of all the children who attended the department during the day by the night staff, as well as a social worker the following morning.

Mandatory training

- Overall, compliance with mandatory training was found to be poor. For example, of the 86 staff who were required to undertake training in the administration of blood products every three years, only 37 staff (43%) had done so.
- 75 (66%) members of staff had attended fire safety training in the previous 12 months.
- Of the 177 staff who were required to undertake annual adult basic life support training, only 41 staff (23%) had done so.
- Between 2010 and 2014, the trust had trained 268 staff in advanced life support, 80 staff in the use of the European Paediatric Life Support (EPLS), 96 staff in the use of Advanced Paediatric Life Support and 159 staff in neonatal life support. These courses are recognised as advanced resuscitation courses and are provided by nationally-accredited training teams.

Initial assessment and management of patients

- Patients arriving by ambulance as a priority (blue light) call were transferred immediately through to the resuscitation area or to an allocated cubicle space. Such calls are phoned through in advance so that an appropriate team are alerted and prepared for their arrival.
- Patients arriving in an ambulance are assessed by an initial assessment nurse, who carries out baseline

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observations, from which a national early warning score is generated. Then an initial patient history and pain score is taken. The patient is then graded in line with the Manchester triage system to determine the acuity of the patient. If, during the initial assessment stage, the patient is identified as needing urgent and more intensive intervention, they are transferred though to the resuscitation area, or to another more appropriate area, depending on the availability of bed spaces.

- During part of our inspection, the department was observed to be very busy. There were insufficient cubicles to house all of the patients in the department and there was a delay in ambulance handover. In these situations, in order to allow ambulances to offload patients and resume work, patients were 'cohorted'. This refers to a practice where trolleys or wheelchairs are lined up within a designated cohort bay within the department. If there were more than five such trolleys, a Hospital Ambulance Liaison Officer (HALO) would supervise the patients.
- During our unannounced inspection, the local ambulance service were unable to provide a HALO, and so ambulance crews were required to wait with their patients, consequently depleting the number of available ambulances available to the ambulance dispatch team.
- When we asked the nursing team (including the senior nurses), medical team (including the clinical lead) and the paramedics who had overall responsibility for patients in these circumstances, we were given conflicting answers. Although they were booked into the department, nurses said that they did not provide care for these patients and treatment was not started while the patient was in this area. The doctors that we spoke with told us that they were unable to perform any investigations or begin any treatment on patients, while they were under the care of the ambulance service.
- One patient who had been 'cohorted', and who remained under the care of the ambulance service, had complained of pain upon arrival to the department. The paramedic caring for the patient told us they wanted to administer pain relief, but had been told not to by an ED doctor. We noted that this patient was required to wait one hour and 50 minutes before analgesia was offered, despite the patient complaining of pain.
- A second person who was in the cohort area, was identified as having a new presentation of a cardiac arrhythmia. This had been identified by the paramedic

who had performed an electrocardiogram (ECG) at the patient's home. The patient was seen by the initial assessment nurse within 10 minutes of arrival. No repeat ECG was performed, the patient was not placed onto a cardiac monitor and there was no evidence that the patient had been escalated to the shift coordinator or consultant.

- A third patient had arrived into the ED at 7:20pm by ambulance and was placed into the cohort area after being initially assessed at 8pm. The patient was noted to have a high temperature and an elevated heart rate. The patient remained in the cohort area until 8:40pm, before any intervention, such as antibiotics, were provided. This fell outside the department's own protocols concerning the management of patients presenting with signs of sepsis, who should receive treatment within an hour of presentation to the department.
- During our unannounced inspection, we observed the senior consultant ward round for the nine patients who were waiting in the cohort area. This 'rounding' took place only once during the two hours we were in the ED.
- A protocol entitled, Ambulance Handover 2014 was provided to us. It had been acknowledged by the trust that the cohort area was not fit for purpose and did not allow any privacy or dignity for patients who were waiting there. The revised process indicated that the first five patients within the cohort area would become the clinical responsibility of the Royal Sussex County Hospital. The exception to this would be when the ED was unable to provide a cohort nurse due to a lack of staff within the department. At this time, the patient would remain under the care of the ambulance service.
- The process of 'cohorting' was described by staff as, "The most shameful part of our work," and, "We do not feel the area is safe." Staff said they felt it was "morally wrong".
- Patients who walked into the department were seen, in the first instance, by a receptionist, who would then direct the patient to a triage area within the urgent care centre. Patients were then reviewed by a senior nurse, before being placed into a specific patient care pathway, such as, to Minors or Majors, depending on the urgency of their condition. Patients requiring an urgent review (for example, those exhibiting chest pain) would undergo an ECG immediately.

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Management of deteriorating patients

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

Nursing staffing

- In response to a review of the nursing establishment and departmental requirements, the overall number of whole time equivalent (WTE) posts had increased from 106.3 in 2013/2014 to 125.1 WTE in April 2014.
- The total number of vacancies as of April 2014 was 30.2 WTE (24.1%). 14.1 WTE posts were attributed to newly-created posts.
- The average sickness rate amongst the ED nursing team between May 2013 and March 2014 was 6.6%.
- The average staff turnover rate amongst the ED nursing team between May 2013 and March 2014 was 10.3%.
- The department employed 11.4 WTE emergency nurse practitioners, which was 0.4 WTE over the budgeted establishment.
- The department was supported by one full-time practice educator, whose role it was to support staff and to facilitate learning within the department.
- The average sickness rate amongst the ENPs between May 2013 and March 2014 was 8.9%, there was a 0% turnover of ENPs during that same period.
- Bank and agency receive a local induction prior to starting their shift. Evidence of this was seen at the time of our inspection.
- Shifts in the main ED were staffed with a mix of band 7 sister/charge nurse grades, who were in charge of the shift, with band 6 and band 5 nurses, healthcare assistants and student nurses completing the team. We saw that the head of nursing was actively recruiting new nursing staff into the ED.
- We were told by staff, that the department had seen a regular turnover of senior nursing management in recent years. The current head of nursing and ED matron had both been in post for approximately ten months, having been seconded from the critical care unit. The secondments were due to finish in June 2014

and there was noticeable anxiety amongst the nursing and medical team that, due to internal restructuring, the head of nursing post may have been at risk. We were advised by the chief executive that the organisational restructuring was currently in the pre-consultation stage, and it was noted that the chief executive had been clear that each division would have the opportunity to design their management structure however they felt would best suit each department.

- We were told that the department had not historically appointed band 6 nurses. At the time of the inspection, there were 20.59 WTE band 6 nurses in post. We saw that the band 6 team were undertaking competency assessments as a number of band 6 staff had been appointed without any recognised post-graduate ED qualifications.
- During each day shift, the department was supported by 18 registered nurses and five healthcare assistants. At night, this reduced to 17 registered nurses and five healthcare assistants.
- When the department was fully staffed, three nurses were allocated to specific cubicles with the Majors 2a cubicle, with one floating nurse and one shift (board) coordinator. Two registered nurses were allocated four cubicles each in 2b, with one nurse coordinating the area. The coordinator from 2b was also responsible for overseeing Zone 4 patients, who were waiting for reviews from specialist departments, but who had been assessed as low acuity. One nurse was allocated to the patient assessment and triage (PAT) area and one nurse was allocated as the cohort nurse. In addition, one band 6 or senior band 5 nurse was allocated as the triage nurse and the department was supported by emergency nurse practitioners who worked a range of day shifts covering from 7pm to 11pm Monday to Sunday. The resuscitation area was staffed by a set team of experienced nurses, with a number of band 5 nurses rotating through the area so that they could develop their nursing skills. The resuscitation area was allocated to three nurses per shift. The clinical decision unit (CDU) and short stay ward (SSW) were both staffed by one registered nurse and one healthcare assistant in each area.
- We saw that the department was consistently reliant on bank and agency staff to ensure that the unit was safely staffed.

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- Item 2 on the ED risk register related to the high usage of bank and agency staff, with as many as four staff being booked on each shift to meet the department's requirements.
- Members of the senior nursing team were concerned that it was often difficult to fully staff the department. At times, it was not always possible to allocate a nurse to the cohort area to oversee the first five patients within that area. This was seen to impact on patient care because, as per the local ambulance handover/cohort protocol, where a nurse was not available, the ambulance crew would remain responsible for the patient, and so staff could not commence any treatment until a cubicle space became available within the department.
- Between January and April 2014 there were 24 Datix incident reports in which it was reported that the ED was not fully staffed, with some shifts short staffed by as many as four registered nurses on one occasion and three registered nurses on three occasions.
- During our unannounced inspection on 27 May 2014, the department was understaffed by four registered nurses. A senior nurse from another division was seen to be supporting staff in the ED. However, we observed the department to be chaotic, due to the sheer volume of patients in the ED. We saw that the nurse in charge was working under extreme pressure to ensure the department ran as smoothly as possible and to ensure patients were kept safe.
- Staffing in the children's ED was adequate, unless there was a high use of the resuscitation room or children being cared for in the short stay unit. This unit was in the emergency department. We noted that there was no allocated nurse for the resuscitation room and nurses were moved from the area they were staffing in order to manage this area.
- We noted that the nurse allocated to manage the children's short stay unit also managed the children's Majors area in the department. There were six beds in the children's short stay unit. This meant that there was no allocated nurse to work exclusively in the unit.
- There was an adequate skills mix in the children's department, with a minimum of at least one band 6 nurse on duty at all times.
- Two children's emergency nurse practitioners worked from 9am until 10:30pm.

- There was a children's nurse consultant who supported the department clinically and provided education for the nursing staff.
- The children's emergency department was 2.5 WTE registrars short.

Medical staffing

- Medical staff working in the children's ED during the day consisted of: consultant cover, one registrar and three senior house officers (SHOs). The SHOs were F1 or F2 junior trainee doctors. Night-time cover consisted of one registrar and one SHO. A children's emergency department consultant would be on-call.
- The consultant on-call at the weekend was also responsible for undertaking the ward round on the children's high dependency unit.
- The department employed 17 consultants, who were present on the unit 24 hours per day, seven days per week.
- We observed board rounds taking place so as to ensure that the consultant in charge was aware of each patient in the main ED department.
- Overall, junior doctors spoke positively about working in the ED. They told us that the consultants were supportive and always accessible.
- The consultant team met weekly to discuss any operational issues, including any foreseeable medical staffing problems that required resolving, so as to ensure the department was suitably covered with medical staff.
- We were told that, when compared to other regional trauma centres, the Royal Sussex County Hospital was understaffed. However, the consultants we spoke with were positive about working at Royal Sussex County Hospital and were proud that they could provide 24-hour cover each day.

Major incident awareness and training

- The hospital had a major incident plan (MIP), which had last been reviewed in January 2014. The MIP provided clinical guidance and support to staff on treating patients of all age groups and included information on the triaging and management of patients suffering a range of injuries, including those caused by burns or blasts.
- We saw that the ED provided annual training on decontamination procedures. The ED staff were divided into six teams, and so the decontamination process was rehearsed six times each year.

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- One senior nurse, who was in charge of the ED, was unaware of where the major incident action cards were kept, or the location of the hospital's major incident store. However, other staff that we spoke with were knowledgeable about the major incident plan and of their roles and responsibilities in the event of a major incident being declared.
- The children's ED formed part of the trust's major incident plan.
- We were told that a 'desktop' major incident exercise was next scheduled to take place on 20 June 2014.

Security

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

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

The ED had an ongoing programme of auditing, which encompassed both national and local audits. Policies and procedures were developed in conjunction with national guidance and best practice evidence from professional bodies such as the College of Emergency Medicine, the National Institute for Health and Care Excellence (NICE) and the Resuscitation Council UK.

There was evidence of strong multidisciplinary working, with a noted area of good practice being attributed to the Royal Sussex County Hospital rapid discharge team, which was funded and delivered by Brighton and Hove Social Services. This service was fully integrated into the ED and was seen to produce positive outcomes for patients using the service.

Evidence-based care and treatment

- Departmental policies were easily accessible on the trust's intranet, which staff were aware of and reported they used. In addition, the ED introduced 'emergency

prompt cards' into the department in March 2014.

Prompt cards were observed to be readily accessible throughout the department and staff were observed to be using them during our visit.

- The emergency prompt cards contained approximately 29 separate protocols and/or guidance to help support staff. For example, prompt cards 12 to 17 referred to advanced resuscitation algorithms (or, a step-by-step procedure based on a set of guiding principles), which had been endorsed and published by the Resuscitation Council UK in 2010.
- Other departmental guidelines and policies had been written in conjunction with guidance and evidence provided by the NICE and the College of Emergency Medicine (CEM).
- A protocol was in place to support staff undertaking rapid sequence inductions (RSI), this is a medical procedure involving a prompt induction of general anaesthesia and subsequent intubation of the trachea. We observed this protocol and checklist being used on one patient during our inspection. The use of the RSI protocol had been audited by the ED; the audit demonstrated an increase in the use of the RSI checklist between 2012 and 2013. During 2012, the RSI checklist was used on 15 out of a possible 70 occasions (compliance rate of 21%), as compared with it being used on 30 occasions out of a possible 80 in 2013 (compliance rate of 45%). It was noted that a requirement to record the use of the RSI checklist was discontinued in October 2013, so it was considered by the ED team that the use of the RSI checklist was likely to be higher. The lead nurse for resuscitation had made the decision to source a stamp which could be used by staff to record the use of the RSI in the future.
- In addition to the RSI checklist, the department also utilised a procedural sedation checklist. During 2012, the checklist was reported to have been used on 89 patients out of a possible 154 (compliance rate of 58%). During 2013, the use of the procedural sedation checklist had increased to 142 out of a possible 162 cases (compliance rate of 88%). The use of the various checklists and emergency prompt cards were considered to reduce the overall number of incidents directly attributed to human factor errors, and ultimately improve patient safety.
- The ED participated in a number of national audits, including those carried out on behalf of the College of Emergency Medicine. Results from the 2013 College of

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Emergency Medicine clinical audit relating to 'consultant sign-off' was compared with the same audit in 2011 to determine whether the ED had made any improvements. The CEM consultant sign-off audit measures a number of outcomes, including: whether a patient has been seen by an ED consultant or senior trainee in emergency medicine prior to being discharged from the ED when they have presented with non-traumatic chest pain (17 years of age or older), children under one year of age presenting with a high temperature and patients who present back to the ED within 72 hours of previously being discharged by an ED.

- During 2011, the number of patients seen by a consultant was 4%, versus a national average of 12%. This had increased in 2013 to 22% of patients being seen by a consultant. The national average was 14%.
- During 2011, the number of patients who were discussed with an ED consultant prior to discharge was 16%, versus a national average of 12%. In 2013, this had increased to 25% of patients being discussed with a consultant, versus the national average of 13%. The number of patients discussed with a senior trainee emergency medicine doctor was 72% in 2013, versus the national average of 36%.
- The number of ED notes reviewed by an ED consultant following discharge was reported as 0% in 2011, versus a national average of 7%. This had improved significantly in 2013, with 22% of ED notes being reviewed, versus the national average of 7%.

Pain relief

- The ED participated in two College of Emergency Medicine CEM audits, which included the management of moderate or severe pain. The management of patients presenting in moderate or severe pain caused by renal colic and the College of Emergency Medicine clinical audit into the management of fractured neck of femur.
- 96% of patients who presented to the Royal Sussex County Hospital ED during 2012-2013 complaining of pain as a result of renal colic, had a pain score recorded. This placed the ED in the upper quartile (quartiles are the values that divide a list of numbers into quarters) when compared nationally. Although, the department did not meet the CEM standard of 100% of patients presenting with moderate or severe pain having a pain score recorded.

- 19% of patients who presented in severe pain with renal colic were provided with analgesia within 20 minutes of arrival. This placed the ED in the lower quartile when compared nationally (the median was reported as 24% nationally). The department was also placed in the lower quartile for patients receiving analgesia within 30 minutes (39%) and 60 minutes (68%). The median for patients receiving analgesia within 30 and 60 minutes was reported nationally as 41% and 73% respectively. The CEM standards recommend that 50% of patients presenting in severe pain with symptoms of renal colic, should receive analgesia within 20 minutes, 75% within 30 minutes, and 98% within 60 minutes upon arrival to the ED.
- Pain scoring tools, relevant to the child's age, were used in the children's ED.
- We saw evidence that pain was appropriately assessed and managed within paediatrics. This included the further assessment of pain following pain relief.
- We noted that there were distraction therapies for children in the children's ED. These included 3D televisions, sensory equipment, bubbles and music. The department had a play therapist who assisted in the management of children who were in pain.

Nutrition and hydration

- We observed staff providing drinks and snacks to patients during our inspection.
- Nutritional risk assessments were undertaken, as required. Where food or drink had been offered, this had been recorded in the patient's emergency department care record. A review of the April 2014 nursing metric for the ED indicated that of the three case notes reviewed, two out of three patients had documented evidence that food or drink had been offered. In addition, where patients were listed as nil by mouth, this had been recorded within their notes.
- The ED nursing documentation booklet provided staff with a prompt to carry out a full skin integrity assessment, so as to protect patients from the risk of skin pressure damage. Five out of a possible seven patients had been recorded as having a documented Waterlow score completed within four hours of admission to the emergency department. Six out of seven patients audited were noted as having a recorded pressure area assessment within their care notes in April 2014.

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- Following the assessment of a patient, intravenous fluids were prescribed and recorded, as appropriate.

Patient outcomes

- The CEM recommends that the unplanned readmission rates for EDs should be between 1 and 5%. The national average is around 7%, which the trust has exceeded since March 2013. Their rate in December 2013 was 8.6%.
- Guidance from the NICE Head Injury Guidelines (2007) recommend that all patients who present to a trauma centre having sustained a head injury, and who have a reported Glasgow Coma Scale score of 13 or less should undergo a computerised tomography (CT) scan within one hour of arrival. Between January 2011 and December 2013, 106 patients who met these criteria were admitted to the Royal Sussex County Hospital. All 106 patients received a CT scan of their head within one hour, with the reported median time from arrival to scan being reported as 0.65 hours, which was comparable with the national average.
- The Royal College of Surgeons and the British Orthopaedic Association consider that the examination of the chest is a fundamental component of the cardio-pulmonary assessment of the seriously injured patient and such an assessment should be supervised by a senior, experienced clinician. The Trauma Audit and Research Network (TARN) monitor the number of patients who undergo a chest examination having sustained a cardiothoracic injury. Between January 2011 and December 2013, 300 patients were admitted to the Royal Sussex County Hospital ED, having sustained an injury to their chest. 86.9% of patients were examined by a consultant grade clinician. This was significantly higher than the national average of 63.2%.
- Clinical staff working in the children's ED were observed to undertake regular local audits concerning the different conditions the child presented with. These included children with bronchiolitis, diarrhoea, vomiting and eating disorders.
- The CEM audit data for 2012-2013 demonstrated that the ED met two out of a possible six CEM standards regarding vital signs being recorded as part of a routine assessment for children under the age of five presenting to the ED with a fever. The ED attained 100% compliance with ensuring that a pulse rate and temperature were recorded for each child who met the CEM audit criteria. This was a significant improvement on the department's

performance during the previous audit period of 2010 when only 30% of children had a pulse rate recorded in their notes and 84% of children who had a temperature were recorded as such.

- The CEM standards recommend that parents or carers who present to the ED with a feverish child under the age of five are provided with written discharge advice. The 2010 CEM audit indicated that the department routinely issued this advice. However, we noted that the 2012 audit data suggested that this was no longer the case; the trust had responded 'No' to the question: Does ED have written discharge advice for parents/carers?

Competent staff

- Appraisals of both medical and nursing middle grades and consultants were being undertaken and staff spoke positively about the process.
- There were conflicting figures for the number of nursing staff that had received an appraisal during the past 12 months. Departmental figures showed that the majority of staff had received their appraisal in time, whereas the human resources department figures showed that only 34.5% of staff had received their appraisal. We spoke about this with the departmental manager. They told us that they thought the discrepancy was due to a delay in updating the system in the human resources department.
- We spoke with junior doctors, who told us that they received regular supervision from the emergency department consultants, as well as weekly teaching.
- 90% of the nursing staff had undertaken the Advanced Paediatric Life Support (APLS)/European Paediatric Life Support (EPLS) training, and there were numerous instructors.
- We saw evidence that staff were supported in maintaining their competence and had training and education in the use of patient group directives (PGDs) for the transcribing of medicines, intravenous fluids and cannulas, venepuncture, plastering, triage, mentorship and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER 2000) regulations.

Multidisciplinary working

- There was effective multidisciplinary working within the emergency department. This included effective working relations with speciality doctors and nurses, social workers, GPs and physiotherapists.
- The main ED was supported by a hospital rapid discharge team (HRDT), which was funded by Brighton

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and Hove Social Services. The team consisted of social workers, specialist nurses, physiotherapists and occupational therapists. They were based within the ambulance cohort bay Monday to Friday. We observed close working relationships between the HRDT and the ED teams. Their role was to facilitate the early discharge of patients who may have otherwise been admitted to a ward while waiting for an appropriate care package to be organised prior to their discharge. We observed the HRDT organise mobility equipment for a patient who had fallen at home, but who had otherwise been identified as low risk and could have been discharged from the ED once they had received their equipment. In addition, the HRDT were able to organise for a home care team to review the patient the following day to ensure they were safe and mobilising well at home. We considered this approach to multidisciplinary team (MDT) working to be highly responsive and an area of outstanding practice.

- We observed close working relationships between the nursing and medical staff within the ED. The trauma team were seen to integrate well with the resuscitation team, as did the anaesthetic team.
- There appeared to be a good working relationship between the ED team and members of cardiology, orthopaedics and acute medicine.
- It was reported to the inspection team that working relations between the emergency nurse practitioners and the band 7 nursing team were “strained”. There were concerns that the emergency nurse practitioners were working independently from the rest of the ED workforce. This was a repeated theme recorded within the ED shift handover forms and also reported within a Datix incident form.

Seven-day services

- The department had access to radiology support 24 hours each day, with full access to CT and MRI scanning.
- Consultant ED physicians covered the department 24 hours per day, 7 days per week.

Are accident and emergency services caring?

Good



Overall, the ED provided a caring and compassionate service.

We observed staff treating patients with respect. However, we noted that when the department was under pressure, the priority was for the nursing and medical staff to provide emergency care. Therefore, it was the perception of some patients that staff did not display a caring attitude at all times.

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

Compassionate care

- In 2012, CQC carried out a survey of patients who used A & E services. We asked 850 people to rate their experiences of the ED services provided by Brighton and Sussex University Hospitals NHS Trust. We received 326 completed surveys.
- The trust scored an ‘average’ rating for 33 out of 35 questions. Of two questions, specifically ‘Not being told one thing by a member of staff and something quite different by another’ and ‘For not feeling threatened by other patients or visitors’, both scored a below average rating when compared to other trusts nationally.
- The trust performed significantly below the England average for the NHS Friends and Family Test. In December 2013, the trust scored 10 as compared with the England average of 56. In November 2013, the ED scored 45 as compared to the national average of 56.
- The ED management team acknowledged the return rate for the NHS Friends and Family Test to be poor and were trying to address this. In February 2014, the trust return rate was 12.2%, as compared to 18.6% nationally.
- We witnessed multiple episodes of patient and staff interaction, during which, staff demonstrated caring attitudes towards patients.
- Staff were attentive to both the child's and parents' needs at the Royal Alexandra Children's Hospital ED.

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- One child we spoke with said, “The nurses and doctors are really nice.”
- One parent we spoke with said, “We have been to the emergency department before. All of the staff are always excellent.”
- Between April 2013 and December 2013, the main adult ED received 16 complaints, which were attributed to poor staff attitudes.

Patient understanding and involvement

- There was clear information on the notice board in the reception area of the Children’s ED about the different pathways of care from triage. These included: being seen by an emergency department doctor, an ENP, out-of-hours GP service or the speciality doctors. The information also included the different designations from discharge.
- The children and parents we spoke with all said that they had been involved in the planning of their care and had understood what had been said to them.
- Patients and relatives told us that they had been consulted about their treatment and felt involved in their care.

Emotional support

- We observed staff giving emotional support to both children and their parents.
- There was a play therapist to help meet the emotional needs of the child.

Are accident and emergency services responsive to people’s needs?

(for example, to feedback?)

Inadequate



The department required improvement to cope with its routine workload, but is inadequate in coping with surges of activity, which occurred on a regular and potentially anticipatory basis. The department’s capacity was listed as the highest risk on the departmental risk register.

There were a number of contributing factors as to why the ED consistently failed to achieve the four-hour target. This included: a lack of available inpatient beds, delays in

making decisions to admit patients, delays in the transfer of patients and finally, an increase in the clinical acuity of patients accessing the ED, which resulted in patients remaining in the department for longer.

Many of these issues were longstanding and were brought to the trust’s attention following a visit from the Emergency Care Intensive Support Team (ECIST) in January 2013, alongside suggestions of how to make improvements. While there have been some areas of improvement, the trust has failed to sustain a suitable momentum in delivering the Emergency and Unscheduled Care Programme.

Service planning and delivery to meet the needs of local people

- Between January and March 2013 the ED at Royal Sussex County Hospital experienced a high number of patients who breached the 12-hour national target. So, once a decision had been made to admit a patient, that patient would be moved to an inpatient bed within 12 hours. In response to the high number of breaches, the trust invited the Emergency Care Intensive Support Team (ECIST) to review the EDs emergency care pathways.
- ECIST made a number of recommendations to the trust, which, once implemented, would likely help resolve some of the access and flow issues experienced by the department. In response to the ECIST recommendations, a new project was endorsed by the trust Emergency and Unscheduled Care – Right Care, Right Place, First Time - Implementation Plan. We saw that the plan had five work streams, each of which had a number of action plans to which key individuals had been assigned as having responsibility. The trust had a ‘Patient Flow and Escalation Policy’, which was reviewed in March 2014. The purpose of the policy was to ensure that: “All patients are admitted to the right place at the right time, first time.”
- The policy included a description of who within the site team should be contacted when there were delays to patient flow.
- The ECIST team noted that delays in speciality review were a consistent theme for the trust. It suggested that internal professional standards should be agreed with speciality teams, in line with Royal College of Nursing guidance that ensures speciality teams reviewed patients within 30 minutes. We found that, while patients were reviewed by junior specialist doctors, a

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decision to admit a patient could only be made by a senior clinician. The staff in the ED told us that it was this part of the process that caused congestion to the emergency care pathway. Some clinicians within the ED believed that the lower levels of senior staff working out-of-hours and at weekends were a contributing factor. Two senior staff that we spoke with suggested that the root-cause of the issues within the ED may have been the failure of some specialities to adopt a seven day working week.

- A presentation was given to the board of directors on 24 February 2014, which described the progress that had been made on the Emergency and Unscheduled Care Implementation Plan. It was acknowledged that there had been an improvement in the overall length of time patients were waiting in ED, with no reported 12-hour breaches. However, it was recognised that the number of four-hour breaches had continued to be higher than the national average.
- Progress had been made on the admission of patients who required only short-term acute medical input, with more referrals made to the medical assessment unit.
- A review of surgical pathways had commenced in December 2013, after the successful appointment of a nurse coordinator. It was recognised that the ED did not have a formal surgical assessment unit at the time of the inspection. The nurse coordinator was tasked with creating a pathway based on other nationally successful programmes, which would allow patients to be referred to a formal surgical assessment unit. This work remained incomplete at the time of our inspection.
- Additional surgical registrars were reported to have been appointed to cover peak times and a new surgical on-call rota had commenced on 10 February 2014. The expectation was that increased surgical cover would allow for earlier senior clinical reviews and, therefore, enhance the emergency surgical pathway. Data provided by the trust indicated that patients continued to experience delays in receiving a decision to admit once they had been referred to a specialist team. We found that the time taken to make a decision to admit a patient after they had been referred to a specialist team had increased from 89.72 minutes in May 2013 to 166.53 minutes in April 2014, with only a mild improvement in November when the time reduced to 105.18 minutes.
- Work stream 4 of the Emergency and Unscheduled Care Implementation Plan was noted as being the “most challenging of the work streams”. Work stream 4 related

to the ‘Early daily inpatient review and decision-making’ to enable improved discharge of patients earlier in the day, as compared to patients being discharged late in the afternoon or early evening. There appeared to be no defined or robust action plan presented to the board to assist in resolving the issues associated with work stream 4.

- Staff within the children’s ED were working with the local Clinical Commissioning Groups (CCG’s) in the auditing of ‘appropriate’ attendance to the ED. Specifically, they were looking at whether children with constipation, fever and asthma could be managed elsewhere using urgent care pathways instead of patients attending the ED.
- The consultant within the children’s ED told us that during busy times the consultants would work clinically for as long as they needed to. This enabled the department could ‘flex up’ if demand from increased attendance was required.

Access and flow

- Following the review of the ED by ECIST in January 2013, there was a slight improvement in the weekly performance of the department in being able to see, treat, discharge, admit or transfer patients within four hours of arrival. This improvement took effect in May 2013 with 96% of patients being seen and discharged or admitted within four hours. The ED has failed to meet the national target of 95% since May 2013, with the lowest performance rate being reported as 89.5% in December 2013 and the highest being 94.2% in June 2013.
- The children’s ED had consistently achieved the four-hour target, with performance being reported as high as 100% in April, May and November 2013.
- According to the NHS England winter SitRep data for the month of March 2014, the trust had 587 occurrences where ambulances waited more than 30 minutes to handover their patient to the ED. Data provided by the trust indicated that 491 ambulances had experienced delays of 30 minutes or more, although this data had not been formally validated by the trust. 53 ambulances were reported to have experienced delays of 60 minutes or more in March 2014, but again, this data had not formally been validated by the trust and the local ambulance service.

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- NHS England also requested trusts to measure the percentage of emergency admissions waiting four to 12 hours from the decision to admit (DTA) until admitted.
- In addition, we were told by multiple sources (and witnessed ourselves) that there was often a delay of several hours until a decision to admit was made. Thus, the patient could be in department for over 12 hours, but this would not be considered a 12-hour breach, as it fell outside the nationally set definition of a 12-hour breach.
- A Datix report dated April 2014, indicated that two patients had both been in the ED for over 18 hours awaiting an inpatient bed. The department confirmed to us that these would not be considered to be 12-hour breaches.
- The national average for percentage of patients that leave the department before being seen (recognised by the Department of Health as potentially being an indicator that patients are dissatisfied with the length of time they are having to wait) is between 2-3% (December 2012-December 2013). Data provided to us indicated that the ED consistently performed better in this outcome, with the overall number of patients reported as leaving the department before being seen for treatment being as low as 2% in December 2013.
- Between September 2013 and February 2014, staff reported 40 incidents relating to capacity concerns within the ED.
- A Datix report of 28 April 2014 reported that up to 12 patients were waiting in the cohort area for up to four hours before being moved to a cubicle.
- On 24 April 2014, approximately 15 breaches of the four-hour target were reported, as a Datix with the contributing factor being insufficient space for patients to be seen and assessed by speciality doctors within Zone 2b or Zone 4.
- On a separate occasion, a patient who had been identified by the ambulance crew as requiring a bed space within resuscitation experienced a cardiac arrest within 10 minutes of arrival into the department. There were no free bed spaces within the resuscitation room, as all bed spaces were full with acutely unwell patients. Staff were required to treat the patient in a cubicle within Zone 2.
- The staff working within the Royal Alexandra Children's Hospital reported problems with access and flow from the short stay unit. We saw evidence that some patients

were in the unit for 30 hours despite the trust's policy stating a maximum time of 24 hours. We were told that the problem occurred when there were no medical beds for children to be transferred to.

- The trust has a clinical site management team which covers the RSCH and RACH. There is a paediatric bleep holder for RACH. This is an allocated band 6 or 7 children's nurse who is the bleep holder and manages operational and clinical problems, including patient flow as they arise. The staff told us that the pager holder also had their own clinical responsibilities and because of this could not adequately address the patient flow problems unless they left their clinical role.
- The staff told us that there were often delays in transferring patients to the children's HDU. This was confirmed by the staff in HDU who told us that they had delays in transferring children out of the unit because there were no available beds on the wards.
- The ambulance waiting times at the Royal Alexandra Children's Hospital were within the acceptable range.

Meeting people's individual needs

- Staff had access to translation services by way of a telephone interpreter system. Staff reported that this system worked well whenever they were required to use it.
- The department was supported by a drug and alcohol team who were situated in the department and could offer advice to patients.
- We were told that access to mental health services were good. We saw that staff could contact the Mental Health Liaison Team to provide input to any patients who required mental health assessments.
- There was evidence of dementia screening being undertaken within the ED department, however, this was not always consistent.
- Children's needs were met by the provision of a play specialist, age appropriate toys and activities, separate waiting areas for different age groups and different pain scoring tools.
- The needs of breastfeeding mothers were met through the provision of a private room for mothers and babies.
- Translation services were available across the trust for people whose first language was not English.
- The needs of parents staying with children on the short stay unit were not always met. Parents told us that there were no arrangements for them to sleep on the unit other than in a chair or on the floor. We discussed this

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with the departmental manager. They told us that the unit did not have beds for parents because its purpose was as a short stay unit however recliner chairs were available.

- The trust had been in black alert on 17 occasions, red status on one occasion, amber twice and green zero times in May 2014. According to the trust 'Patient Flow and Escalation Policy', black status means that there is a very high risk to patient safety and overall patient experience. Contributing factors that would trigger a black alert include but are not limited to, the overall number of discharges as being insufficient to meet demand, the emergency care pathway being significantly compromised, ambulances unable to offload their patients and ED patients with decision to admit times exceeding eight hours.

Learning from complaints

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint, then they would speak to the shift coordinator. If the concern was not able to be resolved locally, patients were referred to the Patient Advice and Liaison Service, who would formally log their complaint and would attempt to resolve their issue within a set period of time. PALS information was available within the main ED.
- The matron and head of nursing for the main adult ED told us that all complaints were logged onto the trust's incident reporting system and we saw evidence of this. Complaints were investigated by the matron or other senior staff within the department, such as the clinical lead, when the complaint related to a member of the medical team.
- Each band 7 nurse within the main adult ED department were responsible for the line management of a smaller team within the ED. We saw that complaints were discussed as part of team meetings in order that people could learn from complaints.
- We were told that, since the main adult ED consultants had moved to a 24/7 staffing rota, the overall number of complaints received by the PALS team, which were directly attributed to the ED, had reduced significantly.

Are accident and emergency services well-led?

Requires improvement



Staff at all grades were proud of working for the service. However, it was noted that due to the sustained pressures and conditions that staff were working under, the workforce was becoming disengaged and demoralised, especially amongst the senior nursing team. There was an exceptional reliance on the nurse in charge when the department was under pressure.

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

Vision and strategy for this service

- The ED and wider hospital had undertaken a plethora of changes to enhance the overall quality offered by the emergency care pathway. However, it was evident that while some initiatives had been beneficial, such as the redevelopment of the Majors area and introduction of the two patient assessment and triage (PAT) areas within the cohort area, there was a lack of sustained momentum in ensuring the delivery of the Emergency and Unscheduled Care Implementation Plan.
- There was anxiety amongst all grades of staff regarding the proposed organisational restructure which was in the pre-consultation stage.
- We found that work on the vision and strategy for the children's ED service was ongoing, with a proposal from the paediatric services to become their own directorate.
- The staff that we spoke with were aware of the chief executive's values and behaviours. The staff had a clear understanding of what these involved and were optimistic that, if successful, the initiative would help address some of the wider cultural issues within the trust.

Governance, risk management and quality measurement

- Quarterly departmental governance meetings were held, during which, clinical incidents and complaints were reviewed. In addition, the clinical lead for ED attended the executive monthly safety and quality meeting and also the weekly safety and quality team incident review meetings. We were provided with the

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minutes from the two most recent ED clinical governance meetings and also the minutes from the April 2014 executive Quality and Safety meeting. It was not clear from the minutes we were provided with whether matters such as those areas of risk recorded on the department risk register were discussed. It was therefore not possible for us to determine how the department was managing those risks.

- Senior clinicians also attended divisional mortality and morbidity meetings.
- Within the children's ED, there were monthly meetings to discuss clinical governance issues, which were attended by the ED consultants, senior nursing staff and managers. Information from these meetings was cascaded to other staff through staff meetings and teaching sessions.

Leadership and culture within the service

- Oversight for the department was in the form of a triumvirate, including a clinical lead (an ED consultant), a nursing lead (an interim senior head of nursing) and general manager.
- It was apparent that the department operated on a medical model, with the clinical lead assuming overall responsibility for the department. The clinical lead spoke positively about the nursing lead and believed that the department's leadership team were united in improving the overall quality of the service.
- Staff repeatedly spoke of a 'flattened hierarchy' within the department. We observed staff of all grades engaging with the clinical lead.
- There was a supernumerary nurse in charge (NIC) for each shift in the department. We were told, and witnessed, during our unannounced inspection, an overreliance on the NIC, especially when the department was under pressure.
- Significant, sustained and unrelenting pressures within the department had impacted on the staff we spoke with and discussions revealed a tired and in some cases, disengaged and demoralised workforce within the adult ED. Despite this, staff still spoke passionately about working for Brighton and Sussex University Hospitals NHS Trust. It was evident, however, that staff were frustrated that, due to circumstances far beyond their control, they could not always deliver the best level of care that they were capable of, when the department was under pressure.

- We saw that when the department was under control, there was a high level of decorum and calmness within the department. Staff were observed to be relaxed and were able to spend time with patients and relatives, providing care and support in a friendly and compassionate manner.
- The staff we spoke with in the children's ED told us that they thought leadership at a local level was good and proactive.
- However, there were concerns within the children's ED about leadership at a higher level within the children's directorate, with staff feeling that this level of leadership was weak. One member of staff said, "Difficult conversations are avoided and things are not addressed as they should be."

Public and staff engagement

- There was no evidence displayed in the department of changes made as a result of patient feedback (as with 'You said, we did').
- The staff that we spoke with were not aware of any public engagement groups or other initiatives whereby input from patients was sought to help improve the overall ED experience.

Innovation, improvement and sustainability

- We spoke with the nurse consultant for children who told us about the different research projects that had been, and were being, undertaken within the children's department. At the time of the inspection, research was being undertaken concerning the different presentations of children with bacterial or viral illnesses.
- All of the staff we spoke with said that the consultants and senior nurses encouraged change and innovation.
- Junior doctors were seen to be involved in the department's ongoing audit programme.
- The introduction of the emergency prompt cards was seen as an area of good practice within the department. This initiative was being coordinated by a national lead in patient safety.
- It was apparent from the evidence we reviewed, and from the discussions we held with staff, that the most pressing area of concern, which required sustained intervention, was the cohort bay within the main ED and the poor patient flow across the rest of the hospital. Staff described the issues of both patient flow and the

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cohort area as “having backlogs at both the front door and back door”. Further engagement with the local CCG’s and wider socio-health economy were needed in order to address the issues experienced by the RSCH ED.

Medical care (including older people's care)

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

Information about the service

The acute medical division at the Royal Sussex County Hospital had eight medical wards and further specialist medical wards, including a 36-bed acute medical unit (AMU).

We visited 16 areas that deliver medical or specialist care. These included acute cardiac care, digestive diseases and diabetes wards, the stroke ward, care of the elderly and dementia care and the infectious diseases ward. We also visited the ambulatory care department, the seven-bed escalation ward (Overton Ward) and the discharge lounge. We looked at other areas used when the capacity of the hospital was not able to place patients in the correct wards.

We talked with 28 patients, three relatives and 38 members of staff. These included consultants, doctors, junior doctors, all grades of nursing staff, healthcare assistants, domestic staff, pharmacists, Allied Healthcare professionals and management.

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

Summary of findings

Medical care services were delivered by caring and compassionate staff who were dedicated to providing the highest possible standards of care under some difficult circumstances. An inability to staff some wards to the identified safe levels and with the correct skills mix at all times, meant that staff felt care and treatment was not always safe and placed patients at risk. The management of patients not admitted to the correct ward due to capacity issues, placed patients at risk of not receiving the right care. While staff reported concerns and incidents, very limited feedback was evident to make positive changes. Improvements were needed in the management of the environment, which in places was poor. Generally, the wards/departments were well-led, although there was a disconnect between the staff providing 'hands-on' care and the executive team.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement



We found that improvements were needed to medical services.

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

The environment in the older part of the hospital was cluttered and some bed spaces, which were not suitable for purpose, were used when the hospital had exceeded capacity.

The management of outliers appeared to be varied and the safe staffing of escalation areas was not consistent to meet the skills mix specific to their needs.

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

Nurse staffing levels were not sufficient on some wards. Records showed frequent shortages on some wards, despite regular use of agency and bank staff. The skills mix of nursing staff was compromised, as staff were moved from ward to ward to cover staff shortages. These shortfalls placed patients at risk and caused delays in care.

Out-of-hours, there was reduced access to senior staff and this placed pressure on junior staff and caused delays in seeing patients.

Documentation was accurate, legible, signed and dated and provided an audit trail of the patient's care and treatment.

Incidents

- There were systems for reporting incidents across the medical directorate. Staff were confident in reporting incidents and were supported by managers to do so. Several staff told us that the electronic system for reporting was time consuming to complete and limited in choices to identify incidents. Between March 2013 and March 2014, the trust submitted 128 incidents to the

National Reporting and Learning System (NRLS).

Medical specialities had the highest number of patient incidents, with 37.5% moderate harm incidents, which accounted for the majority of the total.

- Staff told us that they received little or no feedback from the incidents and alerts they made via the electronic system in place. They told us that they were unaware of any changes that had taken place as a result of incident reporting. This was despite a monthly newsletter sent to all staff called Patients First, safety boards are at the entrance of each ward for staff and visitors which share learning; and patient safety and quality folders on each ward which provide the monthly nursing metrics information which includes Patients Voice and incidents and any learning from them.

Safety thermometer

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

Cleanliness, infection control and hygiene

- The areas of the hospital we visited appeared to be clean and we saw cleaning taking place throughout our inspection. Some areas were difficult to maintain and clean due to the age of the buildings. Staff told us that the cleaning of the wards, for example, the Vallance Ward, was not consistent and sometimes did not meet an acceptable standard. However, we did not see any audits to support this.
- Staff were aware of current infection prevention and control guidelines. There was a sufficient number of hand wash sinks and hand sanitising gels in most areas. We observed staff following good hand hygiene practice and 'bare below the elbow' guidance.

Medical care (including older people's care)

- The trust's infection rates for C. difficile lay within a statistically acceptable range, taking into account the trust's size and the national level of infections.
- The MRSA infection rates lay above the statistical range, with a total of five cases.
- We visited Grant Ward, which specialised in infectious diseases. The environment was poor, with patients being nursed in four-bed bays and sharing side room access for isolation with Howard 2 ward on the level below. Appropriate negative ventilation was not available to ensure the air flow on the ward was safe. There were insufficient toilet and hand wash facilities for visitors and a patient was 'outlying' from another ward in a shared bay. The nurse in charge explained that the risks were minimal, but the environment was challenging, with limited facilities.

Environment and equipment

- There were poor storage arrangements on some wards, with equipment being stored on corridors and in bathrooms. We observed that this created a falls hazard for patients and visitors. The fire doors on some wards were obstructed by equipment and this may have posed a risk if there was an outbreak of fire.
- The CQC inpatient survey 2013 showed that the trust's rating was worse than the other trusts for the question, 'Did you ever share a sleeping area with patients of the opposite sex?' We saw that in the acute medical unit (AMU), one bay area (Bay F) had mixed-sex occupancy. The environment was not ideal for use as it was essentially a corridor with beds. Screens were used when patients required privacy. Staff confirmed that this area often had mixed-sex occupancy. The AMU has had 100% bed occupancy since January 2014 and staff advised us that the use of mixed-sex bays was a reflection of demand.
- The stroke unit, when under pressure to provide capacity, used a bed that was not funded for use. The use of Bed 5 was observed during the unannounced inspection on 30 May 2014. A patient had been admitted from the ED, having suffered from an acute stroke. Staff confirmed this happened when needed. For the adjacent beds to be accessible for therapist, Bed 5 would have had to be moved. Another area of the stroke ward had a bed which was positioned against a wall and staff could not walk around the bed to support the patient to move if needed. Therapists explained that the

close proximity of this bed to the adjacent bed limited assessments and therapy access. By using these areas of the ward as bed spaces patients may be limited in the care they could receive there.

- Resuscitation equipment, including portable defibrillators and suction machines on some wards, did not display the record that confirmed they had been serviced within the last 12 months. These areas included the AMU, Vallance Ward, Baily Ward and the stroke ward. We checked the service records provided by the trust and it was not evident that servicing of these essential pieces of emergency equipment had taken place within the previous 12 month period. The risk of delayed servicing meant that equipment may not have been in good condition for emergency use. On Baily Ward, the resuscitation trolley was not easily accessible as it was obstructed by a seated relative. It was being used as a table for water jugs. This could have impacted on its use in an emergency. Wards, including Baily Ward and the stroke unit, had daily record checks which had not been completed as a matter of daily routine. This may have meant that equipment could be missing or out of date when it came to be used.

Records

- During our inspection, we reviewed five sets of patient records over the 16 areas visited. In all the records we looked at, documentation was accurate, legible, signed and dated and provided an audit trail of the patient's care and treatment. Risk assessments for pressure damage and falls risk assessments were recorded. Care plans contained a plan of actions in place to reduce and manage risks to patient safety and inform staff of the care each patient needed.
- We looked at do not attempt cardio-pulmonary resuscitation (DNA CPR) orders on most of the wards and units we inspected. These had been completed in line with published guidance. Staff were aware of the importance of the correct completion and review of these records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with demonstrated a good knowledge of the Mental Capacity Act 2005 and the implications of this to protect patients' rights. Through a review of patient records, we saw that staff, when needed, had assessed patients' mental capacity for making

Medical care (including older people's care)

decisions. There was evidence that when patients lacked capacity, staff sought appropriate professional input to ensure that decisions would be made in the patient's best interests.

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

Safeguarding

- There was a system for raising safeguarding concerns and staff in all areas explained the process clearly. All of the staff we spoke with had undertaken safeguarding training and felt able to raise an alert when needed.

Mandatory training

- Staff told us they had annual appraisals and could tell us when their last appraisal had been. Most staff felt this was a useful exercise for their personal development.
- They also told us that training was provided, but they were often not able to attend due to staff shortages on the wards. No management training had yet been provided for band 7 level nurses to support them in their management roles. We met with a medical education lead, who explained that there was a rolling education programme for staff. On the day of inspection, neurological observation training was being provided on the AMU. Education audits took place annually, to inform the trust of identified training provided and needed.

Management of deteriorating patients

- The trust used a national early warning score (NEWS) tool, which was designed to identify patients whose condition was deteriorating by recording observations. Staff could then identify and call for appropriate support should a change or deterioration be noted. The chart incorporated a clear escalation policy. We found that this tool was in use and staff understood how to use it. We spoke to the clinical outreach staff, who explained that they supported ward staff throughout the hospital with deteriorating patients and the systems in place were effective.

Nursing staffing

- We found that nurse staffing levels were calculated using a dependency tool and the ratio of staff member to patients was displayed on the wards. Staff told us that these levels were sometimes misleading. The ratio was calculated incorporating some staff who were not

available to work on the ward. For example, in AMU, the coordinator and band 7 nurses were included to make the ratio 1:4. However, those two staff were needed to manage the unit and attend the ward round and were not delivering patient care. This brought the ratio to nearer 1:6.

- We visited Jowers Ward and Vallance Ward on two occasions. We saw, and staff told us, about the busy wards and the difficulties with staff shortages. We looked at staff rotas for both wards, and saw that not all shifts had been covered, leaving staff shortages on both wards.
- Vallance Ward had seven WTE staff vacancies and relied heavily on bank staff to cover shifts. We saw that, over the week prior to our inspection, the template for staffing levels had not been met on 15 occasions, with shifts being short of staff throughout the week. The week prior to that had shifts not covered on 16 occasions. On one shift on the 4 May 2014, there had been one trained nurse and two healthcare assistants. The staffing template for that shift was three trained nurses and two healthcare assistants. Staff expressed concerns about the safety of patient care during these times and the delays in providing patient care. The ward manager was seen to cover most of the shortfalls in staff at the weekend, despite having worked Monday to Friday.
- On Jowers Ward, there were seven staff vacancies being covered by staff from the bank or the agency. We saw from previous week's rotas that shifts to meet the staffing template had not all been filled for both night and day shifts. The rota showed that for the weekend of the 17 and 18 May 2014, no healthcare assistants were recorded, so it was unclear how this ward had been staffed. There was an establishment of six trained nurses, one band 6 nurse and a ward manager in place. Three of those trained nurses had been in post for less than three months post qualification and, as such, were limited in experience to deal with the pressures of this ward.
- We visited Baily Ward, which had five WTE nursing posts vacant. This meant that there was very little back-up cover for unexpected absences or sickness. The ward manager and band 7 nurses would work to fill those shifts.
- We visited the Emerald Unit for dementia care, where there were five trained nurse vacancies. Bank staff were used to make up the staff numbers.

Medical care (including older people's care)

- We spoke with patients and visitors to these wards. They were all positive about the care provided by the nursing staff. Their comments included, "Care is excellent, can't fault it," and, "They are all so busy," and, "They're very short staffed." Other people said, "They have to work very hard to keep up,"

Medical staffing

- 'Medical cover on the AMU included eight consultants, three F1 doctors and two F2 doctors on a training programme. A consultant is on duty 8 am to 8 pm, and on call overnight. The junior staff overnight running the medical take were a medical registrar, two CMT/F2 doctors and one F1 doctor. Medical staff felt this was sufficient.'
- Some areas of medical care and speciality such as elderly care, diabetes and endocrinology did not have seven day access to a consultant. Junior medical staff told us that support for them by senior medical staff was good during the day but out-of-hours access to senior medical staff could be difficult. The medical cover at night was an on-call registrar, two F2 doctors and a further F1 doctor. The respiratory unit did not have its own consultant cover at the weekends and out of normal working hours, so an on-call acute medical consultant was called.
- Monday-Friday 8 am to 6 pm all medical and specialty patients had access to a consultant opinion. Out of hours, some specialties did not have access to specialty consultants, though could consultant the on call medical consultant, ITU or other relevant specialty teams with out of hours rotas as required. Junior medical staff told us that support for them by senior medical staff was good during the day but out-of-hours access to senior medical staff could be difficult. The ward medical cover at night was provided by a CMT/F2 doctor, supported by the on-call registrar. The respiratory unit did not have its own consultant cover at the weekends and out of normal working hours, so an on-call acute medical consultant was called
- Recruitment for medical staff remained ongoing, with shortages of consultants and junior doctors.
- The cardiac speciality also relied on medical cover from the acute medical team.
- We observed the medical handover on the AMU and saw that it was well attended and managed to ensure that all patients were discussed and a plan of action agreed.

- Patients told us that doctors were polite and gave good explanations of the treatment to be provided. Patients felt involved in the decisions about their care.

Are medical care services effective?

Good



Medical care was effective. Care for people living with dementia on the Emerald ward was innovative and creative with new care pathways in place.

The medical wards had clinical pathways in place for care for a range of medical conditions based on current legislation and guidance. Analysis of stroke national audit programme (SSNAP) and National Diabetes Inpatient Audit (NaDIA) data demonstrated that improvements needed to be made in the long-term management of patients with diabetes and those who had experienced a stroke.

Evidence-based care and treatment

- There were no outliers for mortality associated with medical conditions. According to the Dr Foster Intelligence 2012 Hospital Guide, there were no tier one mortality indicators flagged as a 'risk' or 'elevated risk' for medical areas inspected. A monthly morbidity/mortality meeting took place to discuss any issues and take learning forward. Consultants and junior doctors also met weekly to discuss issues and address any areas of concern.
- The stroke pathway had been developed to support patients to have door to needle times that were monitored and developed to provide an improvement in patient care. Staff on the stroke ward carried an emergency pager, which was used to alert them that a stroke patient suitable for thrombolysis treatment was in the ED. This enabled the process to start in the ED and the staff member would transfer the patient to the stroke unit. This reduced the waiting time. All staff on the stroke ward were training in the stroke pathway and a rolling program for thrombolysis training was underway.
- Specialist diabetic consultant, specialist nurse, dietician and podiatrist provision for the hospital were lower than the national average. The hospital was developing a 'Diabetes Direct' service available at the Royal Sussex County Hospital, which supported the care and treatment provided throughout the hospital.

Medical care (including older people's care)

- At the time of our inspection, the Royal Sussex County Hospital was piloting a dementia care pathway project to include Reach for Me, a short booklet to help staff better understand and care for the patient. This was not being piloted in all areas of the hospital. Staff on the Emerald Unit for dementia care had all received dementia care training. However, there was no speech and language therapist available on the dementia unit and this placed patients at risk of not receiving the assessments and treatment they needed relating to safe nutrition and hydration.

Pain relief

- Patients we spoke with told us that they were comfortable and their pain was well managed.
- Medication administration records showed that pain relief was given as prescribed and recorded, to provide a clear audit trail of treatment.

Nutrition and hydration

- Most of the patients we spoke with were complimentary about the meals served at the trust. People were provided with a choice of suitable food and drink and we observed hot and cold drinks available throughout the day. Staff were available to help serve food. Assistance was given to those patients who needed help. The trust use a 'red tray' system to identify when patients need further assistance with eating and drinking.
- Assessments by the speech and language therapy team were not always timely, due to limited therapy staff numbers. This may have placed patients at risk of aspiration.

Patient outcomes

- The Myocardial Ischemia National Audit Project (MINAP) showed that, in 2013, the national (England) call to balloon time. (CTBT) figure for all eligible patients treated in Brighton was better than average. This time is the interval from a call for professional help to the time that the primary PCI procedure is commenced. The equivalent figures for patients admitted directly to the Heart Attack Centre (for example: not including those that were transferred from another hospital) were slightly worse than average. The CTBT figures (direct admission) for Brighton were better than average.
- The Sentinel Stroke National Audit Programme (SSNAP) data showed that, for scanning of patients, treatment of thrombolysis and the 'amount of time spent on the

stroke unit as an inpatient' were all acceptable against the national data. However, areas related to therapy and discharge were below the national data. These areas included: access to speech and language therapists, occupational therapists and physiotherapists. There were 1.8wte occupational therapists and 1 WTE speech and language therapists for stroke at the RSCH. This was not in line with the NICE guidelines, which stipulate one therapist for every 10 beds. This often impacted on the discharge potential of patients because of the delay for therapy.

- An analysis of the National Diabetes Inpatient Audit 2013 showed that the hospital was not performing well against some of the indicators analysed. These areas, including: diabetic consultant availability, specialist diabetic nurse availability, dietician and podiatrist provision were lower than the national average. Patients admitted with active foot disease were at higher levels than the national average, but foot assessments were not completed in line with the national data. Podiatrist hours available per patient were lower than the national average.
- Data seen relating to cardiac arrests for 2012/2013 showed falling cardiac arrest rates, with a good rate of survival that was better than the published national data.

Competent staff

- Appraisals of both medical and nursing staff were being undertaken, and staff told us that, in all areas, they had received a recent appraisal. Staff told us that, on the cardiac unit, all staff had specific cardiac training. However, there was a limited mandatory appraisal process in the coronary care unit (CCU), due to time constraints.
- Staff explained that, when shortages needed to be covered, staff were 'borrowed' from other wards. This impacted on the skills available on each ward and did not ensure that staff had the specific skills needed to care for the patients on each ward. For example, when a mix of medical and surgical patients were admitted as outliers to the coronary day case unit.

Multidisciplinary working

- We observed handovers of information between shifts and saw that these were well attended and orderly. We

Medical care (including older people's care)

saw that there was good communication in the AMU between ED, radiology, wards and the wider community to promote a smooth process and pathway for patients through the hospital.

- We saw, and spoke with, staff from the critical care outreach team. They considered working relationships with AMU and medical wards to be very good and saw them as benefitting patient care.
- We spoke with therapists working on specialist units and were told that working relationships were good and supported patient care. However, reduced access to the relevant therapist did not enhance patient recovery. Patient records showed patients were assessed and reviewed by physiotherapists, occupational therapists and dieticians. Records were kept updated to provide a clear audit trail of care provided.
- All transfers between wards were considered and discussed, we were told by patients and staff, with the patient. Some transfers took place at night to facilitate urgent admissions. Patients on the stroke unit were considered carefully before being moved, as this could impact their recovery.
- The hospital ran an efficient discharge lounge. Staff explained the auditing process to ensure that delays in the discharge lounge were reduced as much as possible. Sometimes, if 'take home medicines' were not available in the discharge lounge and it the time came to administer the patients' medicines, staff needed to find the required medicines by going around to the ward to get medicines for people waiting. This would impact on staff availability in the discharge lounge.
- AMU staff told us that pharmacy staff were very good and that good working arrangements were in place. We noted that on the AMU, the fridge was marked as 17°C for 'maximum temperature reached' for the whole of May 2014 and no member of staff had reset the fridge. On Egremont and Catherine James Wards, the fridge temperature only recorded the daily temperature – not minimum and maximum. This may have had a negative impact on the efficacy of medicines stored in the fridge.
- Some wards had a greater access to psychiatric support, for example, Baily Ward. Staff told us that when needed, and within working hours, psychiatric medical cover was available.

Seven-day services

- There was seven day access to consultant cover for the AMU.

- Consultant cover was available for specific areas of the medical directorate between 8am and 6pm, with access to a medical consultant on-call, out-of-hours. Daily doctor's ward rounds usually took place in acute areas with daily board rounds and daily or mid-week ward rounds for specialist areas (depending on the specialty). Only newly admitted patients, those whose condition had deteriorated, or those flagged for weekend review at the Friday handover saw a doctor at weekends or out-of-hours. For those patients who had been admitted to wards as outliers, these patients were seen mid-week but not at weekends or out-of-hours, unless their condition changed and urgent review was needed, or they had been flagged for weekend or evening review at handover.
- There was no routine Allied Healthcare professional support out-of-hours at the time of our inspection. This meant that therapists were not available at evenings and weekends to assess and manage care for those patients admitted out-of-hours.

Are medical care services caring?

Good



Medical and nursing care was provided by hardworking, caring and dedicated staff that were passionate about providing good patient care. People we spoke with praised trust staff for being kind, caring and compassionate. Staffing levels were challenging for staff who were endeavouring not to allow this to impact on patients' health and wellbeing.

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

Compassionate care

- We found that medical services were delivered by hardworking, compassionate and dedicated staff. We observed that, at all times, staff treated patients with dignity and respect. All the patients and relatives we spoke with were positive about the care and treatment they had received.

Medical care (including older people's care)

- We spoke with 28 patients, whose comments included, "I wanted to say how impressed I am with the nurse's knowledge, attitude... nothing is too much trouble." Many patients told us that staff were caring and kind and always "went that extra mile for you".
- In the CQC's Adult Inpatient Survey 2013, the trust had performed the same as other trusts for all ten areas of questioning in the survey. The trust had also seen an improvement in four of the questions in the survey compared to the CQC's Adult Inpatient Survey 2012. These were questions about the areas of information being provided and discharge planning. However, there was one question that showed a decline and this was around: 'How would you rate the hospital food?'
- The inpatient NHS Friends and Family Test survey showed that Baily Ward was one of the wards that people would be 'extremely unlikely' to recommend.

Patient understanding and involvement

- Staff planned and delivered care in a way that took into account the wishes of the patient, we saw that people's choices and preferences were mostly considered.
- Patients and relatives told us that they felt involved in their plan of care. They knew who was their consultant and had the opportunity to speak with them, and they were provided with explanations of their treatment in a way they could understand. They felt they were able to ask questions, if needed.
- We saw that patients had access to summon assistance. Each patient had a call bell and these were answered promptly. Patients told us that they never had to wait long for help and that staff were always approachable and attentive. Curtains were pulled around each bed when care was being provided, and patients' privacy was respected when they used the bathrooms and toilets.
- We listened to staff speaking to patients and saw that they spoke kindly and checked that patients understood what was happening to them. They sought consent before undertaking care and treatment. Records reflected the discussions with patients and communicated clearly the patient's views and concerns. One ward had developed cards to assist with communication and we saw that access to interpretation and language lines were available.

Requires improvement



Medical services were responsive to patients' needs, but improvements are required.

We found the trust faced significant capacity pressures. This meant that, although patients felt well looked after, they were not always able to be placed on the most appropriate ward, on admission, that would meet their needs. Discharges were sometimes delayed because appropriate therapy was not available. Delays were also caused by lack of care packages or facilities in the wider community. As a result, some patients were kept on medical wards long after they needed to be.

The patient's journey to the right ward often meant them moving several wards until beds became available. Movement of patients at night included patients living with dementia and this was not responsive to their specific needs.

Service planning and delivery to meet the needs of local people

- The trust's bed occupancy averages were higher than the England averages between April 2011 and September 2013. They peaked in January through to March 2012 at 94.5%. Then bed occupancy fell from October 2013 to below the England average to 85.1%. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.
- The most recent CQC Adult Inpatient Survey shows the trust was similar to expectations for giving notice of discharge and on the length of delays to discharging patients.
- Emerald Ward had been refurbished to create a safe and stimulating environment for people living with dementia.

Access and flow

- We found the hospital faced significant capacity pressures. As a result, although patients felt well looked after, they were not always able to be placed on the most appropriate ward for their needs. We found

Are medical care services responsive?

Medical care (including older people's care)

patients were staying on AMU, which is intended to be an assessment for long periods of time, between two and six days, because there were no available beds on other wards.

- We saw that when capacity to meet the inpatient demand was full, patients were placed on wards that did not meet their needs. On one day of our inspection, there were 49 outlying patients, this number could not be subdivided to find out how many were medical patients. Staff worked hard to manage patient flow, so the service was able to manage admissions and avoid patients being admitted to wards outside of the medical directorate. However, we were aware that medical patients were outlying on surgical wards.
- The Overton Ward was being used as an escalation ward for those patients not able to be admitted to the right ward, due to full capacity. This ward was staffed by agency and bank staff and did not have a consistent staff team to ensure that there were sufficient appropriate skills to meet the patients' needs. Staff told us that inappropriate admissions at night could be made to this ward, as there was no capacity elsewhere in the hospital. This meant that the patient would need to be moved again to reach the right ward. Patients were seen by a junior doctor daily, but may have only seen their consultant twice a week.
- Baily Ward, which specialised in diabetes and endocrinology, highlighted that only 25% of the ward capacity was for that speciality and the remainder was occupied by acute medical patients and patients with psychiatric needs. For those patients with psychiatric needs, staff did not have the appropriate training and skills to meet their needs.
- The Cardiac Day Care Unit was used as an overflow area if no other beds were available. These patients might have had medical or surgical needs and might require nursing skills not available, as the unit was not staffed to meet their needs. Each of those patients might have had a different consultant who, staff told us, may be hard to find, when needed.
- Patients and staff told us that sometimes patients were moved several times to get to the ward they needed to be on. For example, from ED to AMU to Overton Ward to a medical ward. This was due to lack of appropriate beds at the time of admission. One patient told us of their journey from ED to AMU for two days then Level 9

and then Vallance Ward. They told us: "AMU staff were understaffed but polite about it, apologising for delays." Level 9 were "amazing, nursing staff worked their socks off and after 12 hours were still polite".

- Patients were also moved at night and early mornings because of capacity issues and the need to transfer patients out of AMU. Staff told us that this included patients with dementia and included the Emerald Unit for dementia care. This could be particularly disruptive and distressing for those patients.
- The AMU had developed an ambulatory care department to help prevent admissions for treatment that could be provided, allowing the patient to return home.
- The majority of patients whose discharge was delayed were elderly people who were waiting for a care or nursing home bed or for a care package.
- The stroke national audit programme identified improvements were required to access to specialist staff and therapists to promote an effective recovery and discharge.

Meeting people's individual needs

- Staff in the AMU explained that for those people with specialist learning disability needs or living with dementia, who required a carer to stay with them, this was facilitated within the unit. Specialist link nurses were available to support vulnerable people to feel safe and supported during their admission. We spoke with one relative, who explained that they had stayed at the hospital to support their relative.
- For patients whose first language was not English, staff could access a language interpreter, if needed. Staff told us that access to this service was not difficult and that the service they provided was valuable.
- Staff told us that access to spiritual support was available for many faiths and that prayer space was available.
- Links were seen to be in place on wards to access specialist support for drug and alcohol services. We were also told of a recent incident when the Royal Sussex County Hospital's homeless support team had been proactive in assisting with a safe and appropriate discharge. We saw that equipment, support and advice was available throughout the hospital for bariatric care.
- Mixed-sex breeches occurred regularly in the AMU ward due to capacity issues.

Medical care (including older people's care)

- We found that on Baily ward, access to the only toilet and shower room allocated solely for the use of female patients, was by way of a side room (the Balcony Room). The person using this room would need to have their curtains drawn at all times should they not wish to be inconvenienced by others using the toilet overnight. This room was also temperature tested, because it felt cold and was found to be 17 degrees.

Learning from complaints and concerns

- Patients and relatives told us they felt able to complain and staff told us they were able to explain the complaints process to patients. Staff told us that they rarely had any feedback or learning from complaints.
- Board reports from the hospital up to February 2014, showed that patient experience scored below the national average with 11% of complaints being reopened this year to date.

Are medical care services well-led?

Good



At a local level the wards/departments were well-led. Staff spoke proudly of the service they provided and were mostly positive about the future of the trust.

There was a disconnect between the staff providing hands-on care and the executive team.

Vision and strategy for this service

- The trust had a set of values and behaviours as their vision. The staff had a clear understanding of what these involved and most staff had been afforded the opportunity to be involved in their development. Some staff told us that they would have liked to become involved, but staffing constraints limited their attendance of meetings and discussions.

Governance, risk management and quality measurement

- Risks were regularly identified and flagged on risk registers at divisional-level. When asked, staff were not aware of the content of the risk registers for the trust or at ward-level. They told us that they emailed alerts and information, but did not receive a response, so did not know if their comments or suggestions had been read or considered.

- Quarterly governance meetings took place to review data gathered and incidents reported. Safety audits of information relating to the medical directorate were seen. These included complaints, a Patient Advice and Liaison Service PALS report and details of serious incidents.
- Audits took place to make comparisons with national data, including areas relating to medical care, such as: SSNAP, NaDIA and MINAP. Staff were aware of the data gathered and in most cases the outcomes and shortfalls.
- Education audits also took place and were reviewed at board-level to identify the areas needed for future training.

Leadership of service

- We saw several examples of good leadership by individual members of medical and nursing staff throughout the medical directorate that were positive role models for staff. Some ward managers and matrons had been praised highly by their staff for their clear leadership and support of the staff team. However, the NHS staff survey 2013 showed that staff said the support from their managers was worse than expected (within bottom 20% of acute trusts nationally). Some staff had experienced difficulty in progressing to a higher promotional level, without understanding the reason for this.
- Junior doctors told us they felt well supported by more senior medical staff and consultants. They told us consultants were accessible and approachable.
- Staff told us that they knew who the chief executive of the trust was and found him accessible and approachable. Staff were unclear about the remaining members of the trust board and could not name them or their role. Some staff were unclear about who the chief nurse was.

Culture within the service

- Staff demonstrated a dedicated culture with a willingness to explain the difficulties they had at ward-level. Staff were willing to work very hard over long hours to ensure patients' needs were met. Staff told us, "This is a great place to work" and "Patients always come first."
- Despite the staff survey results, which indicated worse than expected for job satisfaction, staff spoke proudly of the service they provided and were mostly positive about the future of the trust.

Medical care (including older people's care)

- The trust's performance was rated as worse than expected or tending towards worse than expected for 22 of the 28 key findings in the 2013 NHS staff survey. These included staff feeling they could not contribute to improvements and 'worse than expected' (within bottom 20% of acute trusts nationally) for staff suffering from work-related stress. Staff told us that the greatest challenges they found were around staffing levels.

Public and staff engagement

- We saw that the trust used Patient's Voice surveys to ask patients their views of the care and the Royal Sussex County Hospital. The results, with an action plan, were displayed on each ward. Staff demonstrated a clear understanding of the action plan and how they were being implemented.

Innovation, improvement and sustainability

- Staff told us how much they were looking forward to the building of a new hospital and the improvements for patients. Many staff expressed a sense of disbelief that after such a prolonged planning phase the build would happen. They felt that their difficult environmental circumstances would be unlikely to improve. Staff told us that they didn't understand the decisions made about the order of development. For example, why were staff employed for roles in the new building, which had not yet been started? Many staff told us they did not have involvement in decisions about the development of the hospital.

Surgery

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

Information about the service

The Royal Sussex County Hospital is a designated trauma centre and provided a range of general and specialised surgery, including cardiac, urology, ophthalmic, digestive diseases and gynaecology. There was a separate Sussex Eye Hospital and. There are eight operating theatres in use, as well as an 11-bay recovery room.

We visited the cardiac high dependency unit, the main operating theatres, including the preadmissions area and recovery. In addition, we visited the Sussex Eye Hospital and a number of surgical wards by speciality, including: Vascular/urology, elective day surgery, head and neck, and the colorectal and gastroenterology ward.

We spoke with 17 patients and one relative. We also spoke with 32 staff and reviewed the treatment and care records for 13 patients. We made observations in each area of the environment, taking note of cleanliness and staff interactions with people using the services. In addition, we reviewed information supplied to us prior to our visit and during the inspection.

Summary of findings

The surgical care teams were highly motivated, committed and compassionate about the services they provided to patients. Staff were caring and supported to deliver high standards of care with strong and effective leadership. People who were receiving care, and their relatives, reported a high level of satisfaction with the quality of care and their experience of using the Royal Sussex County Hospital. We spoke with patients who confirmed that staff treated them with dignity and respect.

Pain was said to be managed well and patients said they were given enough information to help them make decisions about their treatment and care. Feedback we heard and read was positive about the care and treatment from all staff. People commented that the care here has been “absolutely fantastic” and it had been a “very good experience.” Another patient said, “Care has been fabulous.”

Nursing staffing levels were improving, but there was a high use of bank to cover vacancies and staff unplanned absence. Mandatory training was provided to staff. However, attendance rates were low in some areas, and action was taking place to improve the completion of training.

Surgery was consultant-led and there were medical staffing arrangements in place to support the surgical services 24/7. Patient treatment and care needs were

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assessed, monitored and acted upon at each stage of their pathway, with involvement from the multidisciplinary team. Patient surgical outcomes were monitored in order to ensure standards were being met.

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

Patient referral access and follow-up arrangements were, in some cases, impacted on negatively, as a result of inadequacies of the booking Hub. Bed occupancy, discharge and flow meant that there were times when patients waited for beds on a surgical ward or were nursed in inappropriate areas.

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

There were numerous items of electrical equipment used for patient care which had not been routinely tested to ensure the items were safe to use. The clinical environment was not always appropriate for certain tests that were being carried out. Equipment storage in some areas presented a hazard to staff as well as additional challenges to cleaning standards.

Are surgery services safe?

Requires improvement



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

Arrangements were in place to ensure the provision of care in a clean environment and to minimise the risk of hospital-acquired infections. There were some concerns about the storage of equipment in inappropriate areas and the lack of safety checks on electrical equipment used for patient care, which the trust should address.

Patients' care needs were assessed and any identified risks managed in accordance with best practice.

Staff ensured patients' rights were protected by appropriately using the provisions of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Consent and safety checks were carried out to a good level for patients having surgery.

Staff were following an out-of-date policy regarding the identification of patients, which could present a potential risk to patients. Attendance at mandatory training was poor. The environment in theatres was cluttered and hazardous.

Although we were told the recruitment processes had improved, there were vacancies for staff in some areas, which impacted on the demands of staff and their ability to meet the needs of patients at all times. The trust needed to improve the uptake of staff attendance at mandatory training and ensure that all staff had an annual performance review, so that they could identify any training and development needs.

Incidents

- Staff could describe the mechanisms for reporting any adverse events, near misses or concerning matters, via the internal electronic data system. Staff were aware of the Never Events that had occurred during 2013, and more recently in April 2014, and had received information related to the learning outcomes from the

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investigations that took place. (Never Events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.)

- Recovery staff completed monthly information regarding patient care. For example, we saw that audit information had been assessed by staff concerning patient fasting, pain assessment and management, pressure area care and patient observations. Results indicated a high level of compliance.
- The surgical division undertook a review of all safety, quality and serious incidents in order to ensure that lessons related to safety of patients were implemented. Incidents were outlined and a designated person was identified for reviewing the matter and reporting on progress within agreed time frames.

Safety thermometer

- The hospital was carrying out the collection of safety information as part of the Safety Thermometer, which included, for example, information about patient falls and pressure areas. The Safety Thermometer is a national tool that all hospitals have to undertake on the same day each month. Safety Thermometer outcomes recorded monthly figures for the wards and compared these with combined figures from across the trust. Separate ward incident summaries were provided as part of the Safety Thermometer overview for each month. We were given an example of measures that had taken place in order to manage recurrent risks. This included increasing staffing levels on the vascular ward at nights in order to address the level of falls. These had subsequently fallen from 74 to 45 in the twelve months up to our visit.
- For transparency, Safety Thermometer information was displayed on wards for public viewing and contained a range of information such as falls, pressure sores and infection rates.

Cleanliness, infection control and hygiene

- Patients who spoke with us told us they were satisfied with the cleanliness of the hospital. One person on the digestive diseases ward said, "Top notch cleaning." Another patient on this ward said the ward was cleaned daily and it was "pretty good". A patient on the orthopaedic ward commented to us that "the cleaner works like a beaver daily". Other comments included, "The domestic works non-stop, very impressed."

Patients were able to use the Patient's Voice survey to indicate their level of satisfaction with cleaning standards and we saw positive feedback on information displayed and provided to us.

- Matrons had a direct responsibility for ensuring that cleaning standards were being delivered in clinical areas. Responsibilities were outlined in the trust's cleaning standards in the matron's manual. Ward and theatre areas we visited were suitably clean or were in the process of being cleaned by domestic staff. Domestic staff had guidance in place to support their cleaning responsibilities and had access to a range of cleaning equipment that reflected the national recommended colour coding for use in different areas.
- Cleaning schedules were displayed on ward areas and staff reported that cleaning standards had improved more recently, with staff reporting that they felt able to challenge the domestic staff where they had concerns. Cleaning audit results were displayed in public areas for the previous month. Results for the vascular ward indicated a level of 94.5%, and on the digestive diseases ward the compliance level was 98% for April 2014.
- Clinical staff had access to a decontamination policy for guidance regarding the safe practice and cleaning of patient equipment. Equipment used for direct patient care was suitably clean and ready for use, with labels on commodes indicating when they had last been cleaned.
- Infection-control updates were circulated to staff in the form a newsletter, including the May 2014 Infection Prevention Update. This provided information to staff about infection results and reminders of standards in practice, such as hand washing.
- Staff on wards and in theatres could demonstrate they were aware of the staff members who had a designated link to the infection prevention and control lead person. Infection control audits of staff compliance with hand hygiene practices had been carried out, and results that ranged from 100% compliance by doctors, nurses and healthcare workers on the vascular ward to 55% compliance for other staff on this ward.
- We observed nursing and medical staff to wash hands between patient care, and using hand sanitising gel. Hand sanitising gels were in place at ward entrances, on bed-ends and outside of rooms. All were well filled and ready for use. Staff were seen using personal protective

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equipment, such as aprons and gloves, all of which were readily available in all areas. Staff complied with the policy of the trust to be 'bare below the elbow' when working in clinical areas.

- Staff handled and disposed of waste, including sharp items and contaminated linen, in accordance with safe practice guidance.
- Safe practices were observed within the theatre environment concerning preparing the environment, surgical equipment and surgical staff gowning up, as well as disposal of waste and cleaning of the theatre between cases.
- Infection rates were recorded by each ward area for *C. difficile*, as part of the Safety Thermometer. The vascular ward reported having a case of unavoidable *C. difficile* on the ward at Christmas 2013. Likewise, the digestive diseases ward also reported one *C. difficile* case in the past year. The orthopaedic ward displayed information to the public indicating that there had not been any *C. difficile* in the previous four months and it had been three years and eight months since the last MRSA.
- We saw that isolation signs were used correctly where patients required special precautions.
- A review of safety data did not identify any concerns regarding patient safety related to post-operative wound infections.
- Preoperative screening for Meticillin Resistance *Staphylococcus Aureus* (MRSA) had been carried out in order to minimise risks to the patient of acquiring post-operative infection.

Environment and equipment

- The ward areas we visited were well maintained, overall, and suitable for the activities being carried out. Main operating theatres had a two-year plan in place to shut theatres down for upgrade and maintenance. We saw theatres that had been upgraded and heard in the morning's briefing meeting, the arrangements for the next theatre upgrade.
- There were some issues regarding storage of equipment in main theatres, resulting in some equipment having to be stored in the corridor, which presented a hazard to staff and difficulties with cleaning. We were told, and saw, that there was some redevelopment of the theatre area and a plan to improve storage and accessibility to equipment.

- Equipment was stored on the main corridor linking the cardiac high dependency unit and the step-down bays. This made it very difficult to move beds and was hazardous to staff, as well as needing additional cleaning.
- Theatre staff reported having access to technical equipment, including surgical instruments, and there were arrangements in place to identify any potential concerns regarding instruments within a briefing meeting, held each morning at 8am. A representative from the decontamination unit attended this meeting.
- Some visual tests were taking place on a corridor, when the recommendation is that they be carried out in a vision tunnel. The toilets were being used for general community access, including local taxi drivers.
- There were numerous items of electrical equipment that did not have evidence of recent electrical safety tests in theatre recovery, the Sussex Eye Hospital and wards. For example, life packs in the cardiac high dependency unit had not been tested since 2011/12, syringe drivers and Bair Hugger's® (used to warm patients), were not tested in 2013. There was no evidence of testing of the portable suction unit in the Sussex Eye Hospital and many other items, such as observational equipment was out of date. This included ear nose and throat equipment, with previous test dates going back as far as 2008.
- Resuscitation equipment checked by us appeared to be in a good state of repair. Most trolleys had automatic defibrillators, and daily checks had, in the main, been carried out. However, we noted that electrical safety tests had not been carried out since November 2011 on the resuscitation equipment situated on the digestive diseases unit.

Medicines

- Arrangements were in place for the safe storage and management of medicines in all areas that we visited. Checks were in place for temperature monitoring of storage fridges. Access to medicines was controlled by key holders and suitably qualified staff. A tracking system was in place for medicines on the head and neck ward and this had additional measures for controlled drug keys.
- Records had been completed for each patient within the care and treatment plans we checked. These included the details of each medicine prescribed, frequency and route of administration.

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- Controlled drugs were stored correctly and records were completed each time such drugs were given to patients. Records were also made of stock levels and wastage.
- Patients' Voice surveys were used as a mechanism for collecting information on patient satisfaction with receiving medicines on time. Satisfaction scores were within acceptable ranges for the surgical wards we visited. One patient on the step-down area of the cardiac high dependency unit said they had not been given an injection on time, as requested by the consultant. This then impacted on their normal medicines routine, which was inconvenient.
- There was said to be good pharmacist support to all ward areas, with pharmacy visits to the wards on a daily basis and also pager contact for other requests. Where able, pharmacy made consideration of prescriptions prior to the day of discharge in order to ensure a smooth process. All prescriptions were screened by a pharmacist to ensure that prescribing was carried out correctly.

Records

- Patient treatment and nursing care records were found to be suitably completed and detailed in their content, to enable nursing staff to provide the required level of care and support. This included specialty care pathways, such as 'valvuloplasty' (a procedure in which a small balloon is inserted and inflated to stretch and open a narrowed – stenosed – heart valve) and fractured neck of femur. Patients individual care needs had been continuously reviewed and required changes were identified and acted upon.
- Surgical pathways, such as short stay needs, as well as pathways for each part of the patient journey, were in place. These were completed by respective staff working in each area. For example, the pre-assessment staff, surgery team and post-operative staff. We saw pathways for fractured neck of femur in use.
- Risk assessments were noted in all records we reviewed, and these included, for example: falls, manual handling needs, venous thromboembolism (VTE) and pressure areas. We also saw bed rails assessment in use and nutritional risk screening. Where interventions were required to manage risks, these were in place, such as the use of special mattresses for those at risk of developing skin damage, the prescribing and administration of blood-thinning prophylaxis treatment and specialised compression stockings for minimising instances of VTE.
- Repositioning charts were also used for patients who were at risk of developing damage to their skin over bony areas.
- Patient records contained evidence of intravenous (IV) cannula placement and checks taking place to ensure that complications did not arise. We saw the practice development lead undertaking an audit of patient notes and acting on discrepancies in VTE scores recorded by doctors on the vascular ward.

World Health Organisation Safety Checklist

- We noted in surgical records reviewed that staff had recorded evidence of the World Health Organisation's (WHO) 'five steps to safer surgery' procedures, although there were gaps in two of the records. One had not been recorded prior to anaesthesia, and one at the point of sign out from theatre. In theatre, we saw audits for compliance with the WHO checks carried out in April 2014 and noted eight cardiac patients did not have the site of surgery identified. It was not possible from the audit tool to see if this was because it was not applicable, for example, if the patient would not be having any grafts harvested from lower or upper limbs.
- In addition to the recorded documentation, we observed, and were included in, the relevant checks within the theatre areas that we visited. All patients that were seen to go into theatre were noted to have the side of the body and respective limb to be operated on marked, as part of safe practice.
- Patients were included in verifying personal information, consent and the site to be operated on both on the ward and on arrival to the anaesthetic room.
- We noted that staff were following an out-of-date policy regarding the identification of patients, which could present a potential risk to patients. The policy was due to have been reviewed in 2012 and was currently being revised. The guidance included the use of different colour-coded arm bracelets and we noted that patients often had several different colour-coded bracelets on. The information was hand written rather than printed. This practice did not reflect the guidance from the National Patient Safety Agency (NPSA) 2007.

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Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Care records we reviewed contained evidence that each person having surgery had consented to the procedure. We observed the nursing staff checking with patients that they had consented to the procedure, and people who spoke with us confirmed they had been given sufficient information to enable them to consent to their planned surgery. Consent forms were designed to enable a copy to be given to each patient.
- Staff had access to the learning disability liaison team. A resource pack was available to support the delivery of care for those with a learning disability, taking into account mental capacity, consent and best interests.
- Information to guide staff, concerning the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, was in place. We saw feedback from a lead nurse for safeguarding, which indicated that the orthopaedic team had been singled out as a good example of effective involvement of an Independent Mental Capacity Advocate (IMCA) to support safeguarding investigation and decisions related to a person's health.

Safeguarding

- Staff were aware of the safeguarding team and who to report any potential concerns to. The trust had a lead doctor, a named nurse and safeguarding nurse in place that staff could access for support and guidance. In addition, the trust had a safeguarding adult's policy in place, which was accessible via the intranet.
- Staff confirmed they had a safeguarding workbook to complete, as part of their training in this area.
- For individuals with learning disabilities attending the hospital for surgery, staff advised that they would be encouraged to bring a relative or carer with them. In addition, staff could also access the learning disability service within the trust, and we saw contact details for arranging this.
- Patients who spoke with us commented on feeling safe with staff and were confident they were being looked after safely.

Mandatory training

- The trust had not met the training targets for mandatory training attendance. We were provided with information that indicated a range of mandatory training for various staff groups, which was expected to be attended at varying intervals. An example of this was annual safeguarding training, which formed part of mandatory

skills for staff working directly with adults. The training was required to be updated every three years and trust-wide figures for training, concerning protecting adults at risk, indicated that in quarter 4, only 50.3% of staff had been trained or updated in this subject.

- We saw that some of the surgical wards had formal arrangements in place to improve staff attendance at training. We saw, for example, that all staff on the vascular ward had completed mandatory infection control training since the focus had increased.

Management of deteriorating patients

- Staff assessed and recorded people's general observations and wellbeing status using the national early warning score system. This enabled staff to identify changing needs and alert medical staff if any deterioration was seen. Pain assessment, respiratory rate and blood pressure were examples of the measurements that staff assessed using this tool.
- Staff had access to a trust-wide policy regarding resuscitation. This policy included information on mental capacity and withholding resuscitation. Staff adherence with the policy was audited in 2013 and an action plan was developed in April 2014 and this outlined the main areas of focus, such as correct form usage to record such events and staff training.

Nursing and clinical staffing

- The trust informed us that, across the services, temporary nursing and medical staff were widely used, and the vacancy rate was 9.4%, as of April 2014. Sickness rates were also identified as a concern by ward staff and these were seen to be higher than the national average.
- On the day of our inspection visit, we did not identify any shortages of nursing staff. People were responded to in a timely manner when call bells were pressed. We saw the electronic system used for planning staff duty rotas, which also recorded staff sickness. The senior sister said that the orthopaedic ward was under the full complement of required staff. This was made worse, at times, when staff from the ward had to cover another ward and 'back fill' was not then provided by bank or agency. We saw evidence of this within the May duty rota and were informed that this had an impact on the ability to undertake managerial responsibilities.

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- We were told that staff who worked in recovery had been stretched at times, particularly at night, when the two allocated night staff were expected to look after patients who had undergone emergency surgery, as well as other patients waiting for ward beds.
- Recruitment was said to be active, with quick publication of positions vacant but there were delays in bringing staff on board. All areas we visited employed staff of a varied skills mix, including nursing staff at different bands and healthcare support workers. Within theatre areas, the team was made up of operating department practitioners, nursing staff, support workers, recovery trained staff and Allied Healthcare support staff.
- The business plan for 2014/15 included additional investment in nursing, such as the introduction of supervisory band 7 nurses into all hospital wards, together with transparent, safe staffing levels. We saw that band 7 supervisors were in place on some wards.
- The hospital had an active internal 'bank' of clinical staff available. A recent change in the payment for bank work shifts was mentioned by some staff as a factor that may reduce their availability to cover gaps.

Medical staffing

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

carried out by the consultant, but that the relevant team, including registrars would partake in treatment and care delivery, under the direction of responsible consultants.

Major incident awareness and training

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

Are surgery services effective?

Good



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

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

Multidisciplinary team working was in place, with physiotherapy and occupational therapy support accessible. Patients felt access to pain relief was effective and administered in a timely manner. There was a consultant-led, seven-day on-call service and on-call pharmacy provision at all times.

Evidence-based care and treatment

Pre-admission assessment

- Patients who were to be admitted for elective surgery were said by staff to be pre-assessed as to their health status and suitability. We saw the pre-assessment process in progress and were able to follow a patient through from the pre-assessment area into theatre, and saw that there were good procedures in place to

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address the needs of the patient. Patient care records indicated that pre-assessment was carried out in accordance with NICE clinical guidelines for preoperative tests, which included anaesthetic risk score.

Use of National Guidelines

- The enhanced recovery programme was used in all specialities, where it was relevant. The programme involved the patients as active participants in their own recovery process and was designed to improve patient outcomes and a reduced surgical length of stay.
- A fractured neck of femur pathway was in place and an orthopaedic geriatrician took the lead on managing these patients. There were surgical pathways for a number of other specialties, such as renal stones, abscess and ear nose and throat patients. However, there was no abdominal pain pathway in place at the time of our visit.
- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations. There was a theatre designated for emergency surgery accessible 24/7. There was a designated lead for the NCEPOD theatre and emergency theatre arrangements were discussed with the lead each day.
- Staff monitored the condition of patients in the post-operative phase of their recovery in accordance with the NICE clinical guideline number 50. This guidance is concerned with recognising and responding to the acutely ill person. Staff used a recognised assessment tool for this monitoring, referred to by staff as the national early warning score tool.
- Staff reported having access to local policies and procedures and we sampled a range of these including: Prevention and Management of Venous Thromboembolism, Safeguarding Adults at Risk Policy, Resuscitation Policy and The Administration of Blood and Blood Components. These policies were up to date at the time of our visit.
- The nursing and medical staff were expected to follow defined protocols in line with the NICE Seven Quality Standards for venous thromboembolism (VTE) Prevention. The protocol included patient groups who were excluded from having prophylaxis treatment.
- Clinical areas carried out audits in order to check that staff complied with required standards and we saw an audit taking place, which resulted in the lead person

following up with medical staff to improve compliance. Results from audits formed part of the compliance metrics and we saw that monthly figures were continuously measured at departmental-level, as well as across the trust.

Pain relief

- Patients who spoke with us confirmed they had their medicines on time and that when pain relief was required, staff provided this promptly. One patient stated pain management was “very good”, adding, “If I ask for painkillers, I get [them] straight away.” Another patient said, with reference to nurses, that they were “quick with pain relief”. Another patient said, “The nurses come back to check that it has worked.” Out of 20 respondents who completed the Patient’s Voice survey during February 2014 on the head and neck surgical ward, an average score of 4.6 was achieved for the question ‘Everything done to manage pain’. On the trauma and orthopaedic ward, the same question scored an average satisfaction rate of 4.7 from the 23 patients who completed the feedback.
- Nursing records indicated that post-operative pain was assessed as part of the NEWS tool.
- As part of the review of patients’ previous medical history, staff assessed individuals for existing measures in place for their pain relief, such as medication needs and frequency.
- Post-operative pain relief was considered by the anaesthetist as part of the procedural pathway and we noted that patients had a choice of managing their pain, such as the use of epidural. We saw an epidural being inserted prior to an operation, with the consent of the patient. The patient was given a full explanation and supported in a caring manner throughout.

Nutrition and hydration

- We spoke with patients who were in the post-operative phase, about the provision of food and drink. One patient who spoke with us said that the food was “very good”. Another patient described the food as “variable”, describing a sandwich they had as “dreadful, horrible bread”. They also said that some food was good. A visiting relative who spoke with us reported that their relative was given a variety of drinks and whatever they asked for. A patient on the step down area of the cardiac high dependency unit said that, although they had lost

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their appetite, the food “is very good” and added that drinks were always available. Another patient described the catering person that morning, saying they “pushed the boat out for people, making fresh toast”.

- Patient records that we reviewed demonstrated nutritional risk assessments were carried out using a recognised tool known as the Malnutrition Universal Screening Tool (MUST). In addition to this assessment tool, staff also used food and nutrition charts for those at risk of weight loss or decreased nutritional intake.
- People were weighed according to their need and body mass index (BMI) records were completed, as required.
- We observed that patients who were able to eat and drink had access to fluids in their bed area.
- Where people required the support of intravenous fluids, care records were completed to indicate fluid intake and output. Prescription charts contained details of the required fluids and frequency of these. Staff made sure that patients ate and drank prior to discharge following day surgery.
- Patients could have specific dietary needs addressed, such as the provision of Halal and Kosher meals on request. Special diets could also be arranged in conjunction with the involvement of the dietician and if required, a speech and language therapist. A patient on the digestive diseases ward who spoke with us, told us they were on a liquid-only diet, but they had “options” and always found something they liked.

Patient outcomes

- Mortality meetings were taking place weekly, during which, the quality of patient care was reviewed for patients who had passed away. The review aimed at identifying any missed opportunities or learning for future practice, which included post-operative deaths. There was no evidence reported to the commission of any risks related to emergency readmissions after elective or non-elective surgical procedures. The surgical quality dashboard reviewed by us did not identify any concerns related to operations, with the exception of quarter three 2013, when three patients had their urgent surgery cancelled for the second time. Quality dashboard data also indicated that up to February 2014 elective overnight stays were slightly elevated in February at 3.76% against a target of 3.45%. The year-to-date figure indicated a risk score of green, with a figure of 3.41%. Average length of stay for

non-elective procedures indicated an amber risk rating for the year to date, with a score in February of 7.20%, against a target of 6.74%. It was not known from the information how this related to specific hospital sites.

- There was no evidence to indicate any risks related to surgery when assessed as part of Patient Reported Outcome Measures (PROMS) for hip and knee surgery, as well as varicose vein and groin hernia surgery undertaken at Royal Sussex County Hospital. PROMS is a series of questions or a questionnaire that seeks the views of patient on their health, or the impact that any received healthcare has had on their health.
- The surgical directorate contributed to most of the national audits for which it was eligible. This is a programme designed to improve patient outcome concerning surgical conditions and involves staff systematically evaluating their clinical practice against standards and to support and encourage improvement in the quality of treatment and care.
- A performance dashboard was used to monitor patient outcome and we saw data supplied to us by the trust indicated that, up to February 2014, elective overnight stays were slightly elevated in February, at 3.76% against a target of 3.45%. The year-to-date figure indicated a risk score of green, with a figure of 3.41%. Average length of stay for non-elective procedures indicated an amber risk rating for the year to date, with a February score of 7.20%, against a target of 6.74%. It was not known from the information how this related to specific hospital sites.
- Patient readmission rates recorded within 30 days of discharge from hospital were rated as an amber risk year to date, up to end of February 2014. Bed occupancy at Royal Sussex County Hospital indicated an average of 97.68%, as of quarter three 2013.
- Staff working in recovery reported that there were frequent occasions where patients stayed in recovery much longer than would be the norm, upwards of four to eight hours. On occasion, they were also looking after ventilated patients in recovery, as there were no beds available on the appropriate critical care unit. A non-surgical patient had been nursed overnight in recovery on the day of our visit as a result of there being no bed available on the ward. This was an inappropriate area to be nursed for this patient and also for individuals who were coming out of operating theatres.

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Competent staff

- People who we spoke with, reported a high level of confidence in the skills and competencies of staff caring for them. One person said, “Some staff are very experienced,” adding that others were in training.
- Data supplied by the trust indicated that appraisal rates for all staff, excluding medical personnel, was 62.1% as of the end of February 2014. Appraisal rates were identified on the trust’s board assurance framework as a risk. Measures were in place to improve compliance with this. Within the recovery area of theatres, we saw that appraisals were shared out between band 6 staff and there were only five appraisals outstanding out of the team of 27, although these were planned.
- Junior doctors reported having annual appraisals and supervisory meetings at the end of each placement. Supervision arrangements were in place for newly appointed staff, with competency checks related to their area of work. A newer member of staff explained how they had an induction before they started work on the cardiac high dependency unit, which was followed by a two-week period where they were not counted in the workforce numbers, during which they undertook observations of practice before assessment of competencies.
- A practice educator was available, covering orthopaedics and head and neck. We saw the positive impact that this role had on staff development, with competencies, supervision and ongoing staff development taking place. Staff induction and development was based on trauma and orthopaedic pathways specific to the respective grade.
- Information supplied by the trust indicated that, within the surgical division, the compliance rate for revalidation and appraisal was 94%, as of 28 February 2014. Medical staff had access to information concerning the appraisal process and links to an external revalidation support team and the General Medical Council.
- We reviewed information that related to the performance outcome for a number of surgical specialties, including the National Vascular Register, and noted that, for elective repair of infra-renal abdominal aortic aneurysm (AAA) and carotid endarterectomy (CEA), outcome results were within expected limites.

Outcome data was seen for cardiac procedures, including coronary artery bypass grafts, valve surgery, aortic surgery and all cardiac surgery. This information did not identify any concerns.

Multidisciplinary working

- Multidisciplinary team (MDT) working, teaching and training was said to be in place by staff. Multidisciplinary team meetings took place on Level 8 and 9a, concerning patient discharges. Patient care needs included the involvement of physiotherapists, occupational therapists and dieticians. Patients who spoke with us confirmed they had been seen by physiotherapists. Staff on the orthopaedic ward said the physiotherapists were “brilliant” and explained that the physiotherapy department had a two-tier system, with some looking after ‘poly-trauma’ patients only, and others, the general patients. There was a concern that the lack of occupational therapists delayed the discharging home process at times.
- Staff on the vascular ward reported that a MDT meeting took place on a Monday with a radiologist present. In addition, they advised that there were two vascular patient ward rounds per day, with reviews of scans carried out in the afternoon round.
- The lead matron for operating theatres worked across both hospital sites, ensuring that collaborative working took place. Theatre and recovery staff reported having excellent working relationships with anaesthetic staff.

Seven-day services

- A consultant-led service was in place at the hospital, with arrangements in place for on-call medical staff. Consultants reported that radiographer support was less available to cases that were not orthopaedic in nature and that radiology provision was difficult at weekends.
- The Sussex Eye Hospital provided a dedicated emergency service 24/7 and the ward also covered out-of-hours’ work, taking patients from as far as Worthing and Uckfield.
- Staff reported there was out-of-hours provision from pharmacy, with a pharmacist on-call after 1.30pm on Saturdays. Services from other departments were generally good. Physiotherapy staff worked seven days a week. The outreach team were available in daytime hours on weekends.

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Are surgery services caring?

Good



The majority of patients expressed a high level of satisfaction with their experience of treatment and care. Positive comments were made from all patients that spoke with us, including: “I am very impressed,” and, “It has been a very good experience.” Other comments included, “I had wonderful care from the nurses and doctors, beyond what I would expect.” Another patient told us, “I have had total respect afforded to me and have felt safe in the skills of staff.” With the exception of one patient, we were told that patients and relatives were involved in decisions about care and treatment. However, one patient on the cardiac high dependency unit expressed a level of anxiety about not being able to ask any questions.

There was information available for patients and their families about surgical procedures, as well as surgical departments, such as the cardiac high dependency unit. Information was written in such a way as to reduce any anxieties and to provide supporting information to that provided verbally by staff. Patient care needs were supported further by accessing other specialist staff and services, including counselling.

Compassionate care

- We saw staff looking after patients with compassion, respect and in a dignified manner in all areas that we visited. We heard staff taking time to explain procedures in a kind and respectful way.
- Staff in operating theatres were seen and heard giving detailed explanations of what would be happening prior to, and at all stages of, the surgical procedure. We heard staff provide reassurance and generally engaging in a discussion with a patient while they were undergoing a surgical procedure under local anaesthesia.
- We spoke with patients about their experiences and received, in the main, positive feedback about the level of care and provision of information. Care was described by one patient as, “Fabulous, can’t fault anything, very attentive, caring and polite.” One patient told how they had been helped to have a bath, telling us this was “nice”, particularly as they could not use the bath at home. Another patient said that there was a variation of the level of care, with “some nurses better than others”.

A patient on the vascular ward told us they were happy with their care and knew what would be happening after discharge to a hospice. A patient on the head and neck ward told us they had been very well cared for and “felt safer” at the hospital in comparison to where they had transferred from.

- A relative who spoke with us on the vascular ward said, regarding the care from staff, “Absolutely amazing care.” They added that they had been in the discussion of their relative’s care needs, which also included being present during the doctor’s ward rounds.
- Discussion with a patient on the digestive diseases ward indicated that they were very happy with their care. Comments made included, “Very good, always someone about when you need something.” This person said their call bell was responded to promptly, particularly at night.
- Patients on the day case unit and in cardiac high dependency unit commented on the level of respect, being looked after well and having lots of information about their treatment. Most were very grateful to staff and had high praise for the way in which they had been looked after. One person said, “I am happy to come again.”
- Patients reported that it wasn’t only clinical staff who were kind and concerned. Domestic staff were said by individual patients to be “jolly” and “fantastic”.
- We saw that regular ‘comfort’ rounds took place on wards, during which, the responsible person assessed how each person was feeling and if their needs were being addressed.

Patient feedback

- The hospital collected feedback from patients through the Patient’s Voice survey and we saw this displayed on ward areas. We reviewed information supplied to us and saw that responses from patients on the surgical wards had, in general, been good in April 2014 concerning the areas in which feedback was sought. Examples of questions covered included: ‘Treated as an individual’, ‘Involved in decisions about my care’, ‘Seen by the same doctor’ and ‘Cleanliness of wards’. The consistent area, where scores were less favourable, was for food.

Patient understanding and involvement

- Patients who spoke with us reported being involved in discussions about their treatment and care, as well as having enough information to make informed decisions. Patients had access to supplementary information to

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assist them in understanding procedures. Information leaflets were available in clinical areas and on the hospital website, covering areas such as: preventing wound infections post cardiac surgery, discharge guidance following types of surgical procedures and post-anaesthetic instructions. We also saw 'welcome' leaflets for areas such as the cardiac ward and high dependency unit.

- Patients were supplied with contact details should they need to discuss anything following their return home and who to contact if there was a problem out-of-hours.

Emotional support

- Staff could contact clinical nurse specialists for advice or direct input in patient care. There was access to a renal counselling service and a palliative care team.
- Patient initial assessment and ongoing evaluation took into account their emotional needs, including any particular mental health matters and learning disabilities. We observed staff in operating theatres providing one-to-one support while a patient was undergoing surgery under local anaesthetic.
- Patients told us that their emotional needs were met. For example, one patient said, "Staff members are really good and put me at ease." However, this same person said that, although they were seen every day by the doctors (on the digestive diseases ward), they were "not given the opportunity to ask questions". This had sometimes made them feel anxious.

Are surgery services responsive?

Requires improvement



The flow of patients through the surgical areas was affected by pressures within the hospital, such as delayed discharges and lack of bed availability. This impacted on other areas such as theatre recovery, the staff of which were often expected to care for patients in an unsuitable environment.

Surgical staff were able to meet the individual needs of patients and provided personalised care in accordance with specific care pathways. Patients had access to interpretation and translation services. Support was available for patients who had a cognitive impairment or other disabilities.

Complaints from surgical patients, although minimal, were acknowledged and responded to. Outcomes from complaints investigations were shared with staff through a range of methods, including meetings and newsletters.

Service planning and delivery to meet the needs of local people

- The surgical arrangements took into account the requirements around emergency, unplanned and elective surgery. However, we were provided with evidence which indicated that, at times, bed flow was compromised because of the lack of beds available. Staff in the recovery area of theatres reported that they were used as overflow for the intensive care unit (ITU) and general high dependency unit (HDU), which caused every-day impact on the department. Patients stayed longer and needed to have meal arrangements organised in an area that was not designed for this level of care. In addition, we were told that, on occasion, patients who had been to the scanner would be temporarily placed on the unit until a bed was available.
- We reviewed information provided to us for the period 1 March 2013 to 31 March 2014, concerning patients admitted or discharged from critical care to theatre recovery on the Royal Sussex County Hospital site, which indicated that, out of a total of 226 patients, 89 were excluded as their length of stay in recovery was less than 0.2 days (4.8 hours). However 35 patients had been admitted to recovery from critical care between the hours of 10pm and 7:34am, in order to create critical care capacity. They were later discharged to wards. The remaining 102 patients admitted to recovery had a length of stay in recovery between 0.3 days and 2.6 days, with two patients having a length of stay of 2.3 and 2.6 days, respectively.
- Inpatient and day surgery facilities were provided to meet the needs of local people on designated surgical wards, by speciality. The staff made every effort to accommodate patients according to their gender. However, we observed that there was one bay on the orthopaedic ward where this had not been possible on the day of our visit, due to bed availability.
- Staffing arrangements were designed around busy times. For example, there were staggered shift patterns in recovery to take into account high activity points around 5pm and 6pm.

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Access and flow

- The trust had a detailed access policy in place to guide staff regarding the admission process for elective and emergency surgery. Non-emergency referrals were made through the booking Hub. Concerns were expressed regarding the efficiency and effectiveness of the 'booking Hub', as well as concerns about the loss of staff knowledge and experience within the team itself, as a result of changes. Concerns were expressed regarding inappropriate patient bookings onto clinics, the lack of scheduling, the under booking of clinics and lost capacity – all of which were perceived to impact on the patient outcome.
- Patients were pre-assessed prior to admission, where they were having elective surgery requiring inpatient stay. Day case patients were assessed prior to their procedure on the day of admission on a designated day case unit.
- Bed occupancy figures were observed, as part of the patient flow and bed capacity management. A bed manager had responsibility for coordinating the operations meetings held daily at 9am, during which, bed capacity and demands were said to be discussed. On the day of our visit, we saw an example of one elective patient who had not been allocated to a ward and one vascular patient cancelled, due to the lack of a bed. Staff indicated that both activity and patient dependency had increased, particularly at weekends, which increased the pressure on beds.
- Staff in the Sussex Eye Hospital reported that they sometimes had medical or surgical outliers, although there was a specific criterion for accepting these. On occasion, the staff had also looked after inappropriate admissions, which then had to be managed under repatriation, through bed managers and matrons. These matters had been reported via the 'adverse events' system.

Discharge planning

- As part of the care pathway, staff were noted to have assessed and planned for patient discharge. For day case surgical patients, staff followed a specific discharge criteria. This included physical observations, such as the person's blood pressure and temperature, as well as information provision and follow-up arrangements.

Patients who spoke with us confirmed that staff had discussed progress and made arrangements for their discharge home, involving them and their family or carers.

- Longer-stay patients had their discharge process commenced as soon after admission as possible, in order to identify and arrange any required ongoing care needs or equipment. The provision of equipment to support the ongoing care needs at home was requested and arranged by occupational therapy, but was dependent on external agencies being able to supply such equipment. There was no supply of items such as raised toilet seats, which may have assisted in discharging some patients sooner. There is a standard stock of equipment available on site for East Sussex and Brighton patients. There is no provision for West Sussex on the RSCH site. Staff reported that the documentation requests for the community-provided equipment took considerable time to complete and we saw that information was often duplicated on this form. There were no discharge coordinators on the orthopaedic ward and staff were, therefore, spending considerable time attending to this aspect of patient care.
- Nursing staff completed records regarding the discharge process, including discharge summaries for patients' GPs. Where delays impacted on the discharge of patients, these were reported on and recorded in care records. Staff reported that some delays in discharge happened as a result of medicines not being written up the day before discharge. However, staff also said they had a supply of some medicines, such as pain relief, that they could issue from an out-of-hours stock on wards. The trust also monitored figures concerning patients who were medically fit for discharge, but who were delayed. For the Royal Sussex County Hospital site, we saw that the main cause of these delayed discharges in April 2014 was because patients were waiting for beds in intermediate care or nursing homes.
- Patient follow-up appointments were arranged via the booking Hub, and where patients were to attend for further surgery, they confirmed that they were aware of when this was planned.
- An electronic patient tracking record known as 'OASIS', an electronic patient tracking record (known as the Online Applicant Status and Information System),

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was used on surgical wards, although the bed manager commented that this was not always updated as quickly as it could be. This made it harder to identify where beds had become available.

Cancellation of surgery

- Staff reported there was a system in place to report the cancellation of surgical procedures. The main reason for these cancellations was cited as due to a lack of critical care and high dependency beds. The latter was also affected by a lack of staff to cover the available beds. Emergency lists were said to be managed by using elective cancellation slots. We saw quality indicator data that did not suggest any concerns regarding high levels of cancellations at this site up to the end of quarter three 2013.

Meeting people's individual needs

- Nursing staff were supported to manage patients who had complex needs. Close observation and nursing on a one-to-one basis was used for individuals who required additional support, including ventilation to assist patients breathing after complex surgery.
- The trust had a contract to provide interpreters to meet the language needs for all patients being treated, across the hospital sites. There was a non-emergency and emergency contact number for the service, as well as an online booking form. There was also an additional service available to contact in the event that SIS was not available. Staff also had access to an agency that provided British sign language, lip speaking and deaf-blind interpretation.
- Portable induction hearing loops were available by direct request from staff, through estates.
- The trust had a learning disabilities liaison team, which staff could access in order to provide support, education and advice for the patient, their family and carers, as well as other staff.
- The trust had a dementia care pathway in place, known as the 'Butterfly Scheme'. This was underpinned by the trust's dementia strategy. Staff said they could access support from the specialist nurse or occupational therapist, as well as the mental health service.
- The Sussex Eye Hospital was noted to be shabby concerning the paintwork and overall fabric, including the floor being in a poor state of repair. We were told it

had last been painted seven to eight years previously and would be updated in December 2014. The main entrance was draughty and there were access issues, as the automatic doors were not functioning.

Learning from complaints and concerns

- The hospital had information displayed in clinical areas and on wards, which advised people using the service as to how to raise a concern or make a complaint through the Patient Advice and Liaison Service (PALS).
- The number of complaints was collected by ward and department, as part of the hospital and trust-wide Safety Thermometer. In addition, we saw that complaints were collected and analysed by division and speciality. We saw that information had been recorded regarding response times and outcomes. By way of example, we looked at two surgical complaints and saw that one related to the booking Hub and one was about clinical diagnosis. Both complaints had been raised in January 2014 and had been responded to and closed.
- Ward managers, sisters and matrons attended a Monday meeting where they discussed feedback regarding adverse events, as well as complaints. Information was communicated to staff at departmental meetings and through monthly newsletters.

Are surgery services well-led?

Good



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

The surgical team benefitted from having a consultant-led service and medical staff felt supported and involved in promoting good patient outcome. Junior medical staff felt the hospital site provided opportunities for learning and the hospital was recommended as a good place for medical trainees.

The surgical ward and theatre staff were motivated and felt supported by effective nurse leadership and the positive working relationships with surgical colleagues. There were good governance arrangements for auditing and monitoring services. Staff learned from things that did not

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go well. Problems and emerging concerns were escalated to senior management with ease. The expected values and behaviours were known and understood by staff, although there were some continuing professional difficulties in one surgical area, which the trust was dealing with.

There were effective governance arrangements in place to ensure that information from the surgical directorate was reviewed and fully considered in order to improve patient outcomes. Patients, staff and the public had a voice and were encouraged and supported to raise concerns or issues about the service.

Vision and strategy for this service

- The trust provided a staff briefing, which outlined the launch of a work stream called 'Foundation for Success' in October 2013. This was set out to develop the trust's core values and behaviours. The board minutes for February 2014 indicated that a presentation would be made to the board advising of progress in phase 1 and how the defined values and behaviours would be implemented as part of phase 2, from April 2014 onwards.
- The surgical leadership team reflected on the requirement to deliver safe, effective, caring, responsive and well-led care and treatment. The chief of surgery, director of operations for surgery and associate chief nurse of surgery were proud of the changes and improvements to patient quality and safety. They demonstrated a commitment to the patients, staff and surgical areas, but at the same time acknowledged there were areas for improvement, which were being addressed. For example, pathways from the emergency department and a surgical assessment unit.
- Nursing staff team leaders were well-supported and well-respected by their own teams. All staff we met were committed to high quality, compassionate and safe care and treatment. Theatre staff had an 8am brief, led by the person in charge concerning the theatre activity, and felt able to contribute to discussion in an open and inclusive manner. The main concern expressed by staff was not being able to give the best care at all times due to staffing levels and issues with patient flow, both of which they felt impacted upon their patients.
- The trust had a clinical strategy for immediate and longer-term visions, which had been submitted for approval to the board in March 2014. The strategy set out the provision of services across each site, including the development of neurological surgery services on the

Royal Sussex County Hospital site in Brighton later in the year. Ward and departmental staff who spoke with us, while they did not specifically describe the vision or strategy, were aware of changes taking place and the impact this would have. For example, the move of some surgical specialties to the Princess Royal Hospital site. For some staff, this would require them to move locations, which some staff expressed concerns about.

Governance, risk management and quality measurement

- The trust had a draft safety and quality strategy for 2013/14, which set out a vision reflecting the World Health Organisation's Six Domains for Safety, as well as the five domains assessed by the commission. The strategy was noted to focus on the provision of treatment and care around five outcomes. Within the strategy, there were defined targets. For example, to reduce patient falls by a further 10% and to ensure that all patients who developed a venous thromboembolism had a root cause analysis of the event.
- The surgical division had service safety, quality and performance meetings, which were held on a monthly basis. Minutes reviewed indicated that serious incidents were fully considered and action taken. For example, we saw that, with reference to a Never Event, the policy on swab and needle count was amended to include checks on prosthesis parts – that is, parts that would need to be taken out once a prosthesis is fitted.
- We reviewed a clinical governance meeting agenda and saw that the Never Event concerning an eye patient was to be discussed later in the month of May 2014.
- The trust reviewed and implemented relevant NICE guidance within the trust and this contributed to the trust's NHS Litigation Authority status. This is an agency that manages claims of negligence against the NHS. The implementation and use of NICE recommendations were being measured through the trust's Safety and Quality Framework, which provided assurance to the board. We looked at the trust's position regarding the implementation of the NICE quality standard concerning surgical site infections, published October 2013. An update and overview of the trust progress against implementing the NICE surgical site infection guidance was in place.
- The board of directors' meetings minutes demonstrated that meetings were used as an opportunity to review an example of the patient's experience of the service,

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including outcomes and areas for improvement. The trust had a Board Assurance Framework in place, and we reviewed the version for 2013/14. Risks were identified by the trust and there were summarised actions to control the risk, the methods for monitoring, frequency, and a designated person responsible for overseeing this.

Leadership of service

- In the main, the majority of staff said there was effective leadership at departmental-level, with matrons who were both approachable and visible. Staff felt there was effective communication from matrons. The chief nurse was said to be visible and, although less visible, staff reported receiving regular communications from the chief executive.
- Staff felt generally well informed and able to discuss issues, or participate in discussions and decisions that impacted on them. A small number of staff reported a lack of direction and clinical decision-making at trust-level, but did not expand on this to explain how this impacted on them or patient outcomes.

Culture within the service

- We observed positive interactions and helpful teamwork amongst the staff we saw during our ward and departmental visits. Staff reported having a good working relationship with consultants and anaesthetists, telling us they were responsive to requests related to patient treatment or care.
- There was a positive culture in evidence of learning, both from incident reporting but also as a teaching environment.
- There were some historical cultural and internal issues within one surgical area that had not been fully resolved. These continued to manifest themselves negatively in a manner that impacted on professional working relationships. Inspectors witnessed inappropriate attitudes between two medical staff. In addition, we were made aware of concerns about leadership in the digestive diseases speciality and some

views that the department was not safe. Examples cited included: job plans not being satisfactory and a lack of independent surgical lists for middle-grade surgeons. We were told that staff had not been included in the rebuild or future developments and that morale within the surgical team in this speciality was low.

Public and staff engagement

- The public were encouraged to feedback through the Patient's Voice survey comments procedure. In addition, the public were encouraged to contribute to the NHS Friends and Family Test and 'You said, we did', (when comments or suggestions were made by people, the service posted the responses to these. The Royal Sussex County Hospital internet had information about the Patient Experience Panel, including the frequency of meetings. This panel welcomed participation from patients, carers and local community groups.
- Nursing and midwifery staff received regular communications from the director of nursing in the form of a newsletter titled 'Nursing and Midwifery Matters' (NMM). The NMM for April 2014 outlined the measures being taken regarding recruitment. It was noted too, that a member of staff had been appointed to work with the provider of the cleaning services in order to address concerns about cleaning standards. Staff also received communications from the chief executive and we saw for example in his message of 31 March 2014, in which a number of staff were mentioned as having been awarded 'Proud to Care Awards'.

Innovation, improvement and sustainability

- The trust's business plan outlined the priorities for 2014/15, with a focus on a range of areas that impacted on patient care outcomes. For example, strengthening their governance processes around quality, safety and learning from identified issues.
- The future changes for the delivery of surgical services was expected to impact on a significant number of staff. Staff had been involved in discussions around these developments.

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

Information about the service

General critical care services at the Royal Sussex County Hospital include a 16-bedded intensive care unit (ICU) on level 7 of the Thomas Kemp Tower and a 12-bedded high dependency unit (HDU) on level 5 of the Millennium Wing. Each of these units had two side rooms, generally used for patients in isolation due to infection, or if a quieter or more private setting was appropriate. General critical care services are managed by a specialist critical care team, who also manage the general critical care unit – intensive care unit (ICU) and the high dependency unit (HDU) – at the Princess Royal Hospital in Haywards Heath. There is also an eight-bedded critical care unit in the Sussex cardiac services unit in the Millennium Wing for elective cardiac patients. This unit is run by the specialist cardiac team. There is an outreach team who provide care, advice and a rapid response for managing acutely ill or deteriorating patients. The team also provides follow-up for patients discharged from critical care onto a ward. At Royal Sussex County Hospital this service is provided from 8am to 8pm, 7 days a week.

On this inspection, we visited the general ICU and HDU on Wednesday 21 May and Friday 23 May 2014. We also made a short visit to the cardiac critical care unit on Friday 23 May. At the general units, we spoke with staff, including: consultants, doctors, student doctors and nurses from different grades, and the outreach team. We met with patients who were able to talk with us, and relatives in both ICU and HDU. We observed care and looked at records and data. At the cardiac unit, we met and spoke with the nurse in charge.

Summary of findings

The critical care teams were strong, committed and compassionate. They were caring and well-led. Care they delivered was highly regarded by those who received it, their relatives and carers. We met patients who described care as “excellent” and delivered by “wonderful, kind staff who are a credit to their hospital”. Feedback we heard and read was overwhelmingly positive about the care and treatment from all staff.

Although, overall, the critical care units were good, the poor flow of patients through the hospital was affecting the ability of the general units to respond effectively. The out-of-hours discharges, delayed discharges, and high bed occupancy were not within the control of the general ICU and HDU, but patients or potential patients were affected by it. Elective surgery had been cancelled due to unavailability of critical beds. Care was compromised for patients who needed to be discharged when it was not optimal to do so.

The lack of any contribution to the Intensive Care National Audit and Research Centre (ICNARC) from the general ICU/HDU and the Sussex Cardiac Centre critical care unit, meant the staff were not able to judge their performance in the same way as the majority of other critical care units in England. The general unit took their clinical effectiveness and governance seriously and followed and monitored their own data collection

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closely, but the data was not looked at in the same way as the nationally recognised indicators. It was currently implementing the processes required to recommence submission of data to ICNARC.

Are critical care services safe?

Good



Critical care services were safe. Incidents were being reported, investigated and learned from. Infection prevention control processes were done well and unit-acquired infection rates were low. Safety risks for patients, as they related to nursing care, were now being monitored and tracked more systematically. The environment was acceptable, although it did not meet the current Department of Health building guidelines in most areas. Equipment was well maintained by an on-site technician. Records were well documented and analysed for emerging risks and possible deterioration.

There were some issues to be resolved with the safe storage of medicines. Pharmacy cover needed to be improved. Nursing staffing levels were improving, but there was a high use of bank and agency staff to cover a high level of vacancies and staff unplanned absence. Nursing staff levels were planned to meet the needs of patients and to meet the guidelines of the Royal College of Nursing. Where nursing staff levels had not been able to meet safe levels, beds had been temporarily closed in response, to ensure the safety of existing patients. Medical cover was good and met safe standards. Consultants worked in blocks of days to provide consistency to patients and their relatives.

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

Incidents

- The general critical care unit and the cardiac unit had no cause to report a Never Event (a serious, largely preventable patient safety incident, which should not occur if the available, preventable measures have been implemented). There was a recent report of one serious incident in the general unit, involving a patient acquiring a category three pressure ulcer. We reviewed the records and talked with staff, and found care pathways had

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been followed and advice had been sought and provided, but the patient had been non-compliant with advice. Another incident relating to the poor internal transfer of a ventilated patient (arriving from the ED) had led to improvements in handover protocols and information passed on. The emergency prompt cards for pre-transfer checks for patients, which included departure and arrival protocols, were clear and comprehensive.

- The units had a good culture of incident reporting, analysing, sharing and learning. We reviewed the incidents for the general unit for the last year and there was a high level of reporting of various degrees of seriousness. This indicated an open culture of reporting incidents within the department. We looked at a sample of incidents reported by the general critical care units in the last two years. Most reported incidents had been allocated to an investigator and had action plans, where required. Staff said feedback from incidents was sometimes very good, but sometimes nothing was heard. Staff agreed they could do more to take responsibility for asking for feedback and learning points. The general critical care department had developed and produced a newsletter called 'Risky Business' to raise awareness of incidents and share learning and development. The newsletters we read included notes from the safety and risk action meeting, highlighted actions not yet completed and listed themes in incident reports from the previous quarter.
- Mortality and morbidity (M&M) were reviewed at local level. The general critical care unit held monthly M&M meetings, where a range of staff attended from different disciplines connected with the patients to be discussed. We reviewed minutes and an action list from recent meetings at the general unit. One identified improvement needed was to extend the hours available for the critical care outreach team. A business case for this has been presented to extend cover to establish a 24/7 team.

Safety thermometer

- The units were performing within expected levels for patient harms. This included hospital-acquired pressure ulcers (which were low), venous thromboembolism, falls with harm, and catheter use with urinary tract infections. The nurse in charge of the cardiac unit described how all patients admitted had risk assessments, which included their fluid balance and

nutrition levels (Waterlow and Malnutrition Universal Screening Tool or 'MUST' scores). Turn charts were established to prevent pressure damage to skin.

Patients assessed as 'at risk' of falls were given a special wrist band to alert all staff to this risk. Patients were also given MRSA-suppressant therapy.

- Results of safety checks relating to patients were displayed in the units in public areas. Each department within the general critical care service had a recently-introduced robust audit of safety observations and scores (referred to as nursing metrics). The unit had been late to introduce these as standard, widely used and essential safety measurements for patients, but this was now being done. In April 2014, in the first collection of data, the audit had delivered some good, but some less satisfactory results of compliance. The matron told us the results would be used at safety and risk meetings, handover, and leadership meetings. In areas where improvements were identified, the practice educator would arrange training and development sessions and look for identifiable improvements. The varied results of compliance had reinforced the need to collect and monitor this data on an ongoing basis.

Cleanliness, infection control and hygiene

- The cleaning staff had clear responsibilities for their work. We were accompanied on the general high dependency unit (HDU) by one of the dedicated cleaning staff, who described and demonstrated their work. The cleaning routines were displayed on the entrance to the unit and the responsibilities for the different shifts during the day and evening. The cleaner described their responsibilities clearly, including how they contributed to infection prevention and control. They explained how they worked almost exclusively in the critical care area and had received specific training in cleaning and maintaining those areas. The audit results for the cleaning for March and April 2014 showed that almost all areas scored 100% against the NHS 2007 Cleaning Standards.
- The units were clean and organised around infection prevention and control. The band 5 nursing staff we met told us they started their shift by cleaning all the specialist medical equipment for their patient. There was good provision of hand-wash sinks and each we looked at had hot water, soap, and paper towels available. There was a good provision of hand sanitising gel in entrances, corridors, at the end of beds, and in

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staff areas. This was used as expected by staff, including maintenance and other staff not always on wards or units. All curtains were disposable and showed the date they were hung. Staff were aware of when they needed to be changed. The easy-clean computer keyboards were designed for infection prevention and control and an electronic system alerted staff to when they needed to be fully cleaned. There was some good use of the 'I am clean' stickers on equipment, but this was not consistent, as some were not signed or dated, and some equipment had not been labelled.

- Staff observed infection control protocols. There was correct use of personal protective equipment, such as clean uniforms or scrubs, gloves, aprons and masks if needed. A junior doctor told us they found all the personal protective equipment for prevention and control of infection, was in good supply and available at all times, including scrubs. Nurses on the general ICU, caring for patients who were in isolation, were following correct procedures, such as changing their protective clothing when withdrawing from that area. The general units had infection control notice boards in the corridors for any visitors to view. This included the latest results of audits and information about how the trust was performing with hospital-acquired infections. There was good adherence to effective hand-washing techniques with all staff we observed.
- Hospital-acquired infection rates were low. For example, in the general ICU there had been no MRSA bacteraemia since December 2012 and no hospital acquired C. difficile since December 2013.

Environment and equipment

- Security of the units was good. The general ICU and HDU units were locked and visitors were required to identify themselves upon arrival and be met by staff. On the Sussex Cardiac Centre unit, we found access was not locked and we were able to walk right into the unit unannounced and unchallenged. The unit was busy when we arrived and there was a large cohort of staff around the nursing station, but no one to address upon arrival. The general critical care unit did have a member of staff present to report to, however, the ward clerk or receptionist had limited time (a volunteer provided some help to the team), so the main desk in both the ICU and HDU was sometimes unattended. This meant access to the unit could be slow or visitors would pull staff away from their posts to respond to the doorbell.

- There was enough equipment for services provided, although some units were required to share equipment if a piece was out of action, for repair or maintenance. Each unit was funded and capable of supporting up to a certain number of patients requiring the highest level of support (level 3 patients). Units had sufficient numbers of ventilators for patients supported with their breathing. Each unit had spare equipment if a piece of kit failed. The general unit had a dedicated technician maintaining and servicing equipment within the unit, who was responsible for distributing guidance and advice on equipment and any changes or new information. We checked the resuscitation trolleys and the required checks were mostly done, but there were some gaps in general ICU and HDU, for which the explanation for the lack of a check was not clear.
- The critical care division had good facilities, although the environments did not meet the latest Health Building Note 04-02 recommended guidance for critical care units. Patients, visitors and staff commented that the relatively new facilities in the HDU were good, but the unit was below ground and there were no windows or natural light. The staff had proposed plans to decorate the unit in such a way as to brighten up the surroundings for patients. Each patient was able to see a clock and the date, but the clocks did not display the 24-hour clock, so patients could not use the time to orientate to whether it was day-time or night-time. There were television and associated services at some beds in HDU.
- The pumps used to automatically administer medicines were regularly checked. This was done at nurse handover and had recently been audited independently. The general ICU audit we reviewed for May 2014 showed which members of staff had recorded their pump check, and which had to be prompted. If a nurse had not checked a pump there were notes to describe what action had been taken (such as a bedside education session from the practice educator). We noted the majority of the unit staff had been assessed during the audit.

Medicines

- Medicines were managed safely, although some storage in the general units needed to be improved. The units had good support from the pharmacy team, but we

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were told there was insufficient time for the pharmacists to provide more than a basic service. This had been highlighted on the trust risk register and a business case presented for additional pharmacy input.

- Medicines were safely administered and records were reviewed in the general units showed medicines given when they needed to be. Any gaps in administration shown on the charts were appropriately explained. Administration was signed by two members of the nursing staff. The only concern with medicines was around some of the storage and sign-out arrangements in the general unit. Controlled drugs, such as opiates were safely stored and signed out by two members of nursing staff, as required. Potassium was safely stored in a locked cupboard on the general unit, although the nurse in charge of the cardiac unit said their stock was not in locked storage. Two nurses were required to sign out potassium, but there was only one signature in the east-side storage in the general ICU since February 2014 and in the west-side storage since October 2013. Some medicines were stored at the patient's bedside (including potassium in solution) to enable easy access for the nurse in charge of the patient. However, these cupboards on the general units were not lockable, and although they were not unattended, this did not meet good practice. The main medicines storage was locked, with keys and number pads that were susceptible to keys being misplaced. Staff recognised this and there were incident reports filed in April 2013. An action plan had been agreed and work to resolve the issues had been agreed, but nothing had been achieved a year later.

Records

- Patient records were maintained safely. We reviewed a number of electronic patient records in the general units and found them to be well completed with all the relevant information and indicators. There were comprehensive, clear and monitored nursing notes. An audit of patient records in the general units in April 2014 had found some areas less well completed and staff said these areas had been highlighted and they would be measured each month.
- Consultants recorded their conversations with patients and relatives in recently introduced formal documentation. Those consultants' notes of conversations with patients and their relatives we read

were mostly clear and legible. The notes included conversations around resuscitation wishes or advanced directives, withdrawal or escalations of care, and relatives' concerns.

- Multidisciplinary input was well documented. There were good notes made by multidisciplinary team members, such as speech and language therapists, physiotherapists and dieticians. There was good use of relevant care bundles, including, for example, catheter care, venous thromboembolism care and line care.
- Some patients in the units may require restraint for many reasons, often including high agitation and delirium. Where restraint had been used, the general units were not actively using care plans. This meant that their support of these patients, or other patients affected by the use of restraint, were not being documented as to its frequency or duration for review and analysis.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were able to give their consent when they were mentally and physically able. Staff acted in accordance with the law when treating an unconscious patient or in an emergency. Staff said patients were told what decisions had been made, by whom and why, if and when the patient regained consciousness, or when the emergency situation had been controlled.
- Staff acted in accordance with the Mental Capacity Act 2005 when patients were unable to make their own decisions. Patients were assessed by the medical staff to decide if they had the capacity to make their own decisions. This process was recorded in the patient's medical records. If a patient was assessed as not being able to make a decision about treatment when one was needed, the treatment would be given in their best interests. The decision about what was in the patient's best interests was made by the medical team, including doctors and nurses, and those who spoke for the patient, including close family or carers. If required, an Independent Mental Capacity Advocate (IMCA) would assist. Staff described how this had been done in the past and said it had worked well, but the organising of an IMCA generally would take longer than was ideal. Two band 5 nurses who had recently joined the general critical care unit from overseas, demonstrated an excellent knowledge of the Mental Capacity Act 2005 and acting in the patient's best interests.

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- Staff understood and acted in accordance with the Mental Capacity Act 2005 if it was decided to temporarily deprive a patient of their liberty. We were able to review a recent example of this in the general critical care unit and all the relevant parties had been involved. The decision had been taken with appropriate legal advice and all the parties had agreed that this was necessary to prevent further harm to the patient. The application for the licence had been made and approved by the relevant authorities.

Safeguarding

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

Mandatory training

- Mandatory training was on track to meet trust targets. We reviewed the mandatory training records for the nursing staff on the general critical care unit and the education planning programme. Due to the nature of patients admitted to critical care, the majority of nursing staff were required to undertake almost the whole suite of mandatory training provided. Most of the standard courses completed were over the 75% completion target and most staff were booked on courses that would push the result up to 100%. This did not include staff who were on planned or unplanned unavoidable absence. There were, however, problems at the trust with the e-learning software, which was criticised by staff in many departments. We were told this was being addressed by the IT department and that system upgrades were taking place to resolve the issues. Staff workbooks for training had been considered as a success by staff, who found this format good for learning.
- The general unit had practice educators to manage and develop training and induction. There were two full-time and one part-time nurse educator. New staff were supernumerary at induction for a month. They were

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

Management of deteriorating patients

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

Nursing staffing

- The critical care units used the Royal College of Nursing guidance to determine nursing staffing levels. Patients who were ventilated (level 3) were nursed by one nurse to one patient. Patients in high dependency (level 2) were nursed with one nurse for two patients.
- Each shift had structured handover sessions for the nursing team. Patients were then handed over at the bedside individually to the nurse taking over their care by the nurse finishing their shift.
- Nursing staff levels were not always adequate for all the funded beds. The units had responded to this in the last 12 months by temporarily closing some beds to new admissions to ensure patients already admitted had safe care. Levels of substantive nursing staff were improving following an ongoing recruitment programme and recent appointments. At the end of March 2014 in the general unit:
 - There was a total of 26 WTE vacancies out of 152 posts (or 17%). New staff had been recruited and were coming into post. The data we were supplied with was basic, but bank and agency spend correlated to some extent with staff shortages through sickness or vacancies. However, there was a substantial drop in temporary staff expenditure in March 2014, despite an increase in sickness and vacancies.

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- Sickness rates at the end of February 2014 were 6.2%, or slightly above the 4% England average. On average for the 11 months to February 2014 they were 5.6%, which was above the trust average of 3.8%.
- The unit had been required to place a high reliance upon bank staff and some agency staff. The matron said nursing staff vacancies on the general unit were high, particularly around band 6 nurses. Recruitment had been and remained problematic, due to the cost of living in the Brighton area and higher wage rates in London. Funding to support critical care had, however, enabled band 5 nurses to access the ICU course to gain promotion to the vacant level 6 posts. We did not review the staffing levels in detail on the cardiac unit, but the nurse in charge told us they were “generally good” and they did not often need to use temporary cover.
- Nursing staff were not always achieving their protected hours of work. For example, the unit was short-staffed due to unplanned absence on the 23 May 2014 during our visit. This resulted in the matron and the practice educator returning to clinical duties to ensure patients were safely cared for. This was done with good humour, but resignation of this being not an unusual situation due to the current level of vacancies.

Medical staffing

- The general critical care unit was consultant-led. There were two ward rounds each day led by the consultant, with input from all other relevant staff. These included: junior doctors, nurses, pharmacists and Allied Healthcare professionals.
- There was good consultant cover in the general critical care unit. There were 15 consultants who were rostered to the units. The ICU was covered by consultants who worked in rotational blocks of three or four days over two weeks. For example, one consultant may have worked Monday to Thursday one week and then Friday to Sunday the following week. Consultants would follow this pattern approximately every three months. The consultant hours covered as a minimum, were 8am to 9pm on weekdays and 9am to 4pm on weekends. The HDU was covered by consultants working in seven day blocks from 8am to 6pm weekdays and 8am to 4pm on weekends. Consultants had an on-call rota for ICU and HDU to provide telephone consultations when not on-site and this extended to returns to hospital and when late stays were required.

- Consultant handovers took place at each rota change. This was, therefore, done each Monday and Friday morning. Some consultants would talk with their colleague coming onto the rota on the evening before, if there were particularly difficult cases or longer explanations required. An hour was allowed on-site for the full rota handover.
- There was a good consultant to patient ratio. There were two consultants on duty in the general critical care unit for 28 beds. The ITU consultant covered 16 patients, which was slightly above the recommended ratio of 1:15, and the HDU consultant covered 12 patients. The consultants were fully committed to the critical care units when they were on-call or on duty and did not have other responsibilities within the hospital to attend to.
- Locum use at the hospital was limited. There were no consultant locums used at the time of our visit, and the 15 consultants working in the critical care unit would change their rotas among themselves to cover colleagues. There was some locum use among junior doctors, but this was occasional and was with reasonably well-known doctors.
- There was a good range of teaching for junior doctors. Teaching was delivered by the supervising consultant each Tuesday from 4pm, which was ‘page free’ so as to not be interrupted unless there was an emergency. A junior doctor we met said the induction onto the ward was done well and they were enjoying their posting. An appraisal and personal development plan had just been completed. The junior doctor said it was easy to access the consultants and they found the level of consultant cover to be safe and well maintained.

Major incident awareness and training

- The trust had a major incident escalation plan for business continuity, which included actions for critical care. The critical care facilities at the hospital were, however, not able to fully double their capacity in 48 hours to follow national pandemic emergency protocols. Staff said this would have been possible before the creation of the 12-bed HDU in 2010, but there would now not be enough equipment or other facilities to provide as many as 56 beds (the elective stroke unit would not be used in this calculation of emergency cover, but would be part of the service converted to emergency facilities). Emergency doubling of beds

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would be more challenging when the neurological services moved from the Princess Royal Hospital site to the Brighton site in 2014, although an extension to the HDU would be opened, increasing the bed stock by four.

Are critical care services effective?

Good



Recognised guidance for care and treatment of critically ill patients was followed by the units. Patients were assessed regularly for pain, nutrition, hydration and effective care or treatment.

The units took part in some national audit work, but were one of only a few critical care units in England not contributing to the Intensive Care National Audit and Research Centre (ICNARC). This meant staff were not able to judge their performance in the same way as the majority of other critical care units in England. It was currently implementing the processes required to recommence submit data to ICNARC. The general unit took their clinical effectiveness and governance seriously and followed and monitored their own data collection closely, but the data was not currently looked at in the same way as the nationally recognised indicators.

Nursing and medical staff were appraised to judge their competency, and professional development programmes were running. If, through audit work, staff were found to be lacking in some area of practice, bedside training and monitoring were arranged.

The outreach team at the hospital was effective in supporting patients who were deteriorating in other parts of the hospital. The team were available from 8am to 8pm, seven days a week. The arrangements for out-of-hours support from other services was adequate.

Evidence-based care and treatment

- Recognised clinical guidance was followed. Policies used to determine treatment provided in the critical care units were based upon the National Institute for Health and Clinical Excellence (NICE) guidelines and the Intensive Care Society and Faculty of Intensive Care Medicine guidelines.
- The units had taken part in national programmes and audit. For example, the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study to

examine the care of patients over 16 years old undergoing the insertion of a tracheostomy tube. An audit of NICE clinical guidelines CG50 (acutely ill patients in hospital) had been carried out and results showed good compliance. The sister with audit responsibilities on the general unit attended the national and regional meetings of the Critical Care Network. Information from those meetings was cascaded to all staff.

- The cardiac unit described their use of haemodynamic monitoring of patients and associated observations of key indicators. This included urine output, peripheral warmth, blood pressure and cardiac output. Under normal circumstances, a person's own regulatory system would maintain a healthy perfusion of tissues. But this may not be the case when a patient needs intensive care following surgery or a major trauma and the body's compensatory ability may be exhausted. Staff would then intervene to re-establish the right balance.
- Organ donation work in the critical care unit was mature and rates were improving. There were dedicated specialist nurses for organ donation, although the clinical lead for organ donation post had recently become vacant. Work done in recent years by the clinical lead had raised the profile and achievements of the organ donation team. There was improved collaborative consulting in donor work. Donations at the trust had increased in the last two years after a drop in 2011/12. Work had been focused, of late, around donation from patients post-cardiac death and this ratio had increased threefold in 2013/14 since 2011/12. Audits of organ donation work reported on why organ donation did not occur and whether there was any learning for staff from failed donations.
- There was a full programme of audit and plans for upcoming work. Audit work was monitored by the clinical lead for governance.

Pain relief

- Pain relief was well managed. Pain scores were documented in patient records using recognised techniques and measures. Nursing staff said, and we observed this, that patients who were awake were regularly checked for pain. Patients also confirmed this happened. The matron said there was a 'common-sense' approach to recognising pain from facial expressions in patients who were not fully awake

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or aware, or who suffered cognitive impairment. The nurse in charge of the cardiac unit said the team used nurse specialists for pain and assessment tools. The electronic system provided nursing staff with a recognised care pathway for pain to follow. Pain was also managed by prophylaxis, which is to anticipate pain and provide relief in advance.

Nutrition and hydration

- Nutrition and hydration was managed effectively. Electronic patient records we reviewed on the general units were well completed and safe protocols were followed. Fluid intake and output was measured, recorded and analysed. Nutritional intake was recorded for all patients and displayed as a chart. We reviewed the ICU nutrition pathway which followed the NICE guidance. Dieticians were available to visit patients and give nutritional advice to clinical staff. Staff told us that the dieticians responded quickly to requests for visits to the unit. They visited the cardiac unit, for example, at least every two days. Energy drinks and food supplements were used for patients who needed them.

Patient outcomes

- Mortality rates at the general units were as expected for a large complex unit. The Royal Sussex County Hospital units did not contribute to the Intensive Care National Audit and Research Centre (ICNARC) data, one of the few NHS ICU units in England that currently did not report to this organisation, although they were implementing the processes required to recommence submit data to ICNARC for the general units, although not the cardiac unit. Data supplied by the general unit for mortality was 13.6% for 2013/14, but this number was not adjusted to allow for predicted mortality. The ICNARC data for hospitals contributing data in England in 2012/13 uses a different mortality measure, so we are not able to offer a direct comparison with that data. This data was, however, below the rate of mortality in the wider trust.
- The number of patients readmitted to the general units within 48 hours following discharge was slightly lower than comparable units reporting to ICNARC. In April 2013 to March 2014 there were 18 readmissions within 48 hours of discharge, which was just over 1%.
- There were a low number of non-clinical transfers out from the general units when compared with similarly measured ICNARC data. This is a measure of where the unit transferred patients to other hospitals in order to

admit other patients. In 2013 there were just eight patients transferred, or 0.4% of admissions. In the first three months of 2014 there were two patients transferred, or 0.5% of admissions.

- There were good handover arrangements for patients being discharged. Occupational therapists and physiotherapists were included in patient handovers and there were improved and effective protocols for how they should be managed.

Competent staff

- The general critical care department and the cardiac unit were on track to complete all appraisals for nursing staff. Of the 172 nursing staff in the general critical care unit, only 14 staff needed to have an appraisal carried out. Other staff, who had not been appraised, had been either only recently in post (so on the induction pathway), had been, or were, absent. Staff said the appraisal process was good and that they benefited from it. Competencies relating to staff roles were tested at appraisal and nursing staff were required to provide evidence of their capabilities. Nursing staff confirmed they did not wait for formal processes if they had problems or wanted to discuss learning or development. They said their managers were available and approachable at all times.
- Nursing induction programmes followed best practice. The introductory induction programme for new staff was the programme designed by the NHS Sussex Critical Care Network. The programme included the responsibilities of the new nurse and their mentor, the role of the practice educator, core competencies, and progress towards objectives.
- The doctors and consultants we met said the revalidation programme was well underway. This was a new initiative of the General Medical Council, where doctors were required to demonstrate their competence in a five-year cycle.
- New nursing staff were mentored by trained staff and training was available. The unit had exceeded the target for mentorship qualifications. Of the 132 appropriate nursing staff across both general units, 101 had a mentorship qualification. Seven more staff were booked to attend mentorship training in 2014/15. Places for 10 more staff to complete the ICU course at Brighton University had been secured for 2014/15. Band 5 nursing staff were able to access band 6 training, so the unit was able to promote personnel internally where possible.

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Multidisciplinary working

- There was good multidisciplinary team working on the units. There were consultant-led ward-rounds, which were supported by staff from other disciplines as required. Allied Healthcare professionals (including physiotherapists, occupational therapists, speech and language therapists and dieticians) regularly attended the ward for planned or requested visits.
- The outreach team followed up with patients who were discharged from critical care onto a ward. The outreach team were available from 8am to 8pm, seven days a week. The team had six WTE band 7 nurses. The team provided support, including education, to teams in, for example, ED, the respiratory ward, trauma and the surgical unit.

Seven-day services

- There was a consultant either at the unit or on-call at home (within the permitted travelling distance) 24 hours a day, seven days a week. Consultants told us they would attend the unit on-call around once every two or three weeks, but that they provided regular telephone advice at other times. There was a senior registrar on-site at all times to provide advice and attendance.
- Staff reported out-of-hours services from other departments were generally good. The pharmacy was available until 1.30pm on Saturday and then on-call over the weekend. The matron said there were rare occasions when medicines were not available from stock out-of-hours. Physiotherapy staff worked seven days a week.
- The outreach team were available in day-time hours on weekends.

Are critical care services caring?

Good



Comments from patients, relatives and carers we heard or read were overwhelmingly positive. Patients were cared for by committed and caring staff. Patients and relatives were involved in decisions about care and treatment and, where they were able, gave informed consent. Patients not able to provide informed consent were cared for in their best interests.

The general critical care units had recently introduced the use of patient diaries, so particularly the unconscious

patients, would be able to see their care and treatment through the eyes of those who supported or visited them when they were in critical care. There was information available for patients and their families about admission to critical care, which was written in such a way so as to address anxieties and explain equipment and therapies in general use.

There was a good understanding among staff of equality and diversity and meeting different needs. Some counselling and mental health services were available for trauma patients and people with drug and alcohol dependency.

Compassionate care

- All the patients we met told us their care had been good. One patient said: "The staff are very kind," and another said: "It's been excellent. Really excellent. I have nothing but praise for them all." A patient in the HDU told us about the nursing staff, saying: "They were with me as soon as I came in, and they've not left me at any time. One of the nurses is always here and I feel very safe." Relatives and carers we met said staff had met with them soon after they arrived the first time, and had updates on each subsequent visit. All visitors we met said they had been given time with the nurses and doctors to ask questions and this had been done in a private room. Letters we read from recent care included compliments such as "treated with utmost care", and, "The dignity afforded by everyone is a tribute to your professionalism and caring attitude...this thoughtfulness was extended to all the family, during what was a very difficult and emotional time," and, "The level of care was outstanding."
- Other feedback for critical care unit was good. We reviewed a survey of just over 200 patients in general critical care, carried out in 2013, for which just over 50% responded. Almost all patients who responded described their care in ICU and HCU as "very good" or "excellent", with the majority being "excellent". This included measures of 'concern and caring', 'considering relatives' needs' and emotional support'. Some of the comments in the survey included: "There was an excellent team ethic of the staff on ICU. The attention to detail was wonderful," and, "The nursing care was the best I have seen in over four years visiting the Royal Sussex County Hospital," and, "Staff were all professional, caring in their manner, at this very scary time."

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- We observed care delivered with privacy and dignity for patients. Nurses and healthcare assistants were talking to patients with kindness and compassion. This extended to patients who were unconscious, delirious or confused. We observed curtains drawn around any patient receiving personal care or where conversations with clinical staff were private. Curtains were clipped together and had 'no entry' signs to prevent other staff or visitors entering without first considering a patient's privacy. Although critical care is almost always a mixed-sex environment, we observed some possible improvements that could have been made to these arrangements in the general ICU area. The HDU had been arranged with separate bathrooms and showers to allow single-sex use.
- Staff understood the principles of delivering compassionate care to patients receiving intensive care. This included supporting patients who were unconscious. Staff said they would talk to a patient and tell them their name, the date and time of day. They would then tell them what they were going to do when delivering care, and why. They would explain, for example, when medicines were given, when staff changed at handover, or if the patient was being moved to another department for a test. We observed a relative arriving onto the HDU and being met by the nurse in charge. The relative told the nurse who was looking after the patient that day and the relative said: "Everyone has been fantastic." A thank-you card from a relative left for the staff to read said: "[The patient] was in such capable hands and being treated with such immense kindness."

Patient understanding and involvement

- Patients felt included and involved in decisions when they were able to be. The patients we met said they had been asked for their consent for any treatment and their opinions for any decisions to be made. They told us staff had given them the advantages and disadvantages of any proposed options, including the risks and benefits. The relative of one patient said staff were "led in everything by what [the patient] wanted".
- Care and treatment was given to patients who could not give valid, informed consent in their best interests. General day-to-day care and treatment decisions, such as giving medications, giving personal care, nutrition and hydration, and performing tests were made by the clinical teams. If more serious decisions were needed, the staff would hold best interest meetings with those people who spoke for the patient, to hear all the views and opinions on future decisions.
- Patient confidentiality was mostly done well. In the units we visited, we did not see written information about patients left unattended or able to be seen by unauthorised people. We did, however, see patients' x-rays left up on a monitor screen in the intensive care unit on two occasions. This included the patient's name and other information, such as date of birth. On the first occasion, we reminded staff of their responsibilities for this information and the scans were removed. We then observed this again on the same screen shortly afterwards for a different patient. The matron of the service told us this would be reported as an incident and staff would be reminded about the confidential nature of patients' information. Some patient notes were also kept at the bedside, but there were no facilities to lock the records away to prevent unauthorised access. Senior staff were aware of this and were looking for a solution to this and the storage of medicines in the same way.
- There was information for patients and their relatives about critical care. There was a guide in the relatives' rooms in ICU and HDU. The guide for visitors told relatives and carers what to expect in critical care and explained it was normal to find admission to this unit stressful and for relatives to be anxious. Explanations of certain procedures, such as the insertion of tubes for breathing or lines for the administration of medication were explained. Relatives and carers were encouraged to talk to the patient and, for example, hold their hand. Relatives and patients were given an information booklet on critical care if the patient was going to be staying more than a few days. This was a booklet accredited to the Department of Health. Other information included how to contact the Patient Advice and Liaison Service (PALS), information on staying on a mixed-sex unit, information on screening for MRSA, organ donation advice, drug and alcohol services and bereavement advice. Most of these were available in different languages and how to access the information was described in those languages.
- There were formal end of life decision-making procedures. Staff were clear about the protocols for producing documentation for withholding resuscitation and the circumstances for that. Each team had at least

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one end of life link nurse for advice and guidance. There were bereavement services for families and carers, and access to the palliative care team. A relative of a person receiving palliative care for a life-limiting condition said the palliative care team had met with the patient and their family about a year previously and they had established a “good relationship” and they were “very helpful”. This person said the care in the ICU “was amazing” and staff “knew [the patient’s] wishes and were very considerate of them in all things”. The relative described how, when the end of life care team visited the patient, the healthcare assistant held the patient’s hand throughout the meeting. The patient’s parents were able to telephone the department at any time of the day or night to enquire about the patient and said, “Nothing is too much trouble. When we visit [the staff] just want us to have good quality time with [the patient].”

- Patients knew the names and roles of staff. Patients told us they knew the names of the staff and nurses, doctors and other staff, including the cleaning staff, always introduced themselves.

Emotional support

- Some patients were able to receive counselling or support. Patients who were admitted following a trauma were able to access counselling services. The critical care service had recently submitted a business care plan to widen counselling services to all patients receiving the service.
- Patients were given information they could understand and able to request information that was withheld if they preferred that. A patient told us they had difficulty understanding their medical problem and had asked medical staff to make sure they explained it to their daughter.
- There were mental health services available for anxiety or depression. Staff recognised how patients could become depressed during long stays in the unit. The mental health services were available from 9am to 5pm in the week and on-call at other times. There was a drug and alcohol service, also available for patients on request. Staff said these services were good, but were coping with a heavy workload.
- Nursing staff on the general critical care unit produced ‘patient diaries’ for patients who stayed longer than three days on the ward. These diaries were championed by one of the nursing team and could have entries from

anyone involved with the patient. This included doctors, nurses, the family and visitors. The families we spoke with said they found the diaries good emotional support for them too. They could see what had been happening and share their thoughts and experiences at the time to pass to the patient when they were discharged. The nursing staff said they had good feedback from patients who were able to see what had happened to them each day during their stay in critical care.

- The general critical care unit organised a regular event for past patients and their relatives using the ICU steps framework. ICU steps (support teams for ex-patients) is a charity formed in 2005 to offer support to patients and relatives www.icusteps.org. Patients and relatives were invited to attend meetings at the hospital to share and discuss their experiences of critical care. ICU steps leaflets and information was also available for patients and relatives in the unit.

Are critical care services responsive?

Requires improvement



Due to pressures elsewhere in the hospital, the general critical care unit was not able to respond at all times to the need to admit or discharge patients. This had resulted in some elective operations being cancelled when a critical care bed was needed. Too many patients were being discharged at night or their discharge into the hospital was delayed, which meant new patients were not able to be admitted.

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

Service planning and delivery to meet the needs of local people

- The service was not able to meet the needs of patients requiring general critical care at all times. Patients in the rest of the hospital were not all being discharged when fit to be. This was for a number of different reasons, mostly connected with their ongoing care. Increases in vascular and trauma services had been made without

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any corresponding increase in the capability from a bed-space or staff perspective to take more patients into critical care. There had been some increase in funded provision in April 2014 (up from 26 general ICU/HDU beds to 28) and there would be a further increase when the neurological services relocated from the Hurstwood Park Neurosciences unit at The Princess Royal Hospital site in Haywards Heath site to the Royal Sussex County Hospital later this year (although these four new beds were dedicated to neurological patients).

- The provision for critical care in the more self-contained Sussex Cardiac Centre was for elective (planned) surgery and, therefore, was more manageable. Patients coming to the cardiac unit were admitted for planned surgery and the admission to a critical care bed was, therefore, largely predictable. The unit was always full but would cancel elective operations on a risk basis if there was no bed available for a patient who was expected to require a higher level of recovery care.
- New ways of working to forward-plan had been introduced. For example, a new standard operating procedure (SOP) for general critical care admissions following elective surgery had been developed and approved by a multidisciplinary team. This included what communication was carried out between critical care and surgical teams, at what point to consider cancelling procedures, and who would make that decision.

Access and flow

- The general critical care units were unable to provide a responsive service at all times due to the poor flow of patients through the hospital. The unit was operating at almost full capacity at all times, but were having to temporarily reduce the number of beds open if nursing-staff levels could not meet safe levels, as was the case earlier in 2014. The issues had been raised through incident reporting and with the leadership of the trust. Consultants and nursing staff said the situation was putting patients who were not able to access the unit at risk. Critically ill patients were being cared for in inappropriate clinical areas, such as remaining in A&E or on medical or surgical wards. The outreach team were supporting patients, where possible, but they were not available after 8pm or before 8am. Staff reported better communication with the clinical site managers regarding discharges from critical care, but the situation remained unacceptable.

The use of a Golden Bed (a bed available each morning for unplanned admissions for critically-ill patients) was agreed and all staff would work towards this being made available.

- Too many patients were being discharged from the general units at night or their discharges were delayed. One relative we met said the patient had been moved from ICU to HDU at midnight, in order to help create capacity for new urgent, unplanned admissions. On the first day of our visit the unit had discharged three patients between 10pm and 7am on the previous night. Studies have shown discharge at night can:
 - Increase mortality risk.
 - Disorientate and stress patients.
 - Be detrimental to the handover of the patient.

Delayed discharges restricted new patients from being admitted and could result in cancelled elective surgery. There had been 23 cancelled elective operations in January to March 2014, due to no critical care bed being available. This was compared with 25 from the period Jan to December 2013.

Meeting people's individual needs

- Equality and diversity were considered. Each unit had an equality and diversity 'Red Box'. This was a resource for staff and patients containing information about various different strands of equality and diversity. The box we looked at included information on vision and hearing impairment, the Mental Capacity Act 2005, sexual orientation, interpreter services, learning disabilities, different religions and faiths, including a comprehensive guide to supporting patients from the Muslim faith (produced by the Sussex Muslim Society), guidance for supporting older people and the trust equality bulletin. All the information was current and some was offered in different languages.
- There were translation services available. There were leaflets available in a range of languages. Staff could use a telephone translation service, which, we were told, was available on short notice. Staff who had used it said it was excellent. The unit was able to arrange face-to-face translation with appropriate notice.
- The trust had staff who were experienced in supporting patients with learning disabilities. The critical care and cardiac units were able to access specialist staff for advice. Carers and relatives were also encouraged to attend the unit and provide advice and support. Nursing staff said they had good support in the past from

Critical care

professional care workers who supported people with learning disabilities who lived in the community. The cardiac unit had recently worked closely with a patient's care worker. Care workers and families were encouraged to visit the units to offer advice and guidance.

- There were staff and link workers available to meet other needs. For example, the hospital had link workers for the homeless and for people with drug and alcohol dependencies. The cardiac unit nurse described how their link for homeless people had supported and advised a patient around their care when they were discharged.

Learning from complaints and concerns

- Complaints were addressed and changes made if required. The unit did not receive many complaints. There had been only seven in the period October 2012 to September 2013, which was one of the lowest divisional rates in the hospital. People who wanted to raise a complaint or concern were directed to the PALs or they could talk with the matron or a senior member of staff. A recent complaint about the handling of communications with a bereaved family led to the staff reflecting upon and reviewing how they handled communication. The matron said staff were able to see the circumstances from the view of the family, and now put communication with others higher with the top priorities of caring for the patient.

Are critical care services well-led?

Good



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

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

Vision and strategy for this service

- The general critical care leadership team reflected the requirement to deliver safe, effective, caring, responsive and well-led care and treatment. The matron and consultant clinical lead were committed to their patients, staff and units. We found the same commitment from the nurse in charge of the cardiac critical care unit in a short, but intense, conversation. Nursing staff team leaders were well supported and well respected by their own teams. All staff we met were committed to high quality, compassionate and safe care and treatment. The overarching concern was not being able to give the best care at all times, due to the issues with patient flow and the impact upon their patients.
- The matron for the general unit, which included the general unit in the Princess Royal Hospital at Haywards Heath, was a strong and respected presence. However, the post was an interim role and had been for the past 12 months. No decision had been made at divisional level about this role being substantive.
- The service was to change in 2014 and it was understood by all concerned that this would need to be well managed. The move of the neurological service and its critical care unit from the site at Haywards Heath would take place in the autumn of 2014. There had been extensive plans and consultation about the move, but some areas were still to be resolved.

Governance, risk management and quality measurement

- The general critical care units had a consultant leading on clinical governance. The units collected, analysed and audited a range of information. This included risks, safety and quality indicators. There was a weekly leadership meeting on the general unit each Monday morning and a monthly safety, quality and performance (SQP) meeting, which fed into a divisional SQP meeting held twice each month. We reviewed the standing agenda for the general unit SQP meeting and the presentation from the April 2014 meeting. Key themes, risks, quality and safety were highlighted and discussed. This included actions already taken to address the concerns and challenges and what risks had been elevated to the trust risk register. The general unit knew where its key risks and challenges were and these were clearly articulated. The minutes of the meetings were forwarded to the trust chief nurse.

Critical care

- There were quality meetings held each quarter with the emergency department and general ICU to share experiences, discuss incidents and look for mutual improvements to services.

Leadership of service

- Leadership of the general critical care services was strong. Staff we met at all levels said they were well supported and had clear reporting responsibilities to their managers, as well as the staff reporting to them.
- The general unit had planned away days for senior staff which included the matron, clinical lead and service manager.
- The leadership of the service extended to the general critical care unit at the Princess Royal Hospital in Haywards Heath. The matron and lead consultant also managed that service and were in regular attendance. All but four of the consultant staff worked across both sites. This enabled a shared commitment to the same vision and values. Staff at both units spoke of their colleagues in the other unit and were knowledgeable about their strengths and challenges.
- The financial situation of the unit was discussed in performance meetings. Staff were, therefore, aware of how they contributed to the financial position of the hospital and their unit and where they were over or underperforming, as affected by finance.

Culture within the service

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

Public and staff engagement

- Staff were recognised for their abilities and contribution. Band 5 nurses, for example, were fast-tracked as much as possible for promotion to higher grades. A nurse in the outreach team had been runner-up in the Commitment to Care Award in the trust recent Proud to Care Awards. Staff commented upon this and were all proud of this nurse and the publicity it had given their department.
- All staff had a voice and their opinions were valued and heard. This included the dedicated member of the cleaning team we met in the HDU. They said they felt as much part of the team as the nursing or medical staff, and were included and valued. One healthcare assistant in the HDU told us they were not, however, invited to team meetings in the unit, although they otherwise felt well supported and valued.
- Due to the nature of critical care, there was no general public involvement with how the service was run, but patients and their relatives were asked to comment in some detail on their care. A new, bespoke survey for the general unit had been designed and was being rolled-out. The matron was looking into a 'You said, we did' programme to show patients and visitors where suggested improvements or adaptations had been made in the unit. An example of this was with recent input from a local Muslim organisation, where their expectations and cultural values were shared.

Innovation, improvement and sustainability

- As part of the trust's status as a major trauma centre, the general critical care unit will be evolving and changing in 2014 with the relocation of the neurological service to the site from the Princess Royal Hospital in Haywards Heath. Staff have been concentrating on this move for some time and have had little time or energy, due to access to service issues, to focus on other plans for innovation, improvement and sustainability. The major change needed has been recognised, and this is for both the general and cardiac units to actively contribute to the provision of data to the Intensive Care National Audit and Research Centre data. This will provide the units with benchmarking and comparative data, so they can see where innovation, improvement and sustainability is most needed to drive up quality and safety standards.

Maternity and family planning

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

Information about the service

Royal Sussex County Hospital provides an ante natal department with a day assessment unit and triage facility, 11 labour rooms, three of which have birthing pools, an emergency operating theatre and recovery facilities, a post natal ward with 29 beds (eight of which are used for ante natal care). There is also a room for bereaved parents to stay overnight. The gynaecology department provides inpatient (nine bedded ward), outpatient (Gynaecology assessment unit and early pregnancy unit) and emergency care services.

There are around 3,500 births a year. Medical cover is provided by a mixed group of 16 full-time and part-time consultants and their teams working across both the Royal Sussex County Hospital and Princess Royal Hospital. Midwives and specialist midwives offer a range of specialist services and are supported by maternity support workers, nursery nurses and a team of ancillary staff. Some of the medical and midwifery staff also work at the Princess Royal Hospital also run by the trust. The trust achieved Clinical Negligence Scheme for Trusts (CNST) level 2 status in February 2014. The trust have level 2 UNICEF Baby Friendly initiative status and are aiming to achieve level 3 by late 2014.

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

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

During the inspection, we spoke with six patients, reviewed four sets of notes. We spoke with four managers, nine midwives, five community midwives, two nursery nurses, one student nurse, one junior doctor, one medical student and a locum consultant. We spent time, over two days, observing and talking to staff on all of the units and in a children's centre. We also joined a doctor's round on the labour ward.

There had been concerns raised, prior to the inspection, about some poor working relationships between some consultants and midwives.

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

Maternity and family planning

Summary of findings

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

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

Instrumental and caesarean section rates were higher than expected. The trust recognised this and had strategies in place to help reduce the rate.

Midwifery staffing levels were sufficient to provide a safe service throughout the obstetrics and gynaecology (O&G) departments

During the inspection, we spoke with three patients, five relatives and reviewed five sets of notes. We spoke with four managers, seven midwives, one nursery nurse and two consultants. We spent time observing and talking to staff on all of the units. We also joined a doctors round on the labour ward. We found that care and support offered to women and their families was compassionate, kind and informative.

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

Are maternity and family planning services safe?

Requires improvement



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

Numerous staff told us that they were often afraid of reporting incidences for fear of grievances being taken up against them by staff who may have been implicated in the incident report. They were worried that, as a result, lessons were not always learnt and practice did not move forward as required.

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

Consultants were not always willing to carry a pager when on-call. This meant that the medical team did not always get the support required.

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

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

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

The trust has a higher elective CS (England 10.7% - trust 13.2%), emergency CS (England 14.6% - trust 15.4%) and instrumental delivery (England 5.9% - trust 8.0%) rate compared to the England average. The trust has developed a service improvement plan for increasing the proportion of normal births that includes the implementation of midwife-led pathways.

Maternity and family planning

Incidents

- O&G reported one Never Event between December 2012 and January 2014. A full investigation was carried out and findings and an action plan were shared with the Women's Division Quality and Safety Committee.
- They reported ten moderate patient safety incidences between March 2013 and March 2014.
- Midwifery staff were clear about incidents that required immediate escalation to the senior obstetrician and midwifery manager on-call, such as maternal death or a baby born in a poor condition.
- Staff felt there was good feedback following serious untoward incident investigations.
- It was reported to the inspection team by numerous staff in the hospital that they were often afraid of reporting incidences, for fear of grievances being taken up against them by staff who may have been implicated in the incident report. They were worried that, as a result, lessons were not always learnt or practice moved forward, as required.
- We spoke to the community midwifery manager, who told us the community midwifery service used the online reporting tool. Staff we spoke to told they were able to use the system and knew how to report incidents to their line manager. We were told that there was an average of two incidents a week, which usually related to dog bites or blood tests not being followed up.

Safety thermometer

- We saw incidences of new venous thromboembolism (VTE), urinary catheters and urinary tract infections (UTI) reported via the Safety Thermometer system. Although the trust rates for VTE and UTI were consistently above the England average, the results were not specifically attributed to the obstetrics and gynaecology (O&G) departments.

Cleanliness, infection control and hygiene

- Incidents of infection were reported, as required.
- Specialist midwives were involved in screening women with more complex needs, such as those with drug and alcohol abuse. They ensured infection control practices were in place and reported any infection control risks to the appropriate teams.
- MRSA incidences in the trust were higher than the accepted range and C. difficile rates were within an acceptable range. O&G was not identified as outliers in this category.

- We saw staff observing good hand hygiene practices and using gloves and aprons where necessary. There were hand-washing sinks available throughout the departments with liquid soap, paper towels and pedal bins at each one.
- Liquid hand sanitising gel and notices encouraging its use were displayed at the entrances to all of the O&G departments.
- Internal hand hygiene audit results were displayed in most of the areas we visited.
- We saw midwifery and medical staff adhering to the 'bare below the elbow' policy.
- We saw evidence that all community midwives and support workers had received infection control training.

Environment and equipment

- Resuscitation equipment, monitoring equipment and ultrasound scanning equipment were regularly serviced and checked for expiry dates. There were some gaps in checking equipment, for example, the fridge used for storing expressed breast milk. Staff reported equipment did not always get checked as often as it should, if they were really busy.
- Staff reported that they had access to sufficient equipment in all departments.
- The trust risk register stated that there was no replacement programme in maternity for some essential equipment. This has been an issue since 2009 and in January 2014 the equipment replacement programme was still being reviewed.
- The trust risk register stated that ultrasound equipment was outdated and in urgent need of replacement. The equipment was on the capital replacement programme 2013/14 as 'high risk' and had not yet been replaced, which could have resulted in poor imaging and a potential to miss foetal abnormality. Funding has since been allocated (March 2014) and the process of securing new equipment was underway. The equipment had not been replaced at the time of the inspection in May 2014.
- The environment was clean and tidy, with a lot of natural light. There was a security system in place on the labour ward and postnatal ward to ensure staff knew who was accessing the units.
- On the gynaecology ward, there was a whiteboard in the open ward area with patient details written on it. This meant that not all information about a patient was being kept confidentially.

Maternity and family planning

- Clean theatre scrubs for use by medical and nursing staff and birth partners who wanted to be present at a birth in the theatres were readily available during the week, but not always at weekends.
- The community manager told us all equipment used by the community midwives was checked daily to ensure it was fit for purpose. We were told homebirth bags and satellite navigation systems were in place in three pool cars.

Medicines

- Medical gases and medicines were stored securely, according to trust policies.
- We saw midwives checking controlled drugs appropriately before dispensing them to a patient.

Records

- Pregnant woman had handheld records that they kept with them and took to every antenatal appointment. They were well organised, detailed and included contact details if people needed advice.
- There were systems in place for when information needed to be shared between internal and external bodies.
- Specialist pathways were in place for high-risk women who had diabetes or epilepsy, for example. There was no pathway in place for maternal request caesarean section, which meant there was no mechanism for questioning the decision. We noted protocols for home births were in place.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw appropriate consent forms had been signed to agree to specific tests and surgical procedures in all of the departments we visited.
- Midwifery and support staff we spoke with showed a good understanding of the Mental Capacity Act 2005 and its relation to decision making in the antenatal, labour and postnatal period.
- The trust Mental Capacity Act 2005 policy (November 2013) states that all medical staff have to undergo Mental Capacity Act 2005 training at least once. It states e-learning is available via the learning and development team.

Safeguarding

- Midwifery and support staff were aware of adult safeguarding and child protection reporting systems within the trust. They had attended level 2 safeguarding training.
- The trust had an effective system for 'flagging' an at risk woman during her pregnancy, labour and in the postnatal period. There were specialist midwives involved in safeguarding cases. We saw good communication between hospital-based staff and community midwives around at risk women.
- The safeguarding midwife had a session about child protection issues and training on the O&G department induction programme for the new intake of doctors.

Mandatory training

- Staff reported, and records confirmed, that staff were able to attend mandatory training sessions.

Assessing and responding to patient risk

- The obstetric national early warning score (NEWS) was in place and staff knew what to look for and how to report any concerns they may have had. We saw completed charts that demonstrated repeated observations had taken place in the required time frames.
- The head of midwifery met with the risk manager every two weeks. They discussed capacity issues that may affect the smooth transition of a woman from the labour ward to the postnatal ward.
- Some operating lists needed to be cancelled, due to the lack of capacity on the ward. This, at times, was due to patients from a different speciality being managed on the gynaecology ward.
- The trust had higher elective CS (England 10.7% - trust 13.2%), emergency CS (England 14.6% - trust 15.4%) and instrumental delivery (England 5.9% - trust 8.0%) rates compared to the England average. The trust had developed a service improvement plan for increasing the proportion of normal births. It included the implementation of midwife-led pathways. Guidance for indication for caesarean section for medical and non-medical reasons was in place.
- There was a Never Event reported in March 2013. This was thoroughly investigated and systems put in place to prevent recurrence. The report and action plan was shared with the Women's Division Quality and Safety Committee and the Patient Safety Team, meaning that improved practice would continue to be monitored.

Maternity and family planning

- Up to the date of our inspection, 6% of women gave birth at home and we were told 90% of home births were low risk. We were told there were always two midwives present when birth was imminent to ensure good outcomes. All community midwives took part in the home birth service. Night cover was arranged by working in the obstetric unit until called for by a home birth midwife.
- Fully equipped pool cars were in close proximity to the maternity unit to ensure rapid response to a home birth. We were told that there was a transfer rate of 1% to 2% to the maternity units at Royal Sussex County Hospital and Princess Royal Hospital.
- We were told that any women who were identified as being high risk were identified on the shared drive computer system, which were overseen by the midwifery supervisors.
- There was an appropriate mix of midwives, specialist midwives, maternity support workers and nursery nurses on the obstetric departments. Staff on the obstetric wards worked 12-hour shifts and felt that was helpful in terms of continuity for patients.
- There was an appropriate mix of trained nurses and healthcare assistants in the gynaecology clinics and on the ward.
- There was limited use of agency and bank staff throughout the O&G departments. All bank and agency staff had been subject to the trust's own induction and recruitment processes.
- Sickness levels were higher than other areas in the trust. They were 5% – higher than the England average of 4.3%. Staff told us they often felt under pressure due to perceived and actual poor working relationships within the consultant group.

Midwifery staffing

- Staffing was based on the dependency of the patients using the services. Midwives told us the birth rate had decreased and, as a result, midwife numbers had been reduced. Midwives reported that although the birth rate had dropped, the workload had not reduced. There were nursery nurses on duty 24 hours a day to provide support to postnatal women.
- The community manager told us there were no vacancies across the community team and the turnover was low. We were told that there was a midwifery bank to call on from both the community midwifery team and the acute maternity units at the Royal Sussex County Hospital and the Princess Royal Hospital. We were told that the recruitment processes were slow and could take up to three months from a midwife being recruited to starting in post.
- Handovers were held at every shift change. There were handovers between medical staff on the labour suite. They were detailed and described concerns.
- Midwife to patient ratio was 1:30. This was not always seen as adequate by midwives. The Royal College of Midwives (RCM) latest advice says there should be an average midwife to birth ratio of 1:28 births. The trust had reviewed the midwife to patient ratio regularly and had seen a decrease in this. Ongoing review of demographics, clinical dependency and activity was in place to ensure safe staffing depending on the need with additional support staff being used when required to ensure safety of women in labour.

Medical staffing

- There were 16 consultants working in O&G. Some worked across both of the trust's sites. During the out-of-hours period, they were supported by registrars and junior doctors. It was reported to the inspection team that some consultants were unwilling to carry pagers when on-call.
- Locum doctors were used in the O&G department. We were told that the same locums were used in order to provide some consistency. Locums told us they felt supported by the medical and nursing staff. They said they had received the trust's induction training and had access to statutory training.
- Some doctors reported tensions in the consultant group and said that some were not engaged in the multidisciplinary approach to a woman's care. They reported that it was worse when consultants from both sites had to meet together.
- There was 24-hour medical cover for the antenatal bay, labour suite, postnatal ward and the gynaecology ward.

Major incident awareness and training

- Senior staff told us there were protocols in place for when issues needed escalating and to whom they should be reported.
- Staff had some knowledge of what constituted a major incident. They said they would report any issues to their line manager, as required.

Maternity and family planning

- We saw the 'Unexpected Situations and Emergencies During Homebirth' flowcharts were in place. For example: breech, neonatal resuscitation and postpartum haemorrhage.
- We saw that all staff had completed fire awareness training.

Are maternity and family planning services effective?

Requires improvement



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

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

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

Some areas of the gynaecology service reported limited space for storage. The early pregnancy unit (EPU) was very cramped at times.

There was poor attendance at multidisciplinary team meetings. Managers and midwives said there were potential patient safety issues and that not all relevant medical staff attended pre-planned meetings to discuss incident reports and as a result they could be slow to implement lessons learnt.

There was medical support available 24 hours a day.

The level of IT connectivity across all of the clinical bases was variable and impacted on the community midwives abilities to: review blood results in a timely way, book clinic appointments and review incidents and governance reports.

Evidence-based care and treatment

- The O&G unit used nationally recognised guidelines such as 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' and NICE guidance.

- Staff were updated about new policies and procedures at their respective departmental meetings and, where appropriate, the Maternity Liaison Services Committee.
- An area of concern for the community manager was the development of information technology (IT) across the community. We were told that there was a pilot in place to enable bookings to be made online at one of the children's centres. The community maternity service covers 56 clinical bases, 41 GP surgeries, three health centres and 12 children's centres. The level of IT connectivity across all of the clinical bases was variable and impacted on the midwives' abilities to: review blood results in a timely way, book clinic appointments and review incidents and governance reports.
- The IT difficulties were increased in areas where GPs no longer wanted midwives based in their surgeries.

Pain relief

- Epidural and pain relief such as ENTONOX® and Pethidine were available throughout labour. There were three birthing pools that midwives reported were well used and helped relieve pain for some women.
- Patients we spoke with told us their pain had been well managed.
- Patients told us if they were offered choices of pain relief and were given information to consider during the antenatal period.

Nutrition and hydration

- There were midwives, maternity support workers and nursery nurses available at all times to help new mothers with feeding their babies.
- There was a feeding room available 24 hours a day with nursing chairs, breast pumps and a fridge for storing milk. Midwives told us that having 24-hour nursery nurse support was a great help as women needed advice about feeding at all times of the day and night.
- Women were encouraged to breastfeed and there were specialist midwives available and advice displayed to help new mothers. The trust's breastfeeding policy was last updated in April 2013.
- We were told that four midwives in the trust were trained to carry out frenulotomy (release of tongue-tie) on babies on the postnatal ward. This meant that babies could learn to breastfeed effectively, more quickly.

Patient outcomes

- There were no reported maternity outliers.

Maternity and family planning

- The trust used the 11 Royal College of Obstetricians and Gynaecologists (RCOG) indicators set out in the Patterns of Maternity Care in English NHS Hospitals to help develop and improve pathways available to women.
- There were 107 maternal readmissions between October 2012 and September 2013, across the trust. This is below the expected 132.5 number for England.
- In the last quarter of 2013 there were 1,475 deliveries across the trust. This is a rise on the previous two quarters and was taken into account when looking at staffing levels on the labour suite.
- There were 1,021 emergency caesarean sections higher than the expected England average of 997.5. There were 876 elective caesarean sections, also higher than the expected England average of 782.5. The trust had a draft maternity service improvement plan designed to increase the proportion of normal births in order to reduce the higher rates of caesarean sections and instrumental deliveries.
- The trust actively encouraged vaginal birth after caesarean section (VBAC). Midwives told us the success rate was good and continuing to improve.
- The hospital had a neonatal intensive care unit (NICU), on-site. The neonatal readmission rate for the trust between October 2012 and September 2013 was 310 compared to the expected England number of 279.6.
- There were no reported unplanned maternal admissions to critical care.

Competent staff

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

Facilities

- Some areas of the gynaecology service reported limited space for storage. The early pregnancy unit was very cramped at times.

- The triage unit and day assessment unit were on different floors, which meant that sometimes women had to move between floors in an often crowded lift.
- The day assessment unit was sometimes noisy, with the two telephones ringing incessantly and cramped surroundings. This meant that there was little privacy for patients, who were being cared for behind either a curtain or a screen.

Multidisciplinary working

- There was poor attendance at multidisciplinary team meetings. Managers and midwives said there were potential patient safety issues and that not all relevant medical staff attended pre-planned meetings to discuss incident reports and as a result they could be slow to implement lessons learnt.
- Multidisciplinary team working between sites, with community midwives, McMillan nurses and community nurses was usually good and meant that women were discharged and supported appropriately.
- Communication with the community maternity team was reported as very good, resulting in effective discharges.
- We saw systems in place for communication with GPs for both the ante and postnatal periods.
- The Royal Sussex County Hospital had a neonatal intensive care unit (NICU). New mothers could stay on the postnatal ward for a period of time, if their baby was on NICU. They could then use the local Ronald McDonald House opposite the hospital so they could be near to their baby. Outreach and support services were provided to the family once they were home, as required.

Seven-day services

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

Are maternity and family planning services caring?

Maternity and family planning

Good



Staff were compassionate and caring on the O&G units. Women and their families told us they felt involved in their care and well informed.

We saw feedback was taken seriously and actions taken to make improvements in order to make people's stay, across the units, more comfortable. Specialist midwifery advice and emotional support was good.

Compassionate care

- The NHS Friends and Family Test for maternity started in October 2013. At the time of this inspection there was a 25% response rate. Overall, the majority of respondents would be 'extremely likely' or 'likely' to recommend the Royal Sussex County Hospital.
- CQC maternity survey results for 2013 showed that under 'care during labour and birth', 'staff during labour and birth' and 'care in hospital after birth, the trust was performing the same as other trusts nationally. The trust performed better than other trusts around partners being able to be involved as much as they wanted during labour and birth.
- We were impressed with the enthusiasm and professionalism of the staff, despite a large number of them having concerns about the poor working relationships within the consultant group.
- Patients we spoke to across all departments were happy with the care and support they had received.
- We were told by a person who had accessed one of the children's centres, "Getting into the system was easy and I feel very well informed." We saw information was given to the person about the website where women could access a range of information leaflets. We observed the midwives were reassuring in their approach and gave the client specific information concerning their pregnancy, antenatal classes and the availability of midwifery contacts.

Patient understanding and involvement

- Women we spoke with told us they felt involved in, and fully informed, about their care. They had handheld records that detailed all the care and support received before and after pregnancy. These documents included contact details, should the woman require any advice or help.

- Nursing and midwifery staff wore name badges. Staff told us patients liked to know the staff names and found it easy to distinguish between the different staff groups.
- The Maternity Liaison Services Committee met on alternate months. Parent representatives on the committee visited the departments regularly to seek the views of women using the services.
- We saw a midwife complete a risk assessment with a woman who was having twins. She made the referral to hospital for a hospital delivery, as a home birth would not be appropriate because the risks were too high. The woman was fully involved and informed in the decision making process.
- We saw an example of a person who had been booked late in her pregnancy and from another area of the country. They were scanned and admitted to the antenatal ward. They were offered translation services, as English was not their first language, but they understood English well. They were given a good explanation about what was going to happen and had a short and long-term plan discussed with them.

Emotional support

- There was a specialist bereavement midwife and bereavement service that won a Sussex Compassion award in the past. There was also a support group that met regularly. On the postnatal ward there was a bereavement room, set apart from the ward to allow for privacy. It contained a cool cot to allow parents to stay with their baby for longer. Written information about support services was available.
- The postnatal ward manager told us they had good working relationships with the community midwives and local GPs, so felt they were able to handover any concerns they may have had about a woman's wellbeing on discharge.

Are maternity and family planning services responsive?

Good



The O&G department responded to patients needs and had improved the options available to women with the

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introduction of 24-hour triage, increased hours in the day assessment unit, more birthing pools on the labour ward and a successful gynaecology assessment unit. This has improved flow recently.

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

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

The home birth service was started in May 2013 and had seen an increase in the home birth rate from around 3% to 6%. We were told by the community manager that it was unlikely the home birth rate would increase above 10%, as the hospitals did not have a midwifery-led unit.

There was good access to translation services and learning disability services. There was level access to shower facilities on the postnatal ward (that had eight antenatal beds) for wheelchair users. There were specialist midwives for teenage pregnancy and the travelling community.

Formal complaints were dealt with using the trust's policy. There was information about how to contact Patient Advice and Liaison Service (PALS). There was a feeling amongst staff that the lack of engagement by some of the consultants around the review of complaints or incident reports meant that lessons were not being learnt and, as a result, improvement to practice had sometimes "stalled".

Service planning and delivery to meet the needs of local people

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

- We spoke to the specialist midwife who provided the Teenage Pregnancy Service for a caseload of 30 to 40 young women each year. We were told that, although the national rate of teenage pregnancy was reducing, the level of complexity has increased. Within the Brighton and Hove area there was a high level deprivation, domestic abuse and substance misuse.
- The midwife worked closely with the safeguarding nurse for maternity services and completed detailed risk assessments in partnership with the safeguarding team, social services and the children's nurses who were linked to the health visiting service. The aim of the service was to promote a normal birth by providing young women with a comprehensive package of care and promote the normality of child birth.
- A specialist midwife told us travellers in the local area knew there was a midwifery service they could access. At the time of the inspection, there were 20 travellers who had self-referred themselves for care to the specialist midwife. We were told that one-stop clinics had been put in place to provide a flexible and responsive service to the travellers. Clinics were provided on both hospital sites.

Access and flow

- It was reported that the gynaecology assessment unit was a success and it had improved the patient "journey". This meant patients had to visit less departments and there was a reduced waiting time for them.
- The gynaecology ward used the enhanced recovery programme. This is because research suggests that if a patient gets out of bed and eats and drinks as soon as possible then their recovery from an operation is quicker, and complications are less likely to develop. The ward worked with women to encourage them in this approach and there were leaflets available, relevant to the operation the women was having.
- Bed occupancy across the trust for the maternity services between October 2013 and December 2013 was 75.1 %, compared to the England average of 58.6%.
- People were seen within expected timescales from antenatal through to postnatal. There was 24-hour medical cover, although a consultant was not always available on the labour ward.
- We saw an example of a person who had been booked late in her pregnancy and from another area of the country. They were scanned and admitted to the antenatal ward. They were offered translation services,

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as English was not their first language, but they understood English well. They were given a good explanation about what was going to happen and had a short and long-term plan discussed with them.

- Women who had a previous caesarean section were being actively offered a 'vaginal birth after caesarean section' (VBAC) option at VBAC clinics. The current uptake rate was 58%. The trust is aiming to introduce midwife-led pathways for VBAC with the aim of 75% uptake.
- The home birth service was started in May 2013 and had seen an increase in home birth rate from around 3% to 6%. We were told by the community manager that it was unlikely the home birth rate would increase above 10%, as the hospitals did not have a midwifery-led unit. We were told a business case has been developed for a midwifery-led unit but, the outcome was not yet known.

Meeting people's individual needs

- There was good access to translation services, the postnatal ward manager told us the service responded quickly to their requests.
- For women who have a learning disability (LD) a plan was developed during their antenatal or preoperative period and support and advice gained from their current LD team if they had one, or from the trust's own LD service, if required.
- On the postnatal ward, we saw there was level access to the toilet and shower facilities for people requiring the use of a wheelchair.
- The acute gynaecology pro forma included a 'brief dementia diagnostic assessment', to be completed for all emergency admissions for patients aged 75 years or over. This had to be completed within 72 hours of admission. The form advised staff of what actions should be undertaken. This included the Brighton and Sussex University Hospitals NHS Trust dementia pathway (available via the intranet), or the completion of a formal assessment.

Learning from complaints and concerns

- There was a feeling amongst nursing and midwifery staff and managers that, due to the lack of engagement from some of the consultant group around complaints and review of incident reports, lessons were not being learnt and improvements in some areas had "stalled".
- All formal complaints were dealt with using the trust's internal policy. Staff told us informal complaints would be directed to the person in charge at the time. If they

were not able to deal with the issue we were told that patients were advised of the Patient Advice and Liaison Service (PALS). We saw information about how to contact PALS on the units we visited.

- We saw examples of inpatient survey results being displayed and what actions had been taken to improve services following comments made. For example, on the postnatal ward a range of flavoured teas had been provided and were welcomed by patients. Hooks had been provided on the back of bathrooms doors to hang robes from and trays had been provided in the showers so women did not have to bend down, especially following a caesarean section, to reach their products.

Are maternity and family planning services well-led?

Requires improvement



Leadership required improvement.

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

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

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

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

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

Maternity and family planning

Vision and strategy for this service

- We were told of plans to increase the ratio of normal births – in order to decrease the number of caesarean sections.
- There were plans to increase the midwife-led pathways for ‘vaginal delivery after caesarean section’, breech, low risk twins and obesity.
- The community manager shared their vision for the development of the community midwifery service, which matched the trust vision for the organisation.

Governance, risk management and quality measurement

- The O&G service had a risk team who received the information reported via the incident reporting system. It was reported that there was limited shared vision working or learning amongst some staff groups.
- There were regular governance meetings, including the supervisor of midwives, Maternity Liaison Services Committee, perinatal and morbidity meetings, maternity audit and protocol meetings.
- Managers told us they thought there was a robust audit cycle.

Leadership of service

- Staff reported good clinical leadership within the O&G departments. They had good feedback from their line managers and felt they could approach them about issues. They felt the management were powerless to deal with the issues of culture and harassment that existed within a small group of staff.
- Staff were aware of who the chief executive and chief nurse were, and said they were both very approachable.

Culture within the service

- Staff were aware of the values and behaviours work, which was ongoing throughout the trust, to encourage staff to respect each other, support each other and work together to strive for excellence. Some staff told us it would make no difference to the problems within the O&G units.

- In order to try to address some of the cultural issues on the O&G unit, the trust had secured the services of an external agency to work with medical staff across the trust. The process started on 23 May 2014.
- Just prior to this inspection and during this visit, we had a number of whistleblowers who came forward regarding concerns around the culture and practice of the small group of staff referred to throughout this section of the report. The trust senior management team were made aware of these issues.

Public and staff engagement

- The Maternity Liaison Services Committee included a number of parent representatives. They attended the meetings and visited the maternity departments to get feedback from patients and their families.
- The NHS Friends and Family Test had a good response within the O&G unit, with mainly positive feedback. Results of the tests were displayed in some units in the department.
- Staff told us they took part in the NHS staff survey. They told us they did get feedback about the results on internal staff surveys.

Innovation, improvement and sustainability

- There was a research midwife based at the hospital. There was a lot of information displayed on the antenatal unit about what projects were ongoing. The research midwife had also set up a journal club to promote information sharing.
- Four midwives within the hospital were trained to carry out frenulotomy procedures to release a tongue-tie and aid successful breastfeeding.
- There was a feeling amongst the staff that innovation and improvements did not always happen, due to the culture within some of the staff groups.

Services for children and young people

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

Information about the service

The Royal Alexandra Children's Hospital is a purpose-built Private Finance Initiative (PFI) building that is designed for 100 beds. There are seven levels in the hospital that provide inpatient and outpatient services. The core services provided are: general paediatrics, child protection, training and education, ED (and trauma), surgery and critical care and anaesthesia.

Specialist surgery includes: plastics and burns, trauma and orthopaedics, neurosurgery, anaesthetics, ear, nose and throat (ENT) and paediatric and neonatal surgery. Specialist medicine includes: respiratory, allergy and cystic fibrosis, diabetes and endocrinology, infectious diseases and HIV, cardiology, rheumatology, oncology, gastroenterology and nutrition, epilepsy and neurology.

Neonatology is provided in the Royal Sussex County Hospital. This is adjacent to the Royal Alexandra Children's Hospital. This service is the regional neonatology unit for Sussex and works with Surrey, Sussex and Kent Neonatal Network. There are 27 cots in total. Eight cots are for neonatal intensive care, nine for high dependency and 10 for special care.

During this inspection, we visited theatres, the day surgery unit, the high dependency unit (HDU), the medical ward, the oncology day unit and the neonatology units.

We spoke with 18 patients or relatives and 35 members of staff including: senior and junior doctors, nursing staff (including specialist nurses), healthcare assistants, Allied Healthcare professionals, senior managers, ward managers and education staff.

Summary of findings

We found children's services to be generally safe, however, we had concerns about nursing and medical staffing levels and the low number of staff that had completed their mandatory training.

The reporting of incidents was satisfactory and the feedback following the investigation of the incidents had improved. The wards and units we visited were clean and staff followed the trust's infection prevention and control policy. The equipment and environment was satisfactory in all areas and had been regularly checked and maintained.

The management of medicines was satisfactory and improvement actions had been put in place to reduce the risks associated with the patient's own locker used to store their medicines. Records were comprehensive and person-centred. People had risk assessments appropriate to their needs.

Procedures were in place to safeguard children and consent was obtained before any medical or nursing interventions were delivered. There were effective procedures in place to manage the deteriorating patient.

Not all of the staff were aware of their role in the event of a major incident, improvements were needed.

Children's services were effective. The hospital used evidence-based care and treatment and maintained a

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clinical audit programme. There was evidence of multidisciplinary working. However, there were occasional delays in holding multidisciplinary team meetings.

There were procedures in place to ensure competent staff. However, there was conflicting data regarding the number of staff that had received an appraisal within the last 12 months. Both the undertaking of appraisals and data input concerning appraisals required improvement.

We found that services were responsive to the needs of the patients and their families. We noted some outstanding practice in some of the areas we visited. This included the surgical day case ward that had an effective system in place to reduce children's distress before they went to theatre.

The hospital needed to improve some of its access and patient flow processes. We noted that there were delays in transferring children from one ward/unit to another. This was predominantly due to a lack of substantive consultant cover on the medical ward to discharge children in a timely manner. The HDU also faced capacity problems, due to not being able to transfer medically stable children to the wards, because there were no empty beds for them to transfer to.

Complaints were appropriately managed and actions undertaken to improve the service or level of care in accordance. We noted that information about how to complain was only available in English.

The service was caring. Parents give positive feedback about the kindness and compassion shown by the staff. Parents were involved in making decisions about the care and treatment of their child and were offered emotional support.

We found the children's services to be well-led at a local level. Some of the staff we spoke with were aware of the trust's values and behaviours, but many were not. This meant that the new vision and strategy for the trust had not been effectively communicated to all staff groups.

There were regular patient safety and governance meetings, and these were attended by the appropriate staff groups and all of the specialities.

Staff were very positive about the culture at a local level and felt that it facilitated good working relations and team work.

Services for children and young people

Are services for children and young people safe?

Requires improvement



We found children's services to be generally safe, however, we had concerns about nursing and medical staffing levels and the low number of staff that had completed their mandatory training.

The reporting of incidents was satisfactory and the feedback following the investigation of the incidents had improved. The wards and units we visited were clean and staff followed the trust's infection prevention and control policy. The equipment and environment was satisfactory in all areas and had been regularly checked and maintained.

The management of medicines was satisfactory and improvement actions had been put in place to reduce the risks associated with using the patient's own locker for storing their medicines. Records were comprehensive and person-centred. People had risk assessments appropriate to their presenting condition.

Procedures were in place to safeguard children and consent was obtained before any medical or nursing interventions. There were effective procedures in place to manage the deteriorating patient.

Not all staff were aware of their role in the event of a major incident, therefore, improvements were needed.

Incidents

- There had been no Never Events between December 2012 and January 2014 within children's services. There had been one serious incident in the Neonatal Intensive Care Unit (NICU) between December 2013 and January 2014 concerning the competence of a member of staff. This was fully investigated and managed appropriately.
- All of the staff we spoke with told us that they knew how to report incidents and felt confident to do so. There were mixed feelings from staff regarding receiving individual feedback from an incident they had reported, although they felt that this was improving. One nurse we spoke with told us that they had received feedback in May this year for an incident that they reported in October of last year.

- We saw evidence that there was communication with staff concerning incidents. This included any emerging themes or patterns, as well as action plans to reduce the risks of further occurrences.
- The managers of the areas we visited told us that incidents were discussed during staff meetings. Staff confirmed that this was the case and said that it helped reduce further incidents.
- The majority of reported incidents within children's services were regarding medication errors.
- The NICU produced a quarterly document called 'Baby Watch'. This gave up-to-date information about reported incidents and learning points from recent incident reports.

Safety thermometer

- The safety thermometer was not used within children's services. The senior nursing staff we spoke with said that this was because there was no paediatric version.

Cleanliness, infection control and hygiene

- The areas we visited during our inspection were clean. We observed staff washing their hands between patients and hand sanitising gel was used appropriately.
- The staff we spoke with had a good understanding of trust policies regarding infection prevention and control. There was adequate personal protective equipment in all areas. This included aprons, gloves and different coloured waste and laundry bags.
- 'Bare below the elbow' policies were adhered to at all times in all of the areas we visited.
- We found that infection control audits such as hand hygiene and ward cleanliness were carried out on a regular basis.
- We noted that there was appropriate information about infection control displayed in both staff and public areas.
- During our visit to the NICU we noted that the door leading into the 'dirty' utility room (the sluice) was propped open. This was directly across from the intensive care nursery. The door should have been closed, to reduce the risk of infection spreading. We brought this to the attention of the nurse in charge.

Services for children and young people

Environment and equipment

- The environments within the children's services were safe. There had been a recent incident concerning a child accessing the balcony area on the medical ward. The ward had reported this incident and was in the process of completing its investigations.
- Equipment, including the resuscitation equipment, was regularly checked and cleaned. There was adequate equipment on the different wards and units to ensure patients' safety.

Medicines

- Medicines were stored correctly in locked cupboards or fridges when necessary. The staff on the medical unit told us that there had been problems regarding the patients' medication lockers being situated next to their beds. They said that this was because they were left unlocked at times and also because people went home without taking their medication with them. There was an action plan in place to reduce the risk of these issues happening and we saw evidence that staff had training in the use of patients' medication lockers, every two years.
- We noted that the correct procedures were followed regarding the administration of controlled drugs.
- We looked at four medical administration records on the medical ward and noted that they were accurate, with no gaps. Patients' allergies had been recorded as appropriate. Weights were recorded to ensure that prescribed medicines were weight-specific in their dosage.
- A number of areas within children's services used patient group directives (PGDs), which allowed nurses to transcribe medicines for their patients. We noted that staff had received the appropriate training and the procedure for transcribing medicines had been followed.

Records

- Records were kept in paper format in all areas. The NICU used electronic documentation for the recording of observations and prescribing. The staff told us that drug errors had reduced since the introduction of electronic prescribing.
- We reviewed preoperative checklists for children who had gone to theatre. We noted that these were completed following the trust's policy for preoperative management.

- We reviewed four patients' care plans on the medical ward. We noted that they were comprehensive and person-centred. Relevant risk assessments had been completed and there were daily evaluation records of whether people's health and emotional needs had been met.
- There was appropriate use of different pathways and protocols for medical and surgical conditions in the areas we visited. We noted that these had been comprehensively completed.
- During our inspection, we noted that records were kept securely and were accessible to healthcare staff, as appropriate.

Consent

- Staff obtained consent from patients appropriately and correctly. The staff we spoke with explained how consent was sought. This involved both the child and the person with parental responsibility.
- We noted that verbal and/or written consent was obtained on the medical and surgical wards, with signatures that stated it had been received.
- One of the parents we spoke with on the surgical ward had a copy of their child's consent form and told us that the medical staff had fully explained the proposed procedure and possible complications before they gave consent.

Safeguarding

- The areas within children's services were supported by a safeguarding nurse who visited the areas on a daily basis.
- We saw evidence that safeguarding assessments were completed by suitable staff, as appropriate. We noted that safeguarding concerns were managed in a timely manner and involved a multidisciplinary team, as required.
- All of the nursing and medical staff that we spoke with could explain the safeguarding policy and procedures and knew what they should do if they suspected abuse.
- Although the medical staff understood their responsibilities concerning safeguarding, the majority of junior doctors we spoke with said that they had not received any safeguarding training. However, we saw evidence that all junior medical staff received a comprehensive induction programme that included safeguarding children and vulnerable adults.

Services for children and young people

- 79.9% of all nursing staff within children's services had received safeguarding training at level 3. The trust should ensure that all staff have regular safeguarding training.
- The safeguarding children team produced a regular 'Safeguarding Children and Young People' newsletter. NICU produced a 'Baby Watch' newsletter around risk in the unit
- All of the children and parents we spoke with said that they felt safe and had no concerns.

Mandatory training

- The practice development educator for children's services showed us the records for mandatory training for nursing staff. We noted that there were significant shortfalls in the training received. This included only 57% of staff being up to date with mentorship training, 43.7% up to date with infection control training and 33.8% up to date with information governance. We were told that the figures were low because staff often had their mandatory study leave cancelled in order to cover shortfalls in staffing on the wards, and because much of the mandatory training was done through electronic learning, which staff did not get protected time for.
- 60% of nursing staff within the NICU had received all of their mandatory training.

Management of deteriorating patients

- The children's wards and the high dependency unit used the Paediatric Early Warning Score (PEWS). This helped to determine if there was deterioration in a patient's condition. There were clear instructions for escalation printed on the reverse of the observation charts.
- All of the staff we spoke with had received the necessary training for PEWS. All were aware of the appropriate action to be taken if patients scored higher than expected. None of the staff reported any difficulties or delays in receiving attention from medical or senior staff if a patient deteriorated.
- The charts that we reviewed showed that observations had been undertaken within the appropriate time frames, with clear documentation of the patients' PEWS score.

Nursing staffing

- NICU nursing staff numbers were assessed by the use of the British Association of Perinatal Medicine (BAPM) acuity tool. There were a number of vacancies on the

unit and shortfalls in staffing numbers were usually covered by the unit's permanent staff. The staff on the unit told us that they felt staff morale was low because of the inadequate numbers of staff. One of the parents we spoke with said that there were not enough nurses at times and that this increased the nurses' stress levels, but did not impact on the level of care given.

- Advanced neonatal practitioners (ANNPs) worked on the unit and rotated between the Royal Sussex County Hospital site and the Princess Royal Hospital.
- We noted that the vacancy rate on the children's HDU was 6.2 whole time equivalent (WTE), predominantly due to staff who were on maternity leave. However, the recommended ratio of one nurse to two patients was maintained and there was a registered nurse with ventilation competence on duty each shift.
- We spoke with staff on the medical ward, who expressed concerns about the staffing levels. Although an acuity tool was not used on the ward, the head of nursing told us that there should be a ratio of one registered nurse to four patients. They said that because they have 22 beds open rather than the funded 18 beds, this ratio was not possible. We were told that the trust was currently recruiting nursing staff to increase the staffing levels on the medical ward.
- The chief executive told us that the trust aimed to have supernumerary band 7 nursing staff. This meant that they would not be included in the nursing numbers for a clinical shift. All of the nursing staff we spoke with did not think that this would be possible and were concerned that their band 7 clinical hours would be replaced by band 5. They said that this would impact on the skills mix.
- The senior medical staff we spoke with said that they felt nursing was under resourced across the children's services.

Medical staffing

- The medical ward was covered by a 'consultant of the week' and did not have a permanent consultant lead. The staff said that, because of this, there were often delays. They said that the consultant also had other roles within the hospital, while they were covering the medical ward. This meant that some of their time could be spent in an outpatient clinic or in theatre. The ward round started at approximately 9.30am and could take up to eight hours to complete. Staff told us that this caused delays in obtaining people's take-home

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medication and in discharging them. Patients were admitted under the consultant of the week but could then be transferred to the care of a speciality doctor if they were already known to them. The consultant on-call for the medical ward out-of-hours was not necessarily the consultant of the week. All of the staff we spoke with said that if there was a lead consultant for the ward then patient care would improve and that there would be more continuity of care.

- The medical ward was covered by two junior medical staff during the day, with one registrar. The registrar told us that they were often 'stretched' and had to cover other areas such as the HDU. During the night, there was one junior doctor on the ward and a registrar 'on-site'. The registrar said that night-times could be problematic, especially if they were caring for a sick child on HDU and were also required on the medical ward. They told us that the on-call consultant was accessible if needed. Out of hours, there was access to on call doctors covering A&E and the ward areas. A consultant is present in paediatric A&E until 2200h at least and on call thereafter overnight. There is a separate consultant on call for the ward areas after 1700h and overnight'
- Staff told us that the medical staffing for the NICU and the children's HDU was adequate and that consultants were easily accessible.
- There were medical handovers at 9am and 9pm. We observed a 9am handover and saw evidence of good multidisciplinary working. The handover was consultant-led, structured and documented. There was appropriate discussion about any safeguarding issues.
- We noted that locum medical staff were used in all specialities. The consultants we spoke with said that they were 'chronically understaffed' at consultant-level and relied on locum cover. They gave examples of the cover required for paediatric surgery and epilepsy services.

Major incident awareness and training

- The trust had a major incident plan. The staff we spoke with were aware of the plan but were not aware of their specific role in the event of a major incident. We asked the ward sisters if they had a protocol or action card to follow in the event of such an incident and none of them were sure.

Are services for children and young people effective?

Good



Children's services were effective. The hospital used evidence-based care and treatment and maintained a clinical audit programme. There was evidence of multidisciplinary working with occasional delays in arranging multidisciplinary team meetings.

There were procedures in place to ensure competent staff. There was conflicting data between the records of the number of staff who had received an appraisal within the last 12 months and the actual which required resolving.

Evidence-based care and treatment

- The children's services used the NICE, Royal College of Paediatrics and Child Health (RCPCH) guidelines to define the treatment they provided. There were pathways and protocols of management and care for various medical and surgical conditions. We saw documented evidence that these were used, and updated appropriately, if there were any changes in the national guidelines.

Pain relief

- We noted that pain assessment tools were effectively used for the different age ranges.
- Patients were given analgesia, as required, and staff monitored whether the analgesia had adequately relieved the child's pain.
- There were numerous distraction therapies and techniques throughout the children's services to help reduce the patients' pain and distract them from painful procedures. Play specialists were available to assist the medical and nursing teams, as required.
- One parent we spoke with in the HDU told us that their child's pain had been effectively managed through the use of a patient-controlled analgesia (PCA) pump, followed by oral painkillers. They said that the nursing staff had regularly assessed their child's pain.

Nutrition and hydration

- The Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) was used on the wards to determine if patients were at risk of malnutrition. We noted that there were plans of care for any children at

Services for children and young people

risk, with input from speciality teams, as required.

Children and babies were frequently weighed, and there was documentation relating to their fluid, nutritional intake and output.

- The consultant staff we spoke with said that there were inadequate numbers of dieticians to fully support a child's management plan if they had nutritional problems. This was confirmed by two of the dieticians we spoke with.
- We noted that drinks, snacks and an appropriate choice of food was available for children and young people. Multiple faith foods were available on request.
- There were adequate facilities for the management of bottle-feeding.

Patient outcomes

- The children's services had an audit programme and participated in national audits, including the audits for paediatric asthma, bronchiectasis (the British Thoracic Society audit), fever, diabetes, epilepsy and paediatric pneumonia, for the Paediatric Intensive Care Audit Network (PICANet).
- The trust participated in the National Neonatal Audit Programme (NNAP) and the results from this were available.
- There was no evidence of risk regarding readmission rates to the neonatal unit.

Competent staff

- Junior medical staff reported 'excellent' access to teaching opportunities and said that they were encouraged to attend education events. The General Medical Council (GMC) National training survey (2013) reported 'better than expected' for paediatric medical staff access to educational resources.
- The neonatal intensive care unit (NICU) had a practice educator for the nursing staff who focused on staff achieving the necessary competencies needed to adequately care for babies in the unit. We noted that 80% of all nursing staff had completed their competency training.
- The nursing staff in the NICU had access to in-house training and the neonatal life support course. The junior doctors in the unit reported 'good educational supervision' and said that the consultant staff took an active interest in their teaching.
- Other junior doctors we spoke with also told us that they felt well supported and supervised by the senior medical staff.

- We spoke with staff on the surgical and medical wards and were told that there was a lack of parity regarding staff accessing courses and study leave. This was confirmed by the ward managers, who said it was dependent on their allocated budget and whether there were enough staff to cover people if they took study leave.
- During our inspection, we reviewed whether nursing staff received annual appraisals. We noted that only 50% of staff working on level 9 (the medical unit) had received an appraisal. The figures obtained through the Human Resources (HR) department showed that only 25% on the medical ward had received an appraisal within the past 12 months. We discussed this with the ward manager. They told us that there was a delay in the HR department updating their system.
- The HR figures for staff receiving an appraisal in all areas was less than 50%. We received figures showing 33% for nursing staff in the surgical day case ward and outpatient department, 44% for the high dependency unit, 31% for the surgical ward and 32% for theatre staff. This was queried with the managers for these areas, who told us that the figures were higher in reality.
- Despite the ANNPs being autonomous prescribers, less than half had received an appraisal within the last 12 months. The matron in charge of the neonatal units told us that the ANNPS rotated between the two main sites of the trust to help main their competency levels.

Multidisciplinary working

- Physiotherapists, speech and language therapists and dieticians visited the children's wards.
- We spoke with one speech and language therapist. They told us that they saw patients "when they could". They said that resources were very limited and there was only one therapist at any one time for the children's services. The consultant and nursing staff we spoke with confirmed this, and said that there were regular delays in getting children assessed and their management plan started.
- Staff on the medical ward told us that, at times, multidisciplinary team meetings were delayed because of the difficulty in getting the necessary disciplines to meet. We saw evidence of this. One patient had their multidisciplinary team meeting postponed for one week. This meant that their discharge arrangements were delayed by one week.

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- We spoke with two parents on the medical ward and they told us that they felt the multidisciplinary team was “excellent”. They said that their child’s specialist team gave “holistic care” and all visited them together in one session.
- We noted that young people up until the age of 18 were cared for within the service and saw evidence that their transition into adult services was managed effectively.
- Children and young people who were in need of mental health or psychological support had access to specialist input.
- Children and young people were, where necessary, transferred between PRH Accident and Emergency and the Royal Alexandra Childrens Hospital. We were told by the staff that we spoke with that the transfers were timely and there was good communication between the transferring and receiving staff.
- The staff we spoke with said that there were good working relations with the social work department and children were seen and assessed in a timely manner. They told us that there were proposals to move the social work team off site and said that they were concerned that this would cause delays.

Seven-day services

- Nursing cover was the same seven days a week. Medical cover changed out-of-hours. Consultants were accessible out-of-hours.
- Patients had access to a physiotherapist at the weekends.
- The radiology service operated out-of-hours and during bank holidays.
- There was an on-call pharmacist and staff had access to ward stock drugs.
- The parents we spoke with on the medical ward told us that they received the same level of care whether it was during the weekend, day or night.

Are services for children and young people caring?

Good



The service was caring. Parents give positive feedback about the kindness and compassion shown by the staff. Parents were involved in making decisions about the care and treatment of their child and were offered emotional support.

Compassionate care

- All of the patients and parents we spoke with were complimentary about the care they had received. One parent said, “The nursing care is excellent. You cannot fault it”. Another parent said, “The staff always knock before coming in. We would definitely recommend this hospital.” One child we spoke with said, “The oncology team have been fantastic”.
- We noted that there was exceptional feedback from parents about the care their children received from staff on the neonatal unit. This reflected the neonatal team winning the trust award for ‘Best Team of the Year’ in 2013.
- During our inspection, we observed all staff care for patients and their families in a kind and considerate manner. Patients’ privacy and dignity were maintained at all times.
- Parents were encouraged to visit and spend time with their children and open visiting times were in place for close family members.

Patient understanding and involvement

- All of the patients and parents we spoke with said that they had been involved in their care and in making decisions around their treatment. One child we spoke with said, “I had all of my questions answered by the doctor before I had my operation.” One parent told us that the medical staff spoke directly with their child, using words that they understood.
- There were age appropriate leaflets and booklets for children and young people that explained the different procedures they could have, as well as their medical or surgical condition.
- Each child had a named consultant and named nurse.

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Emotional support

- The parents we spoke with told us that they had received good emotional support from both the nursing and medical staff for themselves and their child.
- We noted that there were clinical nurse specialists for a number of specialities, including: oncology, eating disorders and diabetes. The parents we spoke with told us that the support from these specialists had been “invaluable”.
- The children’s services had good working relations with the Child and Adolescent Mental Health Services (CAMHS), although staff reported that there were regular delays before children were seen and assessed by them.

Are services for children and young people responsive?

Good



We found services were responsive to the needs of the patients and their families. We noted some outstanding practice in some of the areas we visited. This included the surgical day case ward that had an effective system in place to reduce children’s distress before they went to theatre.

The hospital needed to improve some of its access and patient flow processes. We noted that there were delays in transferring children from one ward/unit to another. This was predominantly due to a lack of substantive consultant cover on the medical ward to discharge children in a timely manner. The HDU also faced capacity problems, due to not being able to transfer medically stable children to the wards because there were no empty beds for them to transfer to. Beds were opened as required to manage capacity issues

Complaints were appropriately managed and actions were undertaken to improve the service or level of care in accordance. We noted that information about how to complain was only available in English.

Access and flow

- Staff reported that there were avoidable delays in the discharging of children from the medical ward. This was predominantly due to children not being seen in a timely manner by the ‘consultant of the week’ due to the consultant’s concurrent commitments. Because of this, children were kept on the short stay unit in the

children’s emergency department for longer than they should have been. This caused a lack of capacity in the short stay unit that had a knock-on effect for the emergency department because they could not admit children to the unit as there were no bed spaces.

- The medical ward was funded to have 18 beds in use. We saw evidence that on most days, 22 beds were used. The ward manager told us that a business case had been agreed to fund the additional four beds and to recruit the additional, necessary nursing staff. They told us that currently, they used bank staff to increase the nursing numbers. The medical staff numbers however, were not increased, even when more than an additional four beds were used. The manager told us that this caused delays concerning children being seen by the medical staff.
- We saw evidence that, at times, there were delays in children being transferred from the HDU to the wards due to their being no available capacity on the wards. This meant that the available capacity in HDU was reduced.
- There was no site management team within the children’s hospital. Band 6 and 7 nursing staff held the pager for operational problems including a shortage of beds. This was despite them also being responsible for the clinical care within their own ward or unit. There were bed management meetings twice a day.
- The parents we spoke with told us that they were not satisfied with the parking arrangements on the hospital site. They told us that it was difficult to find anywhere to park and that staff had not informed them about the parking permits they were entitled to.

Meeting people’s individual needs

- Babies’, children’s and young people’s individual needs were met. This was evident throughout all of the children’s services.
- Play specialists were accessible throughout the hospital. The medical ward had a dedicated play specialist, age-specific toys and activities, including: distraction techniques and a school room. There was a separate area for adolescents.
- The HDU used music as therapy and had ‘grandma’ volunteers.
- We were particularly impressed with how the day case ward met the needs of children going into theatre. There was a ‘one-way’ system that ensured children going into theatre did not see the children that were leaving the

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theatre. Small children could ride in motorised cars to theatre if they chose to do so. There were booklets available for children to read that explained what they should expect to happen while they were in hospital. These were in the format of a monkey telling a story. Parental feedback about the booklets was exceptionally good.

- There were adequate facilities for breastfeeding mothers, throughout the children's services.
- All of the inpatient areas had facilities for a parent to stay overnight and sleep. These included pull-down beds next to the child's bed. There was parental accommodation for parents whose children had to stay in hospital for a long period of time.
- Translation services were available for parents and children.
- Support was available for children with learning disabilities or physical needs, with access to registered learning disabilities nurses, as required.
- With the exception of the medical ward, neonatology and children's services wards and units actively sought the opinions and feedback from children and their parents about the care and treatment they had received. We saw evidence that they responded to the feedback. The medical ward, however, had commenced obtaining feedback the day prior to this inspection and were not, therefore, in a position to respond to any feedback received.

Learning from complaints and concerns

- There were information leaflets available for making a complaint. We only saw English language leaflets and posters displayed throughout the children's hospital.
- All of the staff we spoke with knew the correct procedure to follow if someone wished to make a complaint. This included directing the individual to the Patient Advice and Liaison Service, (PALS) if the complaint could not be dealt with at ward-level.
- We saw evidence that complaints were addressed in an appropriate and timely manner. Discussions about complaints took place at directorate and ward/unit-level. This included determining if there were any themes or patterns to the complaints, as well as identifying any actions that needed to be implemented to reduce the risk of further dissatisfaction and complaints.

Are services for children and young people well-led?

Good



We found the children's services to be well-led at a local level. Some of the staff we spoke with were aware of the trust's values and behaviours, this was a relatively new initiative.

There were regular patient safety and governance meetings, and these were attended by the appropriate staff groups and all of the specialities.

Staff were very positive about the culture at a local level and felt that it facilitated good working relations and team work.

Vision and strategy for this service

- The trust had recently implemented values and behaviours for all staff groups. This was concerned with getting the best outcomes for patients through communication, kindness, fairness, transparency, working together and excellence. Less than half of the staff we spoke with throughout children's services could tell us about this relatively new initiative or what it meant for them.
- The senior medical and nursing staff we spoke with told us that they felt services for children and young people were not high profile within the trust. One person said, "It feels like we are the poor relation." More than half of the senior staff we spoke with hoped that the trust would permit a restructuring of the divisions and that neonatology and children's services would become its own division rather than belonging to the women and children's division. However, other staff said that they would be concerned if the maternity services did not sit within the same division as neonatology.

Governance, risk management and quality measurement

- There were regular children's patient safety and governance meetings. These included representation from all specialities. Medical and nursing (including specialist nurses) staff, matrons and managers (including senior management) attended the meetings. Various governance issues were discussed at the meetings, including: complaints, accidents and

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incidents, staffing levels and quality improvement initiatives. The minutes from the meetings were available. Information from the meetings was cascaded to other staff during staff meetings or teaching sessions, as appropriate.

- There were separate governance meetings for neonatology and oncology.
- During our inspection, we asked the nursing staff we spoke with about the trust's staff survey. They told us that they had completed the survey, but the majority of people did not know how or where to access the results from the survey.

Leadership of service

- There was a defined leadership structure in place for both the nursing and medical staff.
- All of staff we spoke with said that they felt well supported by their line manager. The staff-side representatives we spoke with also said that 'local' leadership was effective and facilitated good team working.
- The nursing staff told us that the consultants had 'excellent leadership skills' across all of the neonatal and children's services. They said that they encouraged team work and valued the nursing staff.
- During our inspection, we observed the leadership skills of the ward/unit managers. We noted that they were calm, professional and well organised. It was evident that staff felt comfortable to ask the manager any questions or raise any concerns.
- The majority of nursing staff from band 6 and upwards told us that they felt 'frustrated' with senior management and felt that nursing staff did not have a "voice" at divisional or board-level. They told us that they found the executive leadership "weak" and reactive, rather than proactive.

Culture within the service

- All of the staff we spoke with felt that the culture within the neonatal and children's service was good at a local level, and that staff morale was maintained because of the working relations at a local level. All of the staff said that the good local culture had had a positive impact on quality and patient experience.

- Staff that worked in the NICU were very positive about the culture within the unit. We were told that it was a harmonious place to work and that the medical and nursing staff worked exceptionally well together.
- There were some negative comments about the culture made by some of the senior medical staff we spoke with. The concerns related to some of the culture outside of the neonatology and children's services, but had an impact on it. These were regarding medical staff not feeling valued by the senior management and executive team, with very limited involvement by the team concerning staff wanting to innovate and improve services.

Public and staff engagement

- There were regular briefs from the chief executive and the chief nurse to all staff groups. These included information about successes, opportunities, training and education, lessons learned from complaints and outcomes from auditing accidents and injuries.
- Some areas across neonatology and children's services had implemented initiatives to promote public engagement. These included parental support groups for parents whose children were in or had been in the NICU and the 'breastfeeding scheme' for babies being cared for by the neonatology units.

Innovation, improvement and sustainability

- The special care baby unit was supported by ANNPs. This was a unique model of care and only reflected by one other unit in the UK. The parents we spoke with were very positive about the provision of this service.
- The neonatology units used electronic prescribing and the recording of observations. We saw evidence that this had reduced medication errors and increased the accuracy of reporting babies' vital signs.
- There was a feeling of a lack of parity across the services regarding nursing staff accessing specialist training and courses. This meant that some staff had to fund their own courses and study in their own time.
- The junior medical staff we spoke with all said that they were encouraged to access training and education and felt supported by the senior medical staff to be innovative, especially regarding audits and research.

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

Information about the service

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

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

During our visit to Royal Sussex County Hospital, we spoke with members of the specialist palliative care and end of life facilitator, a bereavement officer, the lead cancer nurse, a transplant coordinator, porters, mortuary staff, the chaplain and frontline ward staff.

We visited a variety of wards across the trust including Bristol, Howard 1, level 9 (gastric medicine) Jowers and Egremont Wards, the bereavement office, hospital mortuary and chapel. We reviewed the medical records of nine patients at the end of life and observed the care provided by medical and nursing staff on the wards, speaking with three patients receiving end of life care and

their relatives. We received comments from our public listening event and from people who contacted us separately to tell us about their experiences. We reviewed other performance information held about the trust.

End of life care

Summary of findings

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

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

While visiting the ward areas, we randomly checked nine medical records containing do not attempt cardio-pulmonary resuscitation (DNA CPR) forms. We saw that all decisions were recorded on a standard form with a red border. The DNA CPR forms were at the front of the notes we checked, allowing easy access in an emergency and being compliant with the trust 'Resuscitation Policy C007'.

The end of life care facilitator was actively involved in running EOL training courses for staff across the Trust. We saw evidence that EOL training was available to all staff groups. Sessions were due to take place in June and July.

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

Leadership of the SPC team was good, with good team working, although there were varying views regarding the importance of EOL care at board-level.

We found little evidence of what happened above the SPC team concerning the trust's strategy around EOL care. We found that EOL care was not a regular agenda item at board meetings and the Trust had no strategy to implement the recommendations of the End of Life Care

Strategy (2008). This was confirmed by the medical director, who told us that end of life care "end of life care has been looked at mainly through the patient journey stories"

An end of life steering group is in place, but we found that, amongst non-palliative care staff, there was a lack of engagement across the trust.

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Are end of life care services safe?

Good



There was a multidisciplinary SPC team available five days per week, with the hospice providing telephone support out-of-hours. EOL care on the wards was provided by the ward staff who reported they were able to provide EOL care.

Medicines were provided in line with guidelines for EOL care. Generally, our findings showed that do not attempt cardio-pulmonary resuscitation (DNA CPR) forms were being completed correctly.

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

Incidents

- During our inspection, we visited the mortuary where the mortuary manager told us that a recent incident had occurred involving a deceased patient. They described the incident and the steps taken to prevent a similar incident from happening in the future. No further incidents had occurred.
- The critical care matron was able to explain to us in detail that 'After Action Reviews' were being introduced throughout the trust. In these, senior staff would review the clinical information, for example, after an emergency, or death. The clinical information would be reviewed and feedback given to teams to aid learning.
- The critical care outreach team liaised with the end of life care facilitator by bringing cases involving EOL patients to the EOL care team's attention. Incidents were taken to the end of life steering group for discussion.

Cleanliness, infection control and hygiene

- Overall, the standards of cleanliness and hygiene on the wards we visited were adequate.

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

Environment and equipment

- We were told by staff that a sturdy concealment trolley, wheelchair and trolleys are available for the transportation of obese patients, but problems arose in the Barry Building and side rooms, as the doorways were small and wards had little space to manoeuvre. Only three concealment trolleys were available across Royal Sussex County Hospital.
- On the wards we visited, we were told by staff that they did not have any problems getting mattresses and syringe drivers for EOL patients.
- Patients outside the safe working load were transferred to the mortuary on their bed.
- On reviewing a recent audit performed by Sodexo, the external cleaning contractor, during April and May 2014, we observed that the main delays in transporting deceased patients to the mortuary included the lack of concealment trolleys and patient handling duties in the ED and x-ray taking priority. A total of 23 breaches took place over this time.

Medicines

- The Liverpool Care Pathway medicine guidelines comprehensively set out the medication for patients receiving EOL care. Staff we spoke to were able to show us these guidelines.
- The guidance clearly set out the symptoms experienced at end of life and the medication required to manage the symptoms effectively in easy-to-follow flow diagrams.
- We were told by the ward managers on Bristol and Howard 1 wards that medication for EOL care was available on the wards and was easily accessible. The ward manager on Howard 1 was confident in the ability of the nursing staff to care well for EOL patients with syringe drivers, when supported by the SPC team.
- On both Bristol and Howard 1 wards we found that access to the controlled drugs was restricted to the appropriate designated staff and the controlled drugs

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were secured inside a metal, locked cabinet, which was secured to the wall. However, on Howard 1 Ward, the inner cupboard used to securely house the controlled drug drugs was of insufficient size to house all the medication.

- On both wards, a compliant controlled drug register was in place and we found no discrepancies between the stock (controlled drugs in cupboard) and the controlled drug record book.
- We were told by the ward manager on Bristol Ward, that medications were checked by the night staff to ensure drugs were in date and the register was completed correctly. After checking, two registered nurses (RNs) signed and dated the record book. We saw the register was up to date and clearly filled in.
- We observed that appropriate medication was stored in locked fridges in both Howard 1 and Bristol Wards with records confirming that the temperatures of the fridges were checked daily by the nurse in charge of the ward.
- Out-of-hours, we were told that systems were in place to allow ward staff to check the intranet and find where the nearest EOL medication was available, to ensure continuity in care.

Records

- Across the wards we visited, we found that paper medical records were in use and stored in lockable filing boxes at the nurse's stations.
- The trust was introducing an electronic record system that would give all staff access to patients' medical records. An EOL care tab would be available, but we were told that EOL care was at the end of the roll-out programme. Earlier EOL implementation would support the NHS Improving Quality's Transforming End of Life Care in Acute Hospitals (2012) programme, allowing staff across the trust to access the wishes and preferences of their EOL patients.
- The SPC team told us that the patients' reviewed would have their assessment findings documented in the medical records.
- The SPC records contained information to plan the appropriate care to ensure EOL patients' needs were met. This included a holistic needs assessment, which covered the control of symptoms and discussions with the patient and family around the wishes and preferences of the patients, as well as any other support required, such as: social, psychological or spiritual.

- While visiting the ward areas, we randomly checked nine medical records containing do not attempt cardio-pulmonary resuscitation (DNA CPR) forms.
- We saw that all decisions were recorded on a standard form with a red border and the DNA CPR forms were at the front of the notes allowing easy access in an emergency and being compliant with the trust 'Resuscitation Policy C007'.
- We saw evidence in two patients' medical records, of completed DNA CPR forms, which had been completed in the community and had come in with the patients. The forms were kept with the patient, as they moved round the system.
- On level 9a, we saw compliance to the 'Resuscitation Policy C007', with a registered nurse checking the DNA CPR forms daily to ensure that no red or amber ticks were evident on the forms, or any actions were required to make the forms compliant.
- Generally our findings showed that DNA CPR forms were being completed correctly. Completing the DNA CPR forms ensured that appropriate decisions were made about the care of these patients.
- The mortuary manager told us that effective systems were in place to log patients in to the mortuary. We were walked through the process and were shown the ledger type book that contained the required information. We observed that the book was completed appropriately and neatly and was delivered in a respectful way.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We were told by the SPC team that the Mental Capacity Act 2005 assessment forms were available on the hospital intranet.
- We saw an example of the incapacity form, which included 'Assessment of patient's capacity', 'Consulting with others' and 'Details of decisions taken'.
- We did not see any completed forms during the inspection.
- We were given a copy of the hospital guidance, ascribed to the Department of Health, called: 'Liberating the NHS: No decision about me, without me'.
- This department guide covered areas, such as 'Safeguarding adults at risk', 'Mental Capacity Act 2005' and 'Supporting patients with a learning disability'. The guide was well set out, with easy-to-follow diagrams.
- On Egremont Ward, we were told that a special dementia nurse came to the ward when dementia

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patients were receiving EOL care. A multidisciplinary meeting would be arranged with nurses, doctors and family. If the patient was able, they would attend the meeting. This was the forum to agree to the wishes of the patient and family. The care was decided accordingly.

Training

- We were told by the SPC team that end of life training was not mandatory. This was confirmed when we visited the wards, as some staff had received EOL training and some had not. On Bristol Ward, we were told that 40% of staff had received EOL training.
- We were given a demonstration by the end of life care facilitator of the end of life care intranet site. This was a very informative and comprehensive site, which could be accessed by all staff at any time of the day. The site included information, such as: national policy guidance, trust policies and procedures relating to end of life care, rapid discharge pathway, videos and resources, multi-professional training days and the online booking system for end of life study days.
- The end of life care facilitator was actively involved in running EOL training courses for all staff groups across the trust. Sessions that were due to take place in June and July include: 'Talking to families when your patient is dying' and 'Guidance for staff responsible for care after death'.
- We saw study days were organised two days per month for all staff to maximise their knowledge around EOL care. Subjects covered included: 'Advance Care Planning', 'Amber care bundles' and 'The Liverpool Care Pathway for the dying patient'.
- Attendance at the study days were poor due to staff not being released from the wards. This was confirmed during the inspection as a study day on the 21 May 2014 was cancelled due to lack of attendees.
- The end of life care facilitator had a 15 minute slot during the induction programme for new staff to raise awareness around the importance of 'advance care planning' and the need for all to plan for their future care. This is one of the key drivers in the NHS Improving Quality's Transforming End of Life Care in Acute Hospitals (2012) programme.
- We were told by the SPC consultant that their role included training core teams of staff on the principles of palliative and EOL care. This would include multidisciplinary team training and training of medical (FY1 and 2) foundation course doctors and core medical trainees. This was confirmed by a registrar and junior doctor we spoke to on Howard 1 ward who told us they had attended ward rounds with SPC consultant and were able to shadow the SPC team if required.
- On Bristol Ward we were told by the ward manager that all staff were trained on the syringe drivers. Training was undertaken yearly by the company who develop the syringe driver. We were unable to confirm this during the inspection.
- The trust data around syringe driver training demonstrated that in the 12 months ending April 30 2014, a total of 625 nursing staff attended in the small ambulatory pump training day. This figure is comprised of 301 'new' trained staff (either new to Brighton and Sussex University Hospitals NHS Trust or recent graduates) attending a Mandatory Infusion Devices Study Day and 324 staff that attended an Infusion Devices Update Day for Brighton and Sussex University Hospitals NHS Trust staff already experienced in the use of the T34, but required to attend a refresher after 3 years.
- The Mandatory training (syringe drivers) includes a Royal College Nursing Accredited course
- Study days were arranged for EOL care link nurses on the wards. Information was cascaded down to nursing staff at ward-level through handovers and ward meetings.
- The portering manager told us that the training of porters around mortuary duties were under review at the moment after an inspection by the Human Tissue Authority.
- The mortuary manager told us that he has no input into the training of porters within the Royal Sussex County Hospital.
- We spoke to the organ tissue transplant coordinator who has ran teaching sessions on the wards but very little uptake due to the staff pressures on the wards.
- The chaplain told us that they run a course on 'Assessing peoples spiritual needs' as staff are often anxious around the subject and that requests to support patients is usually received from the SPC team or doctors.
- We spoke with the portering manager about the arrangements for transporting patients to the mortuary. We were told that porters received training to ensure that they were able to carry out the necessary

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procedures in the mortuary at weekends and overnight. The porters we spoke to could tell us about the protocol they followed, but one porter told us he was not sure if he had been trained.

Management of deteriorating patients

- We spoke to the critical care outreach (CCO) team leader who told us they were available all week 7.30am -8pm to support ward staff when a patient is deteriorating. The team will undertake a physical assessment, liaise with the medical team and develop a clear management plan. Patients would be treated until decisions are made and provide bedside teaching to support staff in recognising that patients are deteriorating and dying.
- If a patient is dying the CCO team would deliver the appropriate care, talk to patients and the family and would handover or liaise with community teams if the patient is being discharged to the preferred place of care.
- Patients that are recognised as dying would be commenced on the Liverpool Care Pathway after discussion with the Consultant and the multi-professional team, patient and relatives. Decision making is guided by the Diagnosing Dying flow chart in the policy
- The ward manager on level 9A told us that they use the Liverpool Care Pathway as it gives 'good guidance and symptom management.' However, on Jowers Ward we were told they had not used the Liverpool Care Pathway for 2 months and on Egremont they were no longer using it.
- We found on Jowers Ward that AMBER (Assessment Management Best practice Engagement Recovery uncertain) care bundles (ACB) had been used to support patients that are assessed as acutely unwell, deteriorating, with limited reversibility and where recovery is uncertain. The ward manager told us that 'a handful of patients' had gone through amber care bundles however doctors who are outside the specialist area found them difficult to understand'.
- We were told that Consultants were not embracing the amber care bundles and it was therefore ad hoc at the moment. We found a set of medical records that said a patient was on the Amber Care Bundle but the forms were not filled out and staff were 'unsure what to do.'

Nursing staffing

- The SPC Team is made up of 4 full-time CNS's specialists and one part-time CNS's.

- An EOL care facilitator works across the trust. This is a full-time position.
- During our inspection we asked ward managers about their staffing levels and whether they had enough staff when they had to manage EOL patients but we found that no extra staff were allocated.
- On Bristol Ward the staffing establishment has remained constant with 3 registered nurses on all the shifts throughout the working day and week. Recruitment was being undertaken as the ward is short of 3.2 Registered Nurse posts. Vacant posts were being filled by bank and agency staff.
- On Jowers Ward we were told by the ward manager that staff shortages are placing a strain on all the staff. The ward has 3 senior and 3 junior RN to cover all shifts. Staffing is an issue over the weekends and at night. Difficult shifts are filled by bank and agency staff however, on occasion, a RN from another medical ward will support the shifts.
- The Specialist Nurse in Organ Transplantation was part of a small team of nurses across the South East. We were told that the establishment was due to increase to 3 full-time posts across the trust.
- We were told by the ward managers on the wards we visited that recruitment of staff was slow with successful candidates from outside the organisation taking up to 4 months to get into post. This was placing substantive staff under great pressure to maintain good standards of care.

Medical staffing

- Four palliative care consultants were available across the trust. One full-time post and one part time post employed by Brighton and Sussex University Hospitals NHS Trust was supported by 2 part-time consultant posts.

Are end of life care services effective?

Good



The SPC team was introduced as a consequence of the NICE quality standards relating to EOL care and the team based their care on these standards. The SPC team and EOL care facilitator provide evidencebased advice to other healthcare professionals across the trust.

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

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

Multidisciplinary team working was good and the SPC Team and EOL facilitator engaged well with all staff across the trust to improve services and raise EOL issues across the trust. Recent changes to the DNA CPR component of the Resuscitation policy includes policy compliance and an escalation of issues using a red and amber flag system to ensure patients safety is never compromised.

Evidence-based care and treatment

- Use of national guidelines from the National End of life Care Strategy (2008) published by the Department of Health, sets out the key stages of end of life care, applicable to adults diagnosed with a life limiting condition. The NICE end of life care quality standard for adults (QS13) sets out what end of life care should look like for adults diagnosed with life limiting conditions.
- Brighton and Sussex University Hospitals NHS Trust had implemented NICE quality standards for improving supportive and palliative care for adults, with the introduction of a specialist palliative care (SPC) team and end of life care facilitator.
- The trust was actively engaged in the NHS Improving Quality's Transforming End of Life Care in Acute Hospitals (2012) programme, which aims to improve the quality of end of life care, supporting the implementation of five key enablers which include: advance care planning, the AMBER care bundle and rapid discharge pathway for the dying person (their destination could be home or care home with nursing).
- Integrated workings of the SPC team and an end of life care facilitator demonstrated a high level of specialist

knowledge, service delivery and strategic planning, providing wards and departments across the trust with up-to-date holistic symptom control advice for patients in their last year of life.

- The EOL care facilitator told us that the NICE quality standard (QS13) had been discussed at the EOL steering group. Working groups had been set up to focus on and report back to the group on particular standards. We saw evidence that working group four was focussing on communication.
- We saw evidence across all the wards and departments we visited that the SPC team and the end of life care facilitator supported and provided evidence-based advice to other health and social care professionals (for example, on complex symptom control).
- The SPC Team and the end of life care facilitator had introduced systems that enhanced the quality of life for people with long-term conditions, ensuring that people had a positive experience of healthcare.
- The palliative care consultant told us that, through the end of life steering group, the new 'Recognising and caring for a dying person and their carers' guidance was being developed. This replacement to the Liverpool Care Pathway was due to be ready and in use by the 15 July 2014 across the trust.
- We saw the hospital had a comprehensive 'Resuscitation Policy C007', which included recent changes to the DNA CPR component of the policy. This included changes to the form layout, validity, policy compliance and an escalation of issues using a red and amber flag system.

Pain relief

- Patients commenced onto the LCP require regular assessments to ensure that symptoms are managed effectively. Nursing staff completed the assessments to show compliance and demonstrate that pain was reviewed every four hours.
- Patients under the care of the SPC team had their pain control reviewed daily and staff ensured that PRN (pro re nata or 'as needed') medication was prescribed, so through the period of adjustment any breakthrough pain could be managed.
- During daily reviews, medical and SPC teams would commence EOL medication through a syringe driver,

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when symptoms required pain to be managed in a controlled, effective way. We saw EOL patients with syringe drivers in place during the inspection and observed no patients in pain.

- On Bristol Ward we were told that the SPC team was actively involved in the pain management of EOL care patients.

Nutrition and hydration

- On Howard 1 Ward, the ward manager told us that EOL patients that could eat and drink normally would carry on doing so until their condition changed. They did not use a nasal gastric tube feeding for EOL patients.
- On Bristol and Jowers Wards, the EOL care patients received an assessment by the speech therapist and a dietician. A 'feeding at risk' system was put in place to ensure that patients were closely monitored by a registered nurse to alert staff to changes in the patients reflexes and, therefore, the food that could be tolerated safely. A puree diet may be recommended, which would be supported by the registered nurse.
- We were shown mouth care kits that were used on the wards to maintain good mouth hygiene.
- The Liverpool Care Pathway documentation contained a food and hydration section. These needed to be completed every four hours.

Patient outcomes

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

- Ward staff we spoke to confirmed that the trust was continuing to use the Liverpool Care Pathway for EOL care. Staff received guidance from the trust around the continuing use of the Liverpool Care Pathway (17 July 2013), which specified that a senior clinician in consultation with the healthcare team had to make the decision to commence patients onto the Liverpool Care Pathway and decisions should not be made out-of-hours. This showed that the trust had responded to concerns regarding the Liverpool Care Pathway and informed staff of conditions to ensure a safe approach to care for patients.
- On the wards we visited, staff were able to show us the paperwork necessary to commence a patient onto the Liverpool Care Pathway. This included a 'decision-making algorithm' (or a step-by-step procedure based on a set of guiding principles) that ensured the necessary decisions and communications were completed before placing a patient on the Liverpool Care Pathway.
- We were told by the SPC team that, as part of their role, they had developed EOL and palliative care processes and procedures, such as communication skills, around talking to families and the development of an advance care plan service, to ensure that patients' quality of life was enhanced, as they moved towards EOL care.
- We reviewed the audit undertaken by the resuscitation officer (2012/13). Areas where information was not completed properly included: 'No review date' (30/73), 'Failure to authorise emergency decisions within 72 hours' and 'Wrong signature in the consultant's box' (13/73).
- As a result of the audit the DNA CPR form was redesigned, posters had been developed to support staff around how to complete the form and the development of an escalation protocol was put in place. Educational opportunities had been arranged.
- Following referral to the SPC team, patients on the Liverpool Care Pathway were reviewed by the team on a regular basis, depending on the needs of the patient. On assessing the patient, the SPC team will decide whether a patient needs to be seen by the SPC team on a daily, weekly or singular basis.
- We were told by the SPC team that the intensive care unit (ICU) had comprehensive systems and processes in

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place to support patients requiring EOL care, including: 'The withdrawal of treatment protocol'. Staff could tell us about the protocols they followed. The SPC team told us that EOL care was well managed.

Competent staff

- SPC staff were supported through one to one's, appraisals, journal clubs, case studies, continuing professional development days and away days with other teams, across the trust, to develop a knowledgeable, motivated team.
- We were told by the EOL care facilitator that there were no competencies around EOL care.
- We reviewed the personal development plan (PDP) of the SPC team leader and found that one to one's had taken place where objectives had been set and achieved.
- We saw evidence of continuing professional development (CPD) through attending outside courses to further develop skills and knowledge.

Multidisciplinary working

- The SPC team multidisciplinary meeting was held on Tuesdays at 2pm. There was a video-conference link between Princess Royal Hospital and the Royal Sussex County Hospital, to ensure that all staff within the team were included.
- Patients known to the SPC multidisciplinary team who had been discharged or died, were discussed on Friday mornings. Achievement of preferred place of care is further assessed and documented at this meeting.
- The lung, head and neck cancer multidisciplinary teams were attended by a palliative care consultant, but there was no cross-cover during absence.
- A weekly, joint lung cancer clinic was attended on a Tuesday morning by a palliative care consultant, but there was no cross-cover during absence.
- A palliative care consultant would attend the joint head and neck cancer clinic on a Wednesday morning on an ad hoc basis, if there are urgent and complex palliative care needs, but there was no cross-cover during absence.
- We saw evidence, across the wards we visited, of multidisciplinary team meetings to discuss and guide staff on patient management issues. These were attended by a range of staff including: nursing and medical staff, social workers, and discharge coordinators.

- We were told that in gynaecology, two Macmillan nurses attended the ward rounds and multidisciplinary team meetings in order to input into the management of gynaecological oncology patients. Staff reported that EOL was a challenge, but they believed they had good guidelines to follow.

Seven-day services

- We were told by the SPC team that systems were in place (such as palliative care consultant on-call rotas) to provide timely SPC and advice at any time of the day or night for people approaching the end of life or receiving palliative care who might benefit from specialist input.
- The SPC team was currently not staffed or funded to provide a seven day per week visiting service.
- Out-of-hours, the Martlet Hospice would give telephone advice and support. This meant that staff caring for EOL patients had access to specialist skills to support their palliative needs.
- A junior doctor on Howard 1 Ward told us that they felt confident in the support mechanisms in place for EOL patients and would contact the hospice out-of-hours, if needed.
- The chaplaincy team could be contacted via the ward staff. Out-of-hours the chaplain could be contacted via the switchboard.

Are end of life care services caring?

Good



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

Compassionate care

- Staff said end of life care was sensitive and caring. We were able to talk to two people that were receiving end of life care.
- We spoke to two patients who were receiving palliative care. They told us, "Care felt safe here, and people were listening to me," and "The care was outstanding," during the treatment they received in the Sussex Cancer Centre.

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- On Bristol and Jowers Wards, staff told us that patients on EOL care would be offered a side room if this was available (there was only one on the Bristol Ward) and if this was being used to nurse an infection-control patient, EOL patients would have to be nursed in the bays.
- On Howard 1 Ward, only one side room exists that can be used for EOL patients. A two-bed bay can be used if the side room is occupied. We were told by the ward manager that there was a sofa bed in the day room that relatives could use, however, there were no shower facilities available. Refreshments were offered to the family.
- A pink parking ticket could be collected from security. This allowed relatives to park in the oncology car park.
- A bereavement midwife was available at the Royal Sussex County Hospital. A bereavement support group organised a memorial event annually for parents to attend.
- The chaplaincy team had a group of volunteers who sat with dying patients. This was confirmed on Bristol Ward, where the ward manager confirmed that volunteers sat with dying patients who may have been frightened, or have no relatives. One volunteer we spoke to was able to explain to us how they supported an EOL patient.
- The SPC team appointed a 'key worker' to each of their patients, to ensure continuity of care for both the patient and family. For some patients, the cancer site-specific Macmillan clinical nurse specialist would remain the key worker when SPC medical advice was provided. The key worker role would be handed over to the community key worker, on discharge.
- The ward manager on Bristol Ward told us that families were offered tea and coffee and a snack box was collected from the canteen for them during their stay.
- A bereavement room was available on the postnatal ward, for couples who had lost a baby. The room had just finished being refurbished by a couple who had lost their baby. The trust had fitted a shower. The room had a double bed, TV, excellent views on the twelfth floor, drink-making facilities and it was set away from the postnatal ward, so there was plenty of privacy.
- In the Endoscopy Suite, we visited the "quiet room", which was used to break bad news to relatives and also by families who were anxious or upset. The room

contained comfortable seating along with facilities to make a drink a telephone and a computer. Information booklets were available for patients and relatives to read following their consultation.

- In the Jowers Ward, we were told by the ward manager that they had no facilities for families to stay. Staff told us that the staff room had to be released to let EOL care families stay there overnight.
- After medical teams had discussed DNA CPR, the patients and relatives were given an information leaflet, which explained the topic, covering areas such as, 'What cardio-pulmonary resuscitation means' and, 'Do people recover after resuscitation?' as well as 'Does DNA CPR mean not for active treatment?'. This ensured that patients and carers were kept well informed on decisions that affected them.

Patient understanding and involvement

- We were told that, on Howard 1 Ward, doctors were good at communicating with patients and family about the patients' care plans. The ward doctors would review patients daily and talk to families where necessary, in order that patients and family were involved in the decision-making process. One patient had been told that they were terminally ill, but was not dying imminently, so discussions were being made to organise the patient's preferred place of care.
- The ward manager on Bristol Ward told us that, "Consultants are good at communicating with the patients and family," and they are able to identify when further active treatment was not beneficial to the patient. The ward manager also told us that, when a patient was placed on the Liverpool Care Pathway, relatives were taken through the Liverpool Care Pathway documentation page by page to explain the plan of care and answer any questions related to the Liverpool Care Pathway and their relative.
- On the wards we visited, staff told us that they encouraged relatives to get involved in mouth care of end of life care patients. We saw that mouth care kits were available on the wards and were placed at the bedside.
- The organ tissue transplant coordinator explained how families could get involved and be supported through the organ transplant process. The promise to the family was that they could stay with their relative from going to theatre, all the way to the chapel of rest.

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- Families were actively encouraged to get involved in preparing their relative, but we were told that everything was done in accordance with the wishes of the family. A strong bond developed between the transplant coordinator and the family.
- After the death of a patient, the ward manager on Bristol Ward told us that some families wished to be involved in the after-death care. The ward staff respected the families' cultural requests and encouraged them to get involved.
- During our visit to the ED, we were told by staff that there were links with the SPC team to provide emotional and practical support for relatives and staff who suffered after the sudden death of a patient. For patients that required going home to be cared for, the SPC team would facilitate the Rapid Discharge Pathway for the Dying Person.
- The bereavement officer carried out the administration of a deceased patient's documents and belongings, issuing the Medical Certificate of Cause of Death, providing practical advice and signposting relatives to support services, such as funeral directors. The office was open, Monday to Friday, 9am to 5pm.

Emotional support

- All the specialist palliative care team had completed the training necessary to enable them to practice at level 2 for the psychological support of patients and carers.
- All team members who are practicing at level 2 received monthly clinical (group) supervision for at least one hour by a level 3 or 4 practitioner, in compliance with the Specialist Palliative Care Measures (2012).
- Volunteers were available from the chaplaincy to provide emotional and spiritual support. One volunteer told us that they had attended the Macmillan support intensive listening skills course. "We were given two examples where volunteers sat with dying patients. The volunteer told us we were guided by the nurses. One patient liked to be touched, so the volunteer was able to hold the patient's hand while she sat with the EOL patient."
- On Egremont Ward, a healthcare assistant told us that families that needed support could contact the bereavement office, where support could be organised by the staff and where access to the chaplaincy could be made.

- We spoke with the end of life care facilitator, who told us that they were reviewing the way that babies and children were carried to the mortuary, from the ED and the labour ward. The present system could often cause distress and a new way of working was being developed.
- Regular meetings were taking place between the EOL facilitator and the children's hospital to discuss the social and psychological challenges around the death of a baby or child to ensure that parents and children were treated with the utmost dignity and respect at such a distressing time.

Are end of life care services responsive?

Good



All patients requiring EOL care could access the SPC team, with 26% of referrals not relating to patients with cancer. The team received 1,220 referrals in 2012/13 and aimed to review all urgent referrals within 24 hours. The end of life care facilitator role responded to areas of EOL care that needed streamlining and improving and engaged with all staff to develop new processes and procedures.

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

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

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

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

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Access

- We were told by the SPC team that referrals were 26% non-cancer and 74% cancer.
- All patients within the trust, who required palliative or EOL care, had access to the SPC team, Monday to Friday, 9am to 5pm (except on Bank Holidays).
- Through a triage system, the team aim to see all urgent referrals within one working day and routine referrals within two working days. Referrals were prioritised as urgent if, for example, the patient was referred while in the ED or the acute medical unit, or if the patient had unstable or unresolved symptoms, despite regular medication aiming to control the symptom(s).
- Outside office hours, medical advice was available via the consultant on-call at the local specialist palliative care unit, which is Martlet Hospice.
- Inpatient referrals to the SPC team could be made via the SPC webpage, or face-to-face referrals to the team. Urgent advice was available from the clinical nurse specialist (CNS), who could give telephone advice prior to reviewing the patient.
- Outpatient referrals could be made in writing or via email to the palliative care consultants. In certain circumstances, verbal referrals could be made, such as the lung, head and neck cancer multidisciplinary team.
- In 2013/14, the team were referred 1,220 patients, which resulted in 6,840 contacts lasting approximately 30 minutes. This was approximately 25% of the total deaths in the trust.
- Following the Shipman Report a Medical Examiner (ME) was introduced into the trust. The ME was available across the trust weekdays from 9am to 4pm. Referrals could be made via the bereavement office.
- The bereavement officer carried out the administration of a deceased patient's documents and belongings, issuing the Medical Certificate of Cause of Death (MCCD), providing practical advice and signposting relatives to support services, such as funeral directors. The bereavement office could be contacted, Monday to Friday, 8am to 4pm.
- Families wishing to view their relatives in the 'chapel of rest' could contact the mortuary between 9.30am and 4pm, Monday to Friday, to arrange an appointment.

Discharge arrangements

- Systems were in place to facilitate the rapid discharge of patients to their preferred place of care. The SPC nurse explained that a multi-professional approach was in place, which included an occupational therapist to secure rapid discharges to the preferred place of care.
- On Howard 1 Ward, we were told that not all EOL care patients were referred to the SPC team and that, in such cases, the ward would manage the rapid discharge.
- The SPC team coordinated and liaised with the discharge team to provide advice relating to care packages, including care home placement, assessment for future community palliative care support, assessment for hospice admission and assistance with utilising the rapid discharge home to die pathway for end of life care for patients who wished to die at home or in a care home.
- We were given an example in which 100 patients had been discharged to their preferred place of care. Out of the 100 patients, only seven patients were readmitted to hospital to die. This meant that 93 patients achieved their preferred place of care and death.
- We saw comprehensive documents were in place to ensure the rapid discharge of EOL patients. This ensured that patients were transferred home with all the necessary medication, support and documentation in place.
- The guidance included rapid discharge pathway tasks and additional guidance for nurses, including medication, community nursing care and transport for the day of discharge.

Meeting people's individual needs

- The SPC team had developed an information leaflet for families whose relatives are receiving EOL care. The information – called Palliative Care Team – allowed patients and relatives to find out more about the team and the care and services they provide.
- All information leaflets informed patients that an interpreter could translate the information, if required.
- The SPC team assessed patients and undertook an assessment of specialist palliative care needs, which included: symptom assessment and management, psychological needs, complex spiritual needs, complex social and advance care planning.
- The SPC team supported carers by providing support for complex issues that could not be supported by the ward team. They achieved this by contacting and updating

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community services, as appropriate, and providing guidance with carer support, benefits advice as well as providing letters of support, for example, to give to employers.

- We were shown the book box available in the cancer centre to support children whose parents had cancer. The box included a DVD (Talking to Children and Teenagers when an Adult has Cancer), to be given to teachers explaining that a pupil may need support, or space, and books, such as 'As Big as it Gets: Supporting a Child When a Parent is Seriously Ill (Winston's Wish).'
- We were told by the EOL facilitator that the medical examiner would review the deceased patient's clinical information to establish that the clinical care received was appropriate. Any areas where care may have been improved would be input into a Datix report and used to improve learning within the trust.
- The medical examiner would contact the family to ask what they thought of the care. Their responses would be fed back to the end of life steering group to support service improvements within EOL care.
- The ward manager on level 9a and Bristol Ward were able to explain the procedures that took place after the death of a patient. We were shown the pack that contained all the necessary documentation, including: wrist bands, a notification form and a flow diagram around tissue donation. Body bags were available on the ward.
- We were shown that systems were in place to identify patients on the ward and in the mortuary who had the same name, including discreet orange dots placed on the patients' medical records and on the ward board.
- On the wards, we found 'equality and diversity' boxes, which contained: a guide to 'Beliefs, customs and diversity' for staff to refer to, along with laminated copies of 'Care of the dying Muslim and Jewish patient'. This ensured that staff were able to respect the traditions of different faiths at the time of death.
- We were told by staff on the Howard 1 Ward, that normal visiting times were waived and that they were able to visit at any time. This was reflected in other wards across the hospital.
- No multiple faith rooms were available at the Royal Sussex County Hospital, but the chaplain confirmed that Muslim believers could use the chapel for prayers on a Friday, while Christians used the chapel on a Sunday.
- There was a named chaplain for each world faith. We saw that information leaflets were available and contained information on how to contact faith leaders and what to do when patients got to the hospital.
- The chaplaincy service had developed 'calling cards'. These cards were left at the patients' bedsides to let patients know they had had a visit from the chaplain, along with contact details if the patient wished to contact the chaplain.
- The hospital was undertaking the 'Butterfly Scheme' initiative, across the hospital. Anyone with confusion or dementia would have a butterfly symbol on their bed to show that further support may be required.
- On the wards we visited, we found that systems were in place to support staff who experienced a patient who died suddenly. Debriefings took place with senior staff within 24 hours, and the chaplain, if requested, would be present. Further support was available through the Occupational Health Service.
- We found that a booklet was available for families who were bereaved by suicide or sudden death called 'Help is at hand'.
- The transplant coordinator explained to us that they were approaching patients and families to give information around tissue and organ transplantation. We saw that the information booklets were available for patients and families to read and make decisions in a non-pressured environment.
- Royal Sussex County Hospital had a viewing suite where families could come and visit their relatives. We visited the area and saw that the viewing suite was divided into a reception and viewing room.
- The suite was clean, fresh and provided facilities for relatives, such as comfortable seating, water and tissues. The suite was neutral, with no religious symbols, thus accommodating all religions. We were told by the bereavement officer that they support families during the viewing and would ensure that relatives knew what to expect and were safe.
- On our visit to the mortuary, we were shown where deceased patients left the hospital with the undertaker or with family. We found the area to be a loading bay, which did not provide a safe and respectful area in which families could receive their relatives.
- A group coordinated by the End of Life Care facilitator had developed a 'Verification, Certification and Notification of Adult Deaths at Brighton and Sussex University Hospitals NHS Trust' policy, which is intended

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for all staff involved in the care of the dying and recently bereaved. The policy takes into consideration multiple faiths and ensures that systems are in place so that the 'Medical Certificate Cause of Death' (MCCD) can be processed immediately in order for burial to proceed within one day. Out of normal hours, the clinical site manager will be the point of contact.

Complaints

- Any complaints about EOL care received by the Patient Advice and Liaison Service team were passed on to end of life facilitator, who would make contact with the family to resolve any issues in a timely manner.
- Formal complaints were brought to the EOL steering group by the chief nurse. The group would discuss the complaints and discuss ways in which improvements could be made.
- We reviewed the complaints received by the trust around EOL care. We were given an example of where the EOL facilitator was called to the ED to support a patient who had been brought into hospital after their GP had called 999. An advance care planning was in place, but systems failed and the advance care planning was not put into action.
- We saw that several complaints were around the DNA CPR process. We observed that the trust had reviewed the DNA CPR component of the resuscitation policy and that an escalation protocol for nurses and healthcare professionals, with guidance for all in completing the DNA CPR forms, had been developed. Laminated copies were available to place in ward areas to ensure patients' safety is paramount. Daily checks on completed forms were undertaken to ensure forms were compliant.

Are end of life care services well-led?

Good



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

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

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

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

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

Leadership of service

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

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Chief Executive, Medical Director and Chief Nurse were in attendance at the EOL conference on the 6th June 2014 and the lead clinicians for palliative care are making a presentation to the Board in September 2014.

- The hospital contributed to the National Care of the Dying Audit, which was released on the 15 May 2014. Areas where the trust did not perform well included: trust board representation, formal feedback processes and a review of the care after dying policy.

Culture within the service

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

Vision and strategy for this service

- The palliative care consultant told us that the development of a seven day service was a priority.

Governance, risk management and quality measurement

- We found that the SPC team had regular team meetings in which performance issues, concerns, complaints, and general communications were discussed.
- The lead cancer nurse would attend these meetings and relay concerns at the divisional nursing meetings.

- An operational policy was in place that set out the aims and objectives of the SPC team. This was updated yearly.

Innovation, improvement and sustainability

- The end of life care facilitator had developed a comprehensive end of life website that could be assessed by all staff.
- A monthly EOL care newsletter had been introduced to keep staff up to date with EOL care. Multi-professional groups of staff were actively involved in the NHS Improving Quality's Transforming End of Life Care in Acute Hospitals (2012) programme.
- We saw the agenda for the yearly Brighton and Sussex University Hospitals NHS Trust EOL Conference, which attracted speakers from the NHS IQ team and Guy's and St Thomas' NHS Foundation Trust. This year's conference was due to take place on the 9 June 2014.
- An educational series had been developed, in which the SPC team were involved in developing policy documents with other professionals, such as the critical care outreach (CCO) consultant nurse, resuscitation service manager and the chaplain.
- Providing study days for staff around 'Spiritual care assessment', 'Advance care planning process', 'Agitation' and 'The psychosocial aspects of care'.
- Development of a working party to develop and implement the amber care bundles within the trust.
- Partnership working with the Royal Alexander Children's Hospital around support for bereaved children.
- The continuing appointment of a medical examiner across the trust.
- The facility for staff across the trust to shadow the SPC team.
- The distribution of the Preferred Priorities for Care booklets (14,000 of which were given out across the trust).

Outpatients

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

Information about the service

Brighton and Sussex University Hospitals is an acute teaching hospital working across two sites in Brighton and Haywards Heath. The Royal Sussex County Hospital, Brighton, provides the main outpatient services for the population in and around the Brighton and Hove area. Outpatient services treat around 560,757 patients across both hospital sites.

We visited the main outpatient department at the Royal Sussex County Hospital in Brighton and sampled a range of outpatient services. These included: rheumatology, HIV medicine, diabetes, cardiac, vascular, maxillo facial, and neurology. We spoke to nine patients, one relative and 13 staff. We received comments from our public listening event and reviewed other performance information provided by the trust.

Summary of findings

All staff had received infection control training and infection control expertise was available in the unit. We saw that all staff had received training about safeguarding vulnerable adults and knew the steps to take if they suspected abuse. We noted that reception staff had not received training in safeguarding or the Mental Capacity Act 2005.

We observed that the seating arrangements for patients in the main outpatient department had been reviewed across the outpatient department to help improve patient flow and to make it easier for patients to find their way around. Patients told us they liked the chairs and the new seating arrangements were a great improvement. Navigating around the department was now much easier.

On the day of our inspection, we noted that two clinics had been cancelled as consultants had not been allocated to them. Consultants were required to advise the Hub six weeks in advance of their annual leave requirements. Patients had been booked into clinics by the Hub when consultants were on leave.

The matrons and divisional management team discuss the trusts performance on a monthly basis at a meeting chaired by the deputy Director of Clinical Operations, these meetings include RTT and DNA rates. Actions are agreed at these meetings and followed up within the divisions. There was a lack of clarity and understanding in the outpatient department concerning information

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about patient outcomes. The nurse manager did not receive feedback on meetings about the referral to treatment times (RTT) and the did not attend (DNA) rates and progress with the booking Hub. We were unable to identify if there were delays relating to specific clinics, but were told that there were long waits in neurology and rheumatology.

The minutes of the Executive Quality and Safety Committee for April 2014 clarified the actions being taken to address the ongoing concerns surrounding the efficiency and safety of the Hub.

We saw that all support staff had a level 3 diploma in health and social care. Staff had annual appraisals and we saw evidence of this. The appraisal rate was 100%.

We found that clinics functioned in isolation and there was no overarching governance framework in place for outpatient services.

Are outpatients services safe?

Good



We spoke to people using the outpatient department and they told us they felt safe while attending the unit and undergoing their treatment. We observed that patients were cared for in a clean and hygienic environment. We observed that mechanisms were in place to monitor the effectiveness of cleaning or the decontamination of equipment. All staff had received infection control training and infection control expertise was available in the unit. We saw that all staff had received training about safeguarding vulnerable adults and knew the steps to take if they suspected abuse. We noted that reception staff had not received training in safeguarding or the Mental Health Act 2005.

Incidents

- Staff in the outpatient department used an online reporting tool, Datix, to record accidents, incidents or 'near misses' that occurred. Staff had received training in the system and knew how to report an incident to the nurse manager or nurse in charge. The level of incident reporting was low and no 'near misses' had been reported.
- Learning from incidents was shared with staff at ward meetings. For example, an incident where staff money had gone missing had been reported and investigated by the security team and actions to prevent a further occurrence were reported to the outpatient nurse manager.

Cleanliness, infection control and hygiene

- There were systems in place to reduce the risk and spread of infection. Patients told us that the outpatient department was cleaned to a good standard. In the main outpatient waiting areas, we observed that the clinic rooms and corridors were clean and free from clutter. Cleaning was provided by an external cleaning contractor and we saw the cleaning standards for the outpatient department were rated between 92% and 96%. We observed that there was hand sanitising gel in place throughout the outpatient department and we saw staff washing their hands between treating patients. The hand hygiene audits for February, March and April 2014 were rated as being 100%. A nurse who had

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received enhanced training in infection control undertook the hand hygiene audits each month and provided infection control information to outpatient staff.

- The cleanliness of the outpatient department was checked by the nurse manager every morning before patients arrived for treatment. Failures in cleaning standards were reported to the cleaning manager and a process was in place to manage this. Deep cleaning of floors and regular changing of curtains was an ongoing concern. Repeated requests had been made to the cleaning manager to remind them of the deep cleaning requirement of the department. We noted that all floors and curtains were cleaned to the required standard. Staff said the benefit of the CQC inspection was the increased level of cleaning in the outpatient department.

Environment and equipment

- The temperature in the main outpatient department was very hot on the day we visited. The building was old and not purpose built. Air conditioning was provided in a limited capacity across the department. The nurse manager was able to fund the purchase of one air conditioning unit a year and we saw a number of units in operation in the hottest part of the outpatient department. We noted that windows were opened and fans were in place where there were no air conditioning units. Patients and staff complained about the drafts from the open windows.
- We noted that daily equipment checks were undertaken and we saw documentary evidence of this. We observed that four resuscitation trolleys had all been checked daily, but evidence of planned maintenance was last completed in 2011.
- We observed that the seating arrangements for patients in the main outpatient department had been reviewed across the outpatient department to help improve patient flow and to make it easier for patients to find their way around. Since the changes, patients were able to wait in the corridors as 'bus stop' style chairs had been put in place. Patients told us they liked the chairs and the new seating arrangements were a great improvement. Navigating around the department, they told us, was now much easier.
- Systems were in place for the cleaning, decontamination and repair of equipment and we saw evidence of this.

Medicines

- Medicines were stored securely in locked cupboards or fridges, as appropriate. A new pharmacy department had been specifically developed for the use of outpatient services on the Brighton site and were due to open shortly.

Records

- The outpatient department had its own records department, due to the number of patients attending outpatient services. A monthly audit of patient records, undertaken by the nurse manager, was forwarded to the main patients' records department. At the time of our inspection, 20 sets of temporary notes were required each day, due to missing records and misfiling. We were told the nurse manager did not always receive feedback from the records department. We were not aware of any breaches of confidentiality concerning patients' notes in the outpatient department.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Reception staff, who were not managed by the nurse manager, did not receive training in the Mental Capacity Act 2005 and were not aware of it, or mental health and safeguarding needs of patients attending the department.

Safeguarding

- We saw evidence that 100% of care and support staff had attended safeguarding training for adults and children in the outpatient department. We saw that patients with safeguarding and/or mental health needs were identified by staff the day before they attended the outpatient department. This ensured patients' care and support needs were known and staff provided support and guidance to patients when it was required. The nurse manager liaised with the learning disabilities nurse and the safeguarding team when advice and guidance was required.

Mandatory training

- We saw evidence that care and support staff were meeting their mandatory training requirements. For example, manual handling, fire infection control and safeguarding. Attendance across all mandatory training sessions was 85%. The nurse manager had a system in

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place to ensure all staff attended their mandatory training sessions and we saw the outstanding 15% of staff had been allocated to attend future training sessions.

Management of deteriorating patients

- Due to the geographical size and location of the outpatient department there were four sets of emergency equipment in place. This ensured staff responded appropriately in case of a patient requiring emergency treatment in the outpatient department. In the event of a patient's condition deteriorating, a 999 call would be made and the patient would be transferred to the appropriate hospital for emergency treatment.

Nursing staffing

- Patients told us there were sufficient staff to meet their care and support needs at the outpatient department. There were no nursing vacancies and staff turnover was low. Recruitment was a lengthy process (up to three months) and transfers between departments were protracted and upsetting for staff. Support from the human resources department was good, but a lot of chasing up was required by the nurse manager concerning delays in the recruitment process.
- We observed nursing staff interacting positively with patients throughout our inspection and there appeared to be sufficient staff to meet patients' needs.

Medical staffing

- Since the implementation of a centralised booking system (the Hub), there had been issues with the medical cover of outpatient clinics. Medical staffing for outpatient clinics was set in conjunction with the template, which identifies the number of clinics and the doctors required for each session. In order to maintain cover, there is a system via the patient access managers and speciality leads to notify the Hub of any planned leave, in order to prevent staff shortages at short notice, due to a lack of medical staff. This happened when communication between the Hub and patient access managers regarding planned and unplanned leave had not occurred. On the day of our inspection, we noted that two clinics had been cancelled, as consultants had not been allocated to them. Consultants were required to advise the Hub six weeks in advance of their annual leave requirements. Patients had been booked into clinics by the Hub when consultants were on leave. This

had happened on a number of occasions, requiring the clinic to be cancelled on the day and the patients to be sent home. Consultants told us that the Hub did not take any notice of their leave requirements, however early their leave requests had been submitted.

Major incident awareness and training

- We saw there was a major incident plan in place and staff had attended training to enable them to evacuate the department in the event of an emergency occurring.

Are outpatients services effective?

Not sufficient evidence to rate



Patients told us that "overall" they were happy with the effectiveness of the outpatient services at Brighton and felt the staff were caring and knew what they were doing. Data on performance showed the Royal Sussex County Hospital outpatient services were very busy in comparison to national averages. There were also a higher number of cancellations than the national average. Staff were unaware of the cancellation rates in their own outpatient areas or in the wider outpatient department. Incident reports about the booking Hub were received daily and some patients were identified as incurring or at risk of harm, due to the length of outpatient waiting times.

Evidence-based care and treatment

- We saw relevant National Institute for Health and Care Excellence (NICE) guidance was in place. For example, for the treatment of cardiac pain and vascular care and maxillofacial services. NICE guidance was speciality-based within the speciality or the division. We saw copies of the relevant guidance for staff to access in the nurse manager's office in the outpatient department.
- Nurses attended competency-based training based on NICE guidance or Standards for Better Health. For example, training concerning compression bandaging and care of patients with dementia and diabetes.

Pain relief

- Nursing staff were aware of the importance of advising the cardiologist immediately of cardiac patients who presented with chest pain on arrival at outpatient reception.

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Patient outcomes

- There were 10,000 outpatient attendances a month and the nurse manager thought the 'did not attend' (DNA) rate was between 4% and 12%. There was a lack of clarity and understanding in the outpatient department concerning information about patient outcomes. The nurse manager did not receive feedback on meetings about the referral to treatment times (RTT), DNA rates or progress with the booking Hub. We were unable to identify if there were delays relating to specific clinics, but were told that there were long waits in neurology and rheumatology. For example, neurology patients cancellations by speciality were 45.9% and DNA rates for speciality were 10.94%. Rheumatology patient cancellations by speciality were 24.4% and DNA rates were 9.75%. The performance dashboard is presented by the division and the matron, service manager and the lead consultant for each speciality attend.
- The trust has continued to achieve the 18-week RTT standards with 96.6% of patients complying with the outpatient standard. The NHS operational standard for outpatient services is 95%. However, orthopaedic and digestive diseases were unable to achieve compliance in March 2014, due to operational booking issues within the Hub. Performance against the six-week target for 'diagnostic tests' was within the required standard.
- In the minutes of the Executive Quality and Safety Committee for April 2014, concerns were raised around patient outcomes regarding the number of daily incident reports received about the Hub. The incident reporting had shown real harm being caused to patients by these delays. An example was when appointments were not received for two patients who were referred to the Hub for urgent referrals by the neurology nurse specialist. The patients required emergency admissions to hospital. Complaints had continued to be received from patients who were angry and upset and really suffering. The patients found that the explanations they were given about the difficulties around the Hub were difficult to understand.
- A GP had requested the Hub to refer a patient to a specific outpatient consultant, as this was in the patient's best interests. This was not actioned by the Hub. The incorrect referral was identified by the outpatient receptionist and the referral was changed. This demonstrated staff in the outpatient department

were aware of patients' needs and were helping to ensure the best outcome for patients. However, the systems for booking these appointments did not always operate satisfactorily.

Competent staff

- We found patients were cared for by caring and dedicated staff, who were supported to acquire further skills and qualifications by their nurse manager. We saw all support staff had a level 3 diploma in health and social care. Staff had annual appraisals and we saw evidence of this. The appraisal rate was 100%.
- Staff were well supported by the nurse manager and had recently received an appraisal. One staff member told us, "The manager is very supportive and has helped me to develop my knowledge and skills in outpatient [services] and I now feel a lot more confident in my abilities."

Multidisciplinary working

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

Seven-day services

- The main outpatient department was open five days a week and there were no plans to develop seven-day services. HIV medicine (Claude Nicol Centre) offered appointment times in the evenings and a text facility to enable patients to make their own appointments.

Are outpatients services caring?

Good



We observed that people were cared for by staff who were kind and respectful and ensured patients' privacy and dignity needs were met. We observed that patients were involved in planning their own care and were supported to make decisions in a safe and supportive environment.

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Compassionate care

- Staff interaction with patients was friendly and welcoming. We saw staff stopping to greet patients on their arrival to the outpatient department and explaining to them the clinic running times. At 9.30am, clinic delays were 10 minutes. We saw that patients who attended the department regularly had developed relationships with the staff who worked there and there was good humour and gentle banter between patients and staff.
- Patients told us, “The staff are excellent and really look after you,” and, “Nothing is ever too much bother. The staff always explain things to you, so you know what is happening.” Staff treated patients with respect and introduced themselves to patients before escorting them into clinic. We saw patients’ privacy and dignity needs were respected and staff knocked on doors before entering clinic rooms where patients were receiving treatment.
- We observed that there was limited space in some clinic areas and staff took patients away to a quiet area or office if they wanted to discuss a personal matter with them.
- We spoke to the relative of a patient attending the eye clinic, who told us how caring everyone was and how they helped to ensure their relative’s appointments were made at a time to suit them.

Patient understanding and involvement

- A patient said, “I have been coming to the diabetes clinic for three months and I am delighted that the doctor and specialist nurse have sorted out my diabetes for the first time in four years. I have been involved in planning my new diet and medication and have been given lots of advice and support.” Another patient said, “I was very worried about my condition and I have been involved in all of my treatment since attending the cardiac clinic and I am much happier now.”

Emotional support

- The sexual health and HIV service provided service users with an inclusive service, which helps people to optimise their future health. The care environment was supportive, non-judgemental and provided a framework of emotional support that was flexible and tailored to meet people’s individual needs.

Are outpatients services responsive?

Requires improvement



When we spoke with staff in the various outpatient clinics there were some good examples of where services had been responsive to patients and the general needs of the service. These included increased numbers of clinics and extended opening hours.

Patients had expressed frustrations and concerns around the implementation of the centralised outpatient clinic booking system, known as the Hub. The objective of this had been to centralise the booking system in order to provide a robust governance structure to waiting list management and improve the access for patients and users. Initial problems with the Hub had resulted in a backlog of 5,000 referrals and a delay into pathways of up to six weeks. The incident reports had continued to be received concerning the risks to patients caused by the delays in referral and treatment times. Plans were in place to address the service shortfalls.

Service planning and delivery to meet the needs of local people

- A centralised booking system (the Hub) for all outpatient services, was put in place across the trust in October 2013. The implementation of the Hub was monitored by the delivery unit, who oversaw its intended improvements to both service provision and associated monetary savings. A large number of concerns and issues had been raised about the difficulties experienced by patients and outpatient services across both hospitals since the Hub was implemented. Clinics had been double booked or cancelled and patients had not received their first referral letter.
- On our first visit to the outpatient department, two clinics had been cancelled and on our second visit (the following day) three patients complained to the receptionist that their appointments had been changed without their knowledge. Patients’ letters from the Hub were unclear about which hospital patients were required to attend. One to two complaints about the Hub were received by the outpatient receptionists every day.
- Referrals received by the Hub were not scanned into the Referral Management System (RMS) for triaging (prioritising) within 48 hours. The delay led to a backlog of 5,000 referrals (at the Hub) and a delay into pathways

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of up to six weeks. The issue was addressed in January 2014. Patients were added to the waiting list once scanned at the date the patients' referral was received and, therefore, their waiting time was accurate. This led to pressure on services to treat patients in 18 weeks. Referrals were being scanned for triage and registered within 48 hours. A dedicated team has been in place since January 2014 to manage this. Recovery teams were in place, or being developed to understand the impact and the requirement to mitigate the activity lost due to booking issues.

- The management of the two week wait pathway had been adversely affected. Joint work with the Clinical Commissioning Group (CCG) was in place to reduce the pressure with an agreed strategy to downgrade inappropriate referrals and non-compliance with patients to an 'urgent' category.
- Each outpatient clinic had a template, which set out the number of appointments. It appeared that the templates were not identified in the Hub set up risk-assessment process. When bookings via the Hub started, it became apparent that annual leave and study leave of medical staff holding the clinics had not been communicated. This led to the overbooking and underbooking of outpatient clinics.
- The performance of the Hub was monitored through weekly reporting, which identified how many appointments had been booked, how many phone calls had been received by the Hub and the number of complaints from patients and GPs. A theme of the complaints was around the number of lost or missing referrals.
- The minutes of the Executive Quality and Safety Committee for April 2014 clarified the actions being taken to address the ongoing concerns surrounding the efficiency and safety of the Hub. These included:
 - A dedicated email address with a 24-hour response time.
 - A new process to allow software systems involved to 'speak' to each other.
 - A new process for managing follow-up appointments (six weeks plus).
 - Improved ongoing communication with service managers to ensure clinic templates and clinical pathway guidance was accurate and representative of demands.

- A data-cleansing exercise of the waiting list to ensure it accurately reflected the numbers of patients waiting for surgery.
- Lists of who to contact if a patient could not be booked into the required clinic.
- Incident reports continued to be received by the Hub daily, relating to the ongoing concerns affecting the care and safety of patients.

Access and flow

- GPs had complained about the lack of outpatient clinic capacity and this was flagged to the speciality managers on both hospital sites. The Hub delivery unit had responded by providing additional clinics. For example, increased fracture clinics for children during the holiday season. An extra ear, nose and throat (ENT) clinic was put on by the speciality, but they did not advise the Hub, so no patients were booked to attend.
- Letters to patients were sent via the Hub. For new referrals, an acknowledgment letter was sent to the patient, informing them they would be contacted with the date of their appointment in due course. For follow-ups, if these were within six weeks, the appointment was made at the clinic reception before the patient left. If they were not able to make the appointment, due to capacity issues, the appointment would be referred back to the Hub.
- The receptionist then added the patient to the booking list and these were reviewed regularly to ensure that all were captured and booked. For DNAs, if it was the first appointment, then the need for an appointment was reviewed by the clinical staff and rebooked, if required.
- For DNAs, as a follow-up, if this was a long-term follow-up, such as six monthly or annually, this would be rebooked on a case-specific basis. The worst areas for clinic cancellations were digestive diseases and trauma/orthopaedics, where there had been short-notice cancellations. Some of the issues had been due to changes in doctor's rotas and the impact not being factored into the clinic templates.

Meeting people's individual needs

- A number of patients were experiencing problems with transport, particularly at the end of outpatient clinics. The nurse manager advised the out-of-hours transport service about patients' requirements and patients were able to wait in the discharge lounge if it was open. Patients who were required to wait after the discharge

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lounge had closed, waited in the adjoining Sussex Eye Hospital, as they were able to access food and hot drinks there and were supported by the hospital's nursing team.

- Service users who accessed the sexual health and HIV service were supported by a variety of services tailored to their individual care and support needs. For example, for services for HIV testing, or the reporting of sexual abuse, anonymity was retained by people being able to use a booking number, rather than the name of the service user. This ensured service-user confidentiality was maintained, which encouraged more service users to access their services.
- Staff had received specific training to support patients who had a learning disability or experienced confusion or dementia. Staff had access to a communication skills box to help them communicate more effectively with patients with a cognitive impairment.
- For children accompanying their parent or carer to an outpatient appointment a box of children's games was available to help amuse the children.

Learning from complaints and concerns

- The majority of complaints in the outpatient department were made about the Hub. Complaints policies and procedures were in place and we saw Patient's Voice questionnaires were clearly visible for patients to complete.
- We reviewed 15 patients' comment cards. 10 responses were positive about outpatient services. One patient said, "Very impressed with everything, excellent service." Another patient said, "Attentive in all respects, very kind and caring staff." Five negative responses identified problems around the Hub and clinic wait times. One patient said, "The rot has set in, you never know what is happening anymore." Another patient said, "I waited an hour and a half for my appointment and it is just not good enough."
- We saw evidence in the complaints folder of where the nurse manager had addressed patients' concerns. We saw a response concerning the music being too loud in the outpatient department and how this had been addressed.

Are outpatients services well-led?

Requires improvement



The outpatient department was well-led as an individual service. The nurse manager provided support for staff and had mechanisms in place for auditing various aspects of the service. There were systems in place to ensure that staff who worked in the clinics received the information they required to learn from incidents and complaints, and there was a commitment to improve the experience of patients.

Staff were not engaged in the implementation of the Hub and had become frustrated and had become disengaged from the process. There were no formal systems to enable the department nurse manager to be involved in leading improvements in outpatient services, for example, in the implementation of the Hub and the management of RTT and DNA rates.

Vision and strategy for this service

- The trust vision and values around the implementation of the Hub was not owned by staff in the outpatient department. Staff were unclear about how the Hub could provide centralised administration of booking across all outpatient specialities and had lost faith in the implementation process. The provision of a robust governance structure to waiting list management, which would improve the access for patients and users had not been shared with staff and there was a sense of ambivalence about the whole process.
- Staff felt that they were isolated from the main body of the trust and believed their contributions to the care and support of patients and relatives who used the outpatient services went unrecognised.

Governance, risk management and quality measurement

- There were no trust wide formal clinical governance arrangements in place for outpatient services. We were aware of the clinical governance arrangements within the speciality services, which held clinics in the outpatient department. We saw minutes of those meetings, which identified risk and performance issues within the outpatient services. The matrons for the each speciality is involved in the monthly divisional

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performance meetings and also attends the safety and quality meeting. There are monthly outpatient cross site meetings with the band 7s chaired by the lead nurses for outpatients

- The matrons and divisional management team discuss the trusts performance on a monthly basis at a meeting chaired by the deputy Director of Clinical Operations, these meetings include RTT and DNA rates. Actions are agreed at these meetings and followed up within the divisions.
- There was no formal mechanism in place for the nurse manager to be informed of the wider, overarching trust issues concerning the implementation of the Hub, the management of RTT and the high level of DNAs. The nurse manager was not in a position to be able to influence and drive through the necessary changes required to help improve the current difficulties around outpatient services. The learning from the implementation of the Hub had identified poor communication as one of the key themes.
- There was a significant reputation risk to the organisation. GPs across Mid Sussex and Horsham in particular were referring patients to other organisations, due to the service received from the trust when it came to the Hub.

Leadership of service

- The outpatient department was well-led locally. The nurse manager provided leadership and support to the nursing and support team and ensured staff were confident and competent in their skills and abilities. Patients and relatives commented favourably on the running of the service and felt they were listened to. Staff were kind and supportive and had attended mandatory training and had received appraisals in the last 12 months. The nurse manager reported directly to the associate chief nurse for medicine. There was no matron for outpatient services.
- We found that the nurse manager understood risk assessments and was able to identify areas of concern around incidents and complaints. Health and safety was monitored using risk assessments with staff noting risks on the trust's risk register.

Culture within the service

- In October 2013, the introduction of the central Hub for all outpatient bookings had caused issues for those staff

who had been used to making and controlling clinic bookings. There were issues with communication, which had led to frustration and a lack of encouragement.

- Staff enjoyed working in the outpatient department and spoke of "good teamwork" and a "can do" attitude". We observed staff interacting well with patients and saw examples of innovative, high-quality services. The sexual health and HIV service demonstrated a culture of inclusiveness and support to service users and provided an environment that was non-judgemental, free from bias and that promoted optimal health.

Public and staff engagement

- The public were encouraged to feedback through the Patient's Voice survey comments procedure. In addition, the public were encouraged to contribute to the NHS Friends and Family Test and 'You said, we did'. The Patient's Voice questionnaires were circulated every three months. This demonstrated that the provider was listening to patients' views and was able to take action in a timely manner.
- The chief executive regularly communicated with staff across the trust via briefings, for example, in his message of October 2013 staff were encouraged to take part in the project for developing the trust values and behaviours.
- Staff told us they knew who the chief executive and the chief nurse were, but those we spoke with had never seen them in the outpatient department.

Innovation, improvement and sustainability

- The introduction of the Hub had been seen as central to the overall management and streamlining of outpatient bookings and referrals.
- Many staff recognised that there had been difficulties in the Hub implementation, but progress was being made to address the issues and improve communication through monitoring and engagement with the Hub manager, speciality leads and patient access managers.
- Monitoring of clinic cancellations was ongoing, and, despite not meeting the targets for March and April, the view was that things were improving.
- Opportunities for staff to meet their in-house training requirements were good and staff talked positively about the support they received from the nurse

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manager. Opportunities for staff to attend external post-graduate courses were limited. Staff told us that they either had to attend the course in their own time or fund/part fund any external training opportunities.

Outstanding practice and areas for improvement

Outstanding practice

We were particularly impressed with how the day case ward met the needs of children going to theatre. There was a 'one-way' system that ensured children going into theatre did not see the children that were leaving the theatre. Small children could ride in motorised cars to theatre if they chose to do so. There were booklets

available for children to read that explained what they could expect to happen while they were in hospital. These were in the format of a monkey telling a story. Parental feedback about the booklets was exceptionally good.

Areas for improvement

Action the hospital **MUST** take to improve

- The trust must ensure that the environment is suitable for patient investigations, treatment and care and that hazards related to the storage of equipment that impact on staff, are minimised.
- The trust must ensure that electrical equipment, used directly for patient treatment or care needs, is suitably checked and serviced, to ensure that it is safe and fit for use.
- Ensure that planning and delivery of care on the obstetrics and gynaecology (O&G) units meets patients' individual needs.
- Ensure the appropriate use of beds spaces which are suitable by their position, design and layout within wards including the Stroke Unit, Grant ward and Baily Ward.
- Ensure that the values, principles and overall culture in the organisation, supports staff to work in an environment where the risk of harassment and bullying is assessed and minimised and where the staff feel supported when it comes to raising their concerns without any fear of recrimination.
- Ensure that relationships and behaviours between staff groups irrespective of race and ethnicity is addressed to promote safety, prevent potential harm to patients and promote a positive working environment.
- Ensure patients who require access to urgent referrals for treatment through the Hub are supported to do so as a matter of urgency and patient safety.
- The trust must take action to ensure that staff receive mandatory training, in line with trust policy.
- The trust must take action to ensure that staff receive an annual appraisal.

- Evaluate the effectiveness of the current patient flow and escalation policy and implement mechanisms to improve patient flow within the ED and other wards across the trust.
- Review the current cohort protocol to ensure that there are clear lines of clinical accountability and responsibility for patients, which all trust staff and ambulance trust staff are aware of.
- Review the current cohort area within the ED to ensure the privacy and dignity of patients. Ensure that women using the day assessment unit have their privacy and confidentiality maintained.
- Ensure that staff reporting incidents receive feedback on the action taken and that the learning from incidents is communicated to staff.
- The trust must ensure that there are enough suitably qualified, skilled and experienced staff to meet the needs of all patients. In O&G consultants support must be available at all times.

Action the hospital **SHOULD** take to improve

1.The provider is not currently doing something that is required by the Regulation but we have determined that it would be disproportionate to find a breach of the Regulation overall

- The trust should ensure that the functions of the booking Hub are addressed, so that patients who need to be seen postoperatively have access to the correct consultant, at the correct time.
- Medical staff should ensure that patients have the opportunity to ask questions within the doctor's round, so that they are fully informed.
- The trust should make improvements to the efficiency around the discharging of patients from postoperative wards.

Outstanding practice and areas for improvement

- Ensure that staff at all levels feel confident about reporting incidents so that learning and improvements to practice can take place.
 - Critical care staff should ensure that patient information is secure and confidential at all times and that it cannot be viewed by anyone who is not authorised to do so.
 - Ensure same sex breaches are being managed in acute areas such as MAU
 - The trust should continue the work to introduce more midwife-led pathways to help normalise birth and reduce the rates of caesarean sections.
 - Ensure IT connectivity across all clinical bases is at a level where all community midwives can review essential information.
 - Ensure that cover is in place for specialist services as part of the workforce planning.
 - The trust should ensure that there are robust governance systems in place to enable more effective management of the outpatient services at the Royal Sussex County Hospital.
 - The trust should ensure good communication between outpatient services and the medical records department.
 - The trust should ensure that staff understand their role in the event of a major incident, as appropriate to their designation.
 - The trust should ensure parity across wards/units regarding access to training, education and study leave.
 - The trust should ensure that there are effective human resources and processes to assist patient flow.
 - The trust should ensure that information on how to complain is available in languages other than English.
 - The trust should ensure that there are effective working arrangements between all staff groups.
 - Review the current NHS Friends and Family Test response rate and methodology to ensure they are consistent with national return rate.
 - Ensure end of life strategy is given appropriate consideration at board level.
1. The provider is not currently doing something that we have identified as an area for improvement within a domain but which does not link directly to a Regulation
- The trust should consider provision of air conditioning units in the outpatients department as the department is poorly ventilated on hot days.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: People who use services and others were not protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of carrying out an assessment of the needs of the services user and the planning and delivery of care and, where appropriate, treatment to meet the needs and ensure the safety and welfare of the service users. Regulation 9 (1) (a) (b) HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: The provider had not protected service users against the risk of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to enable the registered person to- regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this part of the Regulations: and Identify, assess and manage risks relating to the health, welfare and safety of service users and other who may be at risk from the carrying on of the regulated activity,

This section is primarily information for the provider

Compliance actions

Where necessary, make changes to the treatment or care provided in order to reflect information, of which it is reasonable to expect that a registered person should be aware, relating to- the analysis of incidents that resulted in, or had the potential to result in harm to a service user.

Regulation 10 (1) (a) (b) (C) (i) Assessing and monitoring the quality of service provision.

Regulated activity

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

Regulation

Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

How the regulation was not being met: The registered provider must ensure service users are protected against the risks associated with unsafe or unsuitable premises by means of- suitable design and layout and adequate maintenance of the premises in connection with the regulated activity.

Regulation 15 (1) (a) (ii) (c) (i) Safety and suitability of premises.

Regulated activity

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

Regulation

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

How the regulation was not being met: The registered person had not ensured that equipment was properly maintained in order to ensure the safety of service users and meet their assessed needs.

Regulation 16 (1) (a) (2) Safety, availability and suitability of equipment.

Regulated activity

Regulation

This section is primarily information for the provider

Compliance actions

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

Regulation 17 HSCA 2008 (Regulated Activities) Regulations
2010 Respecting and involving people who use services

How the regulation was not being met: The registered person had not, so far as reasonably practicable, made suitable arrangements to ensure the privacy and dignity of service users.

Regulation 17 (1) (a) Respecting and involving people who use.

Regulated activity

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

Regulation

Regulation 22 HSCA 2008 (Regulated Activities) Regulations
2010 Staffing

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

Regulation 22 Staffing

Regulated activity

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

Regulation

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

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

Regulation 23 (1) (a) Supporting workers

Regulated activity

Regulation

This section is primarily information for the provider

Compliance actions

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation 24 HSCA 2008 (Regulated Activities) Regulations
2010 Cooperating with other providers

How the regulation was not being met: The provider had not made suitable arrangements to protect the health, welfare and safety of service users in circumstances where responsibility for the care and treatment of service users is shared with or transferred to others by means of:

So far as reasonably practicable working in cooperation with others to ensure that appropriate care planning takes place. Subject to paragraph 2 the sharing of appropriate information in relation to- the admission, discharge and transfer of service users

Regulation 24 (1) (a) (b) (i) Cooperating with other providers