Good

Sussex Community NHS Trust

Quality Report

Brighton General Hospital
Elm Grove
Brighton
BN2 3EW
Tel:01273 696011
Website: www.sussexcommunity.nhs.uk

Date of inspection visit: 8 - 11 December 2014;
Unannounced 21 December 2014
Date of publication: 19/03/2015

Core services inspected	CQC registered location	CQC location ID
Children and young peoples Services	Sussex Community NHS Trust	RDR
End of life care	Sussex Community NHS Trust	RDR
Adult inpatient services	Sussex Community NHS Trust	RDR
Adult Community services	Sussex Community NHS Trust	RDR

This report describes our judgement of the quality of care at this provider. 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 people who use services, the public and other organisations.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for community health services at this provider	Good 
Are services safe?	Good 
Are services effective?	Good 
Are services caring?	Good 
Are services responsive?	Good 
Are services well-led?	Good 

Summary of findings

Contents

Summary of findings

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

- We found that the provider was performing at a level which led to a judgement of good.
- The Board provided clear leadership to its staff and the culture of the organisation was found to be positive across all of the services. Engagement was good with the 'Livingroom to Boardroom' approach embedded into the trust values and vision.
- The trust had a detailed vision and strategy in place to meet the needs of the communities it served across West Sussex, Brighton and Hove. In a relatively short time (two years) the new trust board and executive team had transformed the organisation through a change programme that involved substantial cultural and clinical challenges. The senior leadership within the trust had engaged with staff, patients and stakeholders to ensure the success of the transformation programme. We found that staff were fully engaged with the improvement programme and spoke highly of the executive team. The trust had been nominated for several local and national awards.
- There were robust clinical governance arrangements that were clear in terms of lines of accountability up to Board level and through the Clinical Divisions in each of the services.
- There were elements of good practice across a range of units and teams within each core services. The staff were caring and there was good practice to ensure safe,effective and responsive care. The organisation was well led.
- In End of Life care it was felt that the responsiveness of this service was outstanding with national recognition of the transformation by NHS England and the model now being rolled out into six other organisations.
- Childrens services were found to be good in caring. The inspection team observed staff interact with children and their families during the inspection and found the interactions to be very caring, compassionate and tactful. We observed children respond in a very positive way to staff which demonstrated genuine fondness and appreciation for the relationships that had developed.

Summary of findings

The five questions we ask about the services and what we found

We always ask the following five questions of services.

Are services safe?

Good

- Patients were kept safe through robust safeguarding arrangements and the Trust worked well with partner agencies to protect vulnerable people from abuse.
- Services provided to children, young people and families were safe, and arrangements were in place to minimise risks to children and young people receiving care and staff working alone in the community.
- The trust had a total of 3996 incidents reported to NRLS between 1st November 2013 and 31st October 2014 however 91% of these caused low or no harm.
- Recruitment and retention of staff was a problem for the trust notably health visiting although it is noted that there has been an increase in overall numbers of health visitors over the last 3 years; intermediate care services at Brighton & Hove with 16.4 WTE vacancies out of a total of 74.7Wte and the rapid assessment teams at Southgate House and Southfield House with total vacancies of 19.3Wte out of an establishment of 61.9 WTE. The trust is proactively responding to managing this issue with a paper submitted to the Board in June 2014 regarding nurse staffing levels. Recruitment plans are in place and there is robust recruitment however it should be noted that staffing is particularly challenging in the north of the patch due to the ability to commute into London.
- The percentage of staff working extra hours was worse the national average and had increased since 2012 with 76% of staff reporting working additional hours compared to the national average of 71%.
- Staff sickness absence is just above the national average at 5.46% compared to 4.5% national average.
- We saw there were systems to identify, monitor and manage risk to patients. Risks were identified and recorded on risk registers. We saw examples of risk assessments that were regularly reviewed and that control mechanisms were in place to mitigate the risks. An example of this was the missed visits by district nursing teams which is now being managed through

Summary of findings

clear escalation processes regarding increases in workload and a triaging system to enable clinical prioritisation of patients to ensure patients are not adversely affected. There were clear processes for escalation of risks onto the trust risk register.

- There was a Patient Safety Framework in place that cross referenced incidents with performance metrics including staffing, sickness absence rates and use of bank and agency staff
- The Medical Director and Chief nurse were able to articulate the detail of an incident in community nursing that resulted in the death of a patient and the actions taken to mitigate re-occurrence. The review of this resulted in processes being changed to ensure that when staff could not gain entry into a patients home to administer treatment there were clear escalation processes for staff to follow.
- There was a system for disseminating national safety alerts and ensuring that these were reviewed by the appropriate staff. This showed there was a proactive approach to managing risk that was well embedded in practice. The National Patient Safety Thermometer was implemented.
- The organisation had major incident and business continuity plans in place. Staff told us they participated in practical evacuation exercises and were able to tell us their responsibilities in the event of a major incident. This meant that there were contingency plans to ensure patients remained safe in the case of a major incident.
- Many of the buildings providing in-patient care were old with the fabric of the buildings challenging for staff to maintain high levels of cleanliness. However, we found that all the hospitals were clean, hygienic and well maintained. The trust had developed an in house estates team to address some of the immediate challenges with the fabric of the buildings. The Director of Finance and Estates felt this had made a positive difference.

Are services effective?

Good

- Overall, we found services to be effective.
- We found a clinically led audit programme in place at the trust, one which was reviewed every three months. There was also extensive research activity which was not only contributing to

evidenced based practice at a local and national level, but was also successful at gaining funding to expand and improve the services delivered at the Chailey Heritage site. Clinical audit programme included both internal and national audits

- We observed that policies and care reflected current guidance such as that provided by the National Institute for Health and Care Excellence (NICE). We found there were systems to review new guidance and to disseminate this to staff. The 2013/14 Quality Account states that the trust has systems and processes in place to ensure compliance with NICE guidance. This requires NICE guidance to be signed off by the Medical Director. Implementation is through regular reporting to the Clinical Effectiveness Committee. In 2012/13 the trust had fully implemented 53% of directly applicable guidance and partially compliant with 33% of directly applicable guidance. The 2013/14 Quality Account states the trust is currently implementing the remaining 14% of guidance.
- The community in-patient services all participated in the National Patient Safety Thermometer scheme, and this demonstrated that the patient outcomes measured were in line with national averages. We saw that there were plans to display performance information in a common format on ward areas for staff and patients to see.
- Patient outcomes were in line with those expected nationally. There had been a successful trial of an Early Warning Trigger Tool which is designed to identify those teams who may be experiencing increasing pressure due to increases in activity, sickness absence of staff or staffing levels due to vacancies. The purpose of this is to trigger resposnes form management teams to review resources and workloads and agree priorities and actions to reduce any increased risks.The 2013/14 Quality Account states that proactive care teams have increased the numbers off patients who have personalised care plans in place within five days of being referred to the team. This has risen from 27% in September 2013 to 83% in December 2013.
- Throughout all of the services provided by the trust there was evidence to demonstrate that the rights of patients subject to the Mental Health Act were protected and staff were aware of the the Mental Health Act code of practice and the deprivation of Liberty Safeguards. Appropriate documentation was reviewed in both community nursing teams and inpatient services.

Summary of findings

- The Midhurst Macmillan specialist palliative care service had been cited by NHS England and the Kings Fund as being an example of best practice. Following a two year independent review of the service, the clinical effectiveness in providing patients with their preferred place of care and preferred place of death were shown to be exemplary and it was also shown to have cost benefits over inpatient services. The programme is now being piloted in six other areas around the country to test its effectiveness in other settings.
- The Information technology infrastructure was identified as a risk by all members of the executive and middle management team and this was evidenced throughout the services in terms of lack of consistent performance data. In addition many community teams were using different documentation systems with some using electronic systems and other teams still using a paper based system. There was an IT strategy in place however it was acknowledged that this required significant financial investment. Staff report frustration with the lack of hardware to access systems , slow connection speeds and the extended time to implement SystemOne. The trust has reviewed the SystemOne programme and is working with Capita to look at a comprehensive solution with Inpatients and community adult teams identified as next to be addressed in terms of priority.
- Staff appraisals varied across the trust locations and the Integrated Performance Report from July 2014 showed the trust did not meet their target of 90% of staff receiving an annual appraisal. In September 2014 88.4% of staff had received an annual appraisal.
- Statutory and mandatory training again was varied across the localities and services. Statutory training for substantive staff was 77% in September 2014. The 2013/14 Quality Account states that the statutory training programme has been completely revised and that there had been significant improvement in attendance following implementation of a 'did not attend' charge to the service.

Are services caring?

Good

- All the staff we saw and spoke with demonstrated commitment to the delivery of safe, effective and caring treatment for their patients. We observed staff responding to patients, their families and carers with kindness, compassion and in a professional manner.

Summary of findings

- We also witnessed staff communicating with children with learning disabilities in a way which demonstrated outstanding communication skills and the positive relationships which had been developed with these children, for example in the way the children were asked for their opinions.
- Staff were highly motivated in their roles and demonstrated a strong dedication and commitment to the Trust, despite the staffing challenges it was facing. Staff willingly went the extra mile to ensure that the service was delivered regardless of the obstacles. We found examples of how teams constantly reviewed their ways of working.
- The trust overall scored 90.21% for 'Privacy, Dignity & Wellbeing' in the latest PLACE assessment compared to the national average of 85.26%. Friends and family test responses are not meeting the minimum target of 15% response rate with the trust achieveing a response rate of 11.7% year to date as at September 2014. A number of steps have been taken to improve the response rates including new posters and the questionnaire being handed to the patient earlier in their stay.

Are services responsive to people's needs?

Good

- We found that the trust was responsive in meeting the complex needs of the people of West Sussex, Brighton and Hove together with the commissioners of services. However there were differing models of care due to commissioning arrangements and historic differences in the provision of care meant that across the county patients experienced different models of care and treatment.
- There were arrangements to meet the specific needs of patients, including those with learning disabilities and bariatric needs. We found some weaknesses in the care of people living with dementia but saw there was an organisation wide action plan to address this. There were examples in both childrens services and community adult services were teams planned services to meet the needs of hard to reach groups for example travellers and homeless people.
- Services across the localities were responsive to the needs of hard to reach groups and the iinspection team observed examples of how these services worked in practice.
- With regard to access to services this is measured through the non-admitted (outpatient) pathway of 18 weeks from referral to first definitive treatment with a national target of 95%. All patients on a non-admitted pathway received their first definitive treatment within 18 weeks.

Summary of findings

- Patients attending the Urgent treatment Centres and Minor Injuries Units were seen within the national target of 4 hours.
- There were 5,882 delayed transfers of care with 31.9% of these due to lack of completion of assessments patients , this is compared to a national average of 18.4%. It is noted in the July Board minutes that there had been reported some success in reducing delayed transfers of care however in the north locality they had started to increase.
- The trust received 204 complaints in 2013-14 with 91 attributable to aspects of clinical treatment followed by delayed / cancelled appointments (41) and attitude of staff (31).
- Patients were informed how they could raise a concern or complaint. We saw that complaints were investigated and that agreed timescales were met most of the time however the September Integrated Performance Report indicated that response times for complaints had fallen below target for month 5 and 6.
- We found there were systems to ensure that learning from complaints was shared within the organisation. Patient stories /complaints were brought to the Board meetings to share patient experiences and where actions were identified service teams were requested to return to the board meeting to ensure the executive teams were updated.
- The Chair had introduced an initiative called 'Chat with the Chair', she would go to differing locations within the trust and work and invites staff to drop and chat about anything on their mind.
- The Chief Nurse has introduce "Sit and See" where she goes to different locations within the trust to watch staff and patient interactions.

Are services well-led?

Good

- The trust had set out their priorities for the year 2014-15 in the Quality Account and had a Quality Improvement Plan which outlined their five year strategic outcomes and associated performance metrics.
- The trust had a detailed vision and strategy in place to meet the needs of the communities it served across Sussex, Brighton and Hove. In a relatively short time (two years) the new trust board and executive team had transformed the organisation through a change programme that involved substantial cultural and clinical challenges.

Summary of findings

- The senior leadership within the trust had engaged with staff, patients and stakeholders to ensure the success of the implementation of the transformation programme. We found that staff were fully engaged with the improvement programme and spoke highly of the executive team. The trust had been nominated for several local and national awards.
- The trust encouraged and supported staff to take responsibility and ownership of their service. This encouraged innovation with staff taking pride in the service they offered. Staff from all levels in the organisation felt valued and listened to. They told us that the executive team actively sought their opinions and where possible acted upon them. Although caseloads and workloads were high, staff across the organisation spoke of the positive working environments and told us how proud they were to work for the trust. The Executive team were able to provide information regarding risks to the organisation and were actively involved in the managed of some of the key risks identified.
- The Executive team were highly visible within the organisation. The Director of Finance would work alongside healthcare assistants on a regular basis to understand frontline services. Meetings by the Executive team were held across different locations with the Chair often undertaking walkrounds. Staff across the services knew the Executive team.
- There were some concerns raised by staff regarding the management structure with specific comments regarding the lack of clarity around the Clinical Director role. The Medical director acknowledged this and told us that there were a number of relatively new Clinical Directors who required support in developing in this role.
- There were clear monitoring and reporting structures in place. The Executive Leadership Team met twice a month which had clinical representation and had a specific focus on clinical and corporate governance and operational performance and metrics and provided assurance to the Board. Part of the assurance framework within the trust was the development of a 'star chamber' whose role was to review quality impact assessment of business cases and cost improvement programmes that affected staffing or any proprosal that was over £50,000. The star chamber was attended by the Chief Nurse and the Medical Director.

Summary of findings

- Clinical strategy was determined through the Clinical Executive Committee, this group also had the responsibility of advising on key clinical decisions where services were being either reduced or expanded.
- Risks were well documented and reviewed regularly. The Medical Director told us of an incident when he was able to access an Urgent Treatment Centre early in the day and found he could gain access to patients notes as they had not been stored away in line with trsut policy. The Medical Director set up a weekly quality meeting with the team to set improvement objectives and monitor progress.
- Staff we spoke with told us they felt supported by their immediate managers to provide good quality care, with managers being approachable and visible. The trust were better than the national average for the domain 'Support from immediate managers in the 2013 staff survey and had improved from the previous year.
- The trust held an annual leadership conference and there was a Senior Leadership exchange held quarterly to engage with all levels of management throughout the organisation.
- The trust had undertaken substantial work in preparing staff for the inspection in order to reduce their anxiety around the inspection process and enable them to speak confidently about their service. For example staff had been encouraged to review their services in line with CQC's five domains of safe, effective, caring, responsive and well led. This meant that all the staff we spoke with talked knowledgably and with confidence about their service; highlighting the areas of good practice and acknowledging areas which could be improved together with the actions they were taking to address the issues.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Frank Sims, Chief Executive Hounslow and Richmond Community Healthcare NHS Trust

Team Leader: Amanda Stanford, Care Quality Commission

The team included CQC inspectors and a cross section of specialists: including, a director of nursing,a community matron, a school nurse, a GP, district nurses, palliative care nurse specialist, physiotherapists, a dentist, a health visitor and 3 people with experience of using services or caring for someone using services

Why we carried out this inspection

We inspected this provider as part of our comprehensive community health services inspection programme.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit between 8th and 11th of December 2014. During the visit we held focus groups with a range of staff who worked within the service, including nurses, doctors, therapists and administration staff. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the services. We carried out an unannounced visit on 21st December 2014.'

To get to the heart of people experience of care provided by the services, 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?

Information about the provider

Sussex Community NHS Trust was formed in October 2010 following the merger of two predecessor NHS organisations: West Sussex Health and South Downs Health NHS Trust.

The trust has recently entered a strategic partnership with Capita in order to assist with attaining FoundationTrust status, reviewing the estates strategy and supporting the delivery of the cost improvement programme. The £22m partnership between the Sussex Community NHS Trust and Capita will run for five years. The estate was managed through Propco

The Executive Board members are all relatively recent appointments with most of the members taking up post from 2012. The Chief Nurse was the last appointment in April 2014.

The trust's vision to provide 'Excellent care at the heart of the community' was underpinned by three strategic goals;

- To provide excellent care every time to reinforce wellbeing and independence.
- To work with partners to personalise services.
- To be strong and sustainable, grounded in the communities and led by excellent staff.

Summary of findings

The trust provides care to people in the county of West Sussex and the separate unitary authority area of Brighton and Hove with a total population of c 1,091,000. Care is provided to more than 8000 people. The trust is divided into three localities West Sussex and coastal; North and Brighton & Hove.

The Trust operates through two clinical divisions which cross all three localities:

- Adult services - Predominantly home based services 24/7 to maintain and support people in their homes, from basic care, proactive management of long term conditions and rapid crisis intervention preventing hospital admission.
- Children and specialist services – Provides birth to adulthood services with social care partners and a range of specialist community and well-being and prevention services.

The Trust provides in patient care in 299 beds over 8 locations.

There are 4,549 staff across all the core services and the trust has a budget of £194.7 million

There have been seven inspections at locations registered to Sussex Community NHS Trust in the past and these were at seven locations, all were found to be compliant. The following locations have not been inspected previously Brighton General Hospital, Crawley Hospital, and Zachery Merton Community Hospital.

What people who use the provider's services say

Patients told us they were more than satisfied with the service they had received, comments about staff included, “brilliant, they can’t do enough for you”, and, “What would we do without them, we’d all be in hospital or not here at all”.

Relatives of patients including some who had been recently bereaved told us they could not see how the service could have done more, comments included, “They explained everything clearly and honestly which was exactly what X (their relative) would have wanted”, and, “It’s such a relief having X (their relative) at home, it’s where they want to be, they don’t want strangers all around. I know staff in the hospital are wonderful but it’s not what you want”.

The trust overall scored 90.21% for ‘Privacy, Dignity & Wellbeing’ in the latest PLACE assessment compared to the England average of 85.26%. , and 82% of staff are likely or extremely likely to recommend the trust as a place to receive care.

Good practice

At Arundel Hospital we saw how a wall sized patient journey board had been designed reflecting all aspects of the patient journey and care needs. We saw how all members of the multi-disciplinary team used the board to ensure that the most up to date information was displayed. Staff told us that it was a ‘great aid’ to making sure all staff were aware of each individual’s health status and care requirements. We saw how following a handover meeting this board was again updated.

We found an exemplary example of good practice at Arundel Hospital with a “Major Incident Box” which was stored in a prominent position within the staff room and contained everything staff would require to manage an incident. The Ward Manager told us that this had been developed with the involvement of all levels of staff.

A proportion of mandatory training was moving towards e Learning modules. Some older staff expressed concern they did not have the information technology (IT) skills to make the most of this opportunity. However, at Arundel hospital we were given examples of how individuals had been supported to undertake e learning in a group environment, affording them support and opportunities to discuss the learning further. Staff commented that this not only helped them but made the training more participative and fun.

Summary of findings

Midhurst Macmillan specialist palliative care service as evidenced by the formal evaluation of the service as published in the European Journal of Cancer Care, Endorsement by NHS England as one of eight High Impact Interventions which commissioners should consider to improve quality of care and the Inclusion of a case study in the Kings Fund report: Co-ordinated care for people with complex chronic conditions. They were responsive to the needs of the patients in their care and achieved 85% of their patients being able to die in the place of their choosing.

We found many examples of good and innovative practice in individual services where passionate and committed staff acitivily promoted the health and wellbeing of their patients. Such as the Homeless and carers projects; community nursing services that although understaffed worked hard to ensure that patient outcomes did not suffer; specialist services such as the neurorehabilitation and respiratory services. However all of these services were able to flourish because of the support and encouragement from the trust board.

The board, executive and non executive members of Sussex Community Trust together with senior managers and leaders throughout the trust had worked hard to make the trust a place where staff felt proud to work. We found that staff were fully engaged with the improvement programme and spoke highly of the executive team.

The Chair had introduced an initiative called 'Chat with the Chair', she would go to differing locations within the trust and work and invites staff to drop and chat about anything on their mind.

The Chief Nurse has introduce "Sit and See" where she goes to different locations within the trust to watch staff and patient interactions

The trust encouraged and supported staff to take responsibility and ownership of their service. This encouraged innovation with staff taking pride in the service they offered. Staff from all levels in the organisation felt valued and listened to. They told us that the executive team actively sought their opinions and where possible acted upon them. Although caseloads and workloads were high staff across the organisation spoke of the positive working environments and told us how proud they were to work for the trust.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the Trust should take to improve

The Provider should review its recruitment policy to ensure that the vacancy levels in the trust reduce to ensure sustainability.

The Executive team should give consideration to strengthening the role of the middle management teams and in particular clarifying the role of the Clinical Director within the clinical teams.

The trust should review how to achieve consistency of standards within services across the three localities to minimise variation.

Ensure delivery of estates strategy to address some of the concerns raised during the inspection e.g Crawley Urgent Care Centre room for mental health attendees

Review the timescales in relation to the roll-out of electronic systems that support and record care to ensure that there is assurance that risks are always identified, assessed or monitored using an effective system and there is consistency across the localities.

Review and strengthen to role of the Clinical Directors within the services ensuring clarity of responsibilities

The Trust should take action to review record keeping and ensure that all records are well maintained, up to date and personalised to meet patients' needs

The Trust should undertake an audit of medicines administration and documents relating to this to ensure that patients receive the correct medicines at the correct time.

The Trust should review its processes for pain assessment and evaluation.

Summary of findings

The Trust should ensure that all appropriate staff have access to and attend dementia training.

Sussex Community NHS Trust

Detailed findings

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Patients were kept safe through robust safeguarding arrangements and the Trust worked well with partner agencies to protect vulnerable people from abuse.

Services provided to children, young people and families were safe, and arrangements were in place to minimise risks to children and young people receiving care and staff working alone in the community.

The Trust had processes in place to report and record safety incidents, concerns, near misses and allegations of abuse, and were able to evidence these

Although the hospitals reported that there had been problems with a high level of vacancies in some locations, especially relating to nursing and therapy staff, we found the trust was actively recruiting staff and there were arrangements in place to ensure that staffing levels remained sufficient to meet patients' needs. However, the shortage of therapy staff in some hospitals meant that some patients were waiting longer for therapeutic interventions to aid their rehabilitation. In some instances this resulted in delayed discharges. Due to shortages in the district nursing teams some patients had not received a visit from the team as planned.

However the Chief Nurse, Matron and Manager had put into place a risk assessment process for prioritising visits at those times when a patient's visit had to be postponed.

The Medical Director and Chief Nurse were fully informed of the serious incidents relating to District Nursing and had put into place actions to mitigate against these from happening again. This included a process for what to do if a patient refuses a District nurse entry into the home.

We found that all the hospitals were clean, hygienic and well maintained.

Medicines management was found to be safe, and equipment well maintained throughout the Trust.

Our findings

Incidents, reporting and learning

- Incidents were investigated appropriately and root cause analysis was used for reviewing serious incidents. There were good mechanisms for feeding back the outcomes of investigations to teams and individual staff. We saw that lessons learnt were widely disseminated and staff were able to show us examples of when

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

practice had been changed, both at local level and across the trust. This demonstrated that there was an effective system for the management of critical incidents.

- We saw that safety information was monitored, for example using the NHS Safety Thermometer system.
- 91% of all incidents reported in the last 12 months caused low or no harm to the patient and the number of incidents reported has steadily declined since July 2014.
- The National staff survey found that the Trust scored above average for fairness and effectiveness of incident reporting procedures

Cleanliness, infection control and hygiene

- Clinical areas were clean and well maintained. There were systems to monitor cleaning standards monthly and we saw the results of these audits.
- Staff demonstrated a good understanding of infection control precautions.
- The staff we observed delivering personal care wore, and had access to, an ample supply of PPE (Personal Protective Equipment).
- The sharp bins in the inpatient areas were signed, dated and no more than three quarters full.
- We saw the continuous hand hygiene audits undertaken in each centre and that they demonstrated a high level of compliance.

Maintenance of environment and equipment

- Staff told us that they did not experience any issues with obtaining or maintaining equipment for end of life care patients.
- Some hospital services such as Arundel District Hospital had limited storage space which meant the provision of specialist beds could be difficult to manage;
- We were told that requests for specialist equipment were always met but lack of storage meant some delays were inevitable as equipment had to be brought in from other locations.
- Patients were seen in a wide variety of locations throughout the trust ranging from GP surgeries, community hospitals, and clinics and in their own homes. There were no concerns raised about the maintenance of the environment and equipment although it was noted that some of the older locations looked tired and in need of refurbishment.
- Not all the facilities were fit for purpose. We observed that the urgent treatment centre (UTC) in Crawley had a room identified to care for distressed patients with mental health conditions. We were told that patients often waited alone in this room whilst awaiting a mental health referral or visit from a community psychiatric nurse. The room was not suitable for caring for patients at risk of self-harm as there were numerous ligature points and equipment that could cause an injury. The environment had not been risk assessed to ensure it was safe for the type of patients accommodated there. Following the inspection we were told that a risk assessment had taken place. Staff told us about some of the difficulties that the design and layout of the buildings presented.

Medicines management

- Medicines were stored securely in locked cabinets or trolleys. We tested medicine cabinets and trolleys on all wards during our inspection and found them to be locked. We found that prescription pads were stored within locked cabinets and that access to all medication keys was controlled by the nurse in charge.
- We found that where medications were stored the ambient temperature was checked. Medicines that required it were stored in designated refrigerators which were locked with the temperatures checked and recorded appropriately. This meant that patients' medications were stored at the correct temperatures to avoid deterioration that would affect their effectiveness.
- We did find some discrepancies in patients' medication charts that we viewed. For example at Salvington Lodge we looked at three patient medication charts and found two with unaccounted missed doses
- Lockable medicine boxes were available on loan to patients who needed to keep controlled drugs in their home.

Safeguarding

- Patients were kept safe through robust safeguarding arrangements and the Trust worked well with partner agencies to protect vulnerable people from abuse

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

Records systems and management

- We found that patients' records were available to support safe care and treatment, but were not always stored securely in some hospitals.
- In some hospitals we found that patient records were difficult to navigate and found examples where the hospital's generic care support plans did not reflect, evaluate or record the needs and treatment of individuals. This meant that information was not easily accessible for staff to maintain the appropriate levels of care to individual patients.
- The trust used an electronic patient notes system and had a portable version which allowed staff to update records in the home. Staff also completed a paper record in the patient's home so that everyone who visits had an up to date record of any input. This meant that there was a duplication of records which is not ideal but was unavoidable. Staff were aware of the importance of ensuring that the written notes reflected the electronic records.
- The Trust made us aware that there was a lack of electronic patient records due to the current IT infrastructure.
- We were aware that work was being undertaken to address this, and that a new system will be introduced in 2015.

Lone and remote working

- The trust had policies and procedures in place to protect staff when working alone or remotely. We noted that the policies had recently been updated to take into account the new ways of working from centralised hubs. The policy included mandatory conflict resolution training and communication links to the local office at set time of the day.
- We saw the trust used a safe word to alert other staff when they were in distress and needed support. All the staff we spoke with were aware of the safe word although few had had reason to use it.
- The community nursing teams had access to personal alarms, however not all staff who worked alone had access to the alarms for example the specialist heart failure nurses who made home visits to challenging patients. They told us this had been identified as a risk for their service and escalated through their managers.
- The community children's nursing team operated a "Checking in" system whereby staff texted or rang the office based nurse to notify them of their location. There was a process for escalating any issues whereby a staff member failed to check in.
- Support and guidance was provided to staff by way of managers who operated on-call rotas.

Assessing and responding to patient risk

- A central Risk Register was held by the Trust. This register included risks, what actions are being taken and what date this would be reviewed. The risk register was regularly reviewed by The Senior Management Team.
- We found that the trust had systems in place to manage anticipated risks and develop action plans from trust and board level to individual services and patients. We found that staff at all levels and grades took responsibility for the areas within their control and had a good understanding of risk management.

Staffing levels and caseload

- Staffing levels were acknowledged throughout our inspection as a challenge for the Trust. This was evident on all of the Wards that we visited.The Trust had been working hard to recruit to their permanent and bank establishments as a result. However, staff reported that due to the length of time spent in processing applications and undertaking suitability checks by Human Resources, many applicants became frustrated and secured positions in other organisations.
- A report outlining the issues was presented at a public board meeting on 26th June 2014. The report highlighted national guidance requirements for NHS Trusts and presented actions that the Trust had taken to date. The report laid out a new 'Safe Staffing' template which provided staffing levels and skill mix to deliver safe, effective care to a patient group demonstrating increasing frailty, complexity and dependency. In addition, the uplift in the Registered Nurse template provided for supernumerary status for new starters to ensure appropriate orientation and competency, whilst supporting staff retention.'The Safe Staffing template' provided for greater resilience in terms of quality and continuity of care and operational delivery, and included a supernumerary Band seven ward manager and accommodated a 25% uplift to cover annual leave entitlement, sickness and statutory training.

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

- We acknowledge that the trust was in the process of an international staff recruitment drive in an attempt to address the staffing vacancies. However, there was a concern that the situation is not sustainable long term and may have an impact on work-related stress, increase long term sickness, and damage the good will and morale of staff.
- However, in the staff survey, it was reported that 76% (compared to sector average 71%) staff worked extra hours.

Deprivation of Liberty safeguards

- The trust had policies, procedures, advice and guidance for staff relating to the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DOLs) capacity and consent. These were readily available to staff on the trust's intranet together with best interest guidance and relevant forms to conduct mental capacity assessments.
- Staff understanding of the act varied across the trust with some teams having full understanding with capacity firmly embedded in practice and other teams were not so confident and told us they would need to look up the policies to make sure.

Managing anticipated risks

- In addition to the overarching trust risk register each hospital maintained its own local risk register and we saw examples of these. We noted that these were current and complete. Staff told us that they felt confident in raising concerns or risks with managers for inclusion on risk registers both at local and organisational level.
- All managers we spoke with were able to clearly articulate the risks for their area of responsibility. During focus groups held with staff they were able to describe risks particularly pertinent to their working environment.
- There were robust arrangements for disseminating national safety alerts.

Major incident awareness and training

- The Trust had a Business Continuity Plan in place to manage situations such as electrical failure, flooding, and severe weather. We saw that these plans were updated annually.
- The hospitals in the North of the region had escalation plans in place to take patients from the local Acute Trust during a major Incident.
- Both the major incident and adverse weather procedures were tested and staff responsiveness was audited, which demonstrated both procedures were robust enough to deal with unforeseen incidents.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

Overall, we found services to be effective.

We found a clinically led audit programme in place at the Trust, one which was reviewed every three months. There was also extensive research activity which was not only contributing to evidenced based practice at a local and national level, but was also successful at gaining funding to expanding and improve the services delivered at the Chailey Heritage site.

We observed that policies and care reflected current guidance such as that provided by the National Institute for Health and Care Excellence (NICE). We found there were systems to review new guidance and to disseminate this to staff.

The community in-patient services all participated in the National Patient Safety Thermometer scheme, and this demonstrated that the patient outcomes measured were in line with national averages. We saw that there were plans to display performance information in a common format on ward areas for staff and patients to see.

Patient outcomes were in line with those expected nationally.

The Midhurst Macmillan specialist palliative care service had been cited by NHS England and the Kings Fund as being an example of best practice. Following a two year independent review of the service, the clinical effectiveness in providing patients with their preferred place of care and preferred place of death were shown to be exemplary and it was also shown to have cost benefits over inpatient services. The programme is now being piloted in six other areas around the country to test its effectiveness in other settings.

Our findings

Planning and delivering evidence-based care and treatment

- We found there was system for reviewing latest guidance from National Institute for Health and Care Excellence (NICE). NICE guidelines were available on the Trust's Intranet systems and staff demonstrated that they were able to access these. Each ward team had link nurses who were responsible for keeping updated with current practice in their area and disseminating this to other members of staff. Link nurses had roles in areas such as infection control, palliative care, wound care, dementia and nutrition.
- We saw examples of national guidance being implemented. For example in the area of nutrition we saw that guidance from NICE relating to screening for malnutrition was in place. We saw that relevant NICE guidance such as that relating to Falls (CG161), Infection Prevention and Control (QS61) Medicines Adherence (CG76), Pressure Ulcers (CG179) and VTE (QS3) were all being broadly followed.
- We saw evidence of outstanding care and treatment from the Midhurst Macmillan Unit. The service had been forced to change its working practices in 2006 when the King Edward VII hospital closed. Following a review of services and consultation with patients and the wider health community the trust identified that it was possible to provide hospital level care to people in their own homes. The service looked at the provision of equipment and at staff levels and skill mix required to properly support patients and their families.
- The service was independently reviewed over a two year period to assess its effectiveness. As a result of the review the model of care provided had been endorsed by NHS England and is held as a model of good practice in publications from the King's Fund. It is now being piloted in other trusts with the assistance of Macmillan Cancer Support.
- End of life care in the trust had previously been provided in line with the Liverpool care pathway (LPC). The LPC was withdrawn nationally in 2013 following media reports which exposed abuses of the guidance meaning people in some areas may not have received appropriate care. In order to ensure their patients received appropriate end of life care Sussex Community NHS trust introduced a management care plan for end of life care patients. This centred care on individual needs rather than following a set format. We reviewed the management care plan and saw that it contained the elements which it would be expected to include such as pain management, breathlessness and nausea with guidance on eating and drinking, bowel and bladder function and spirituality
- The Trust policy and guidance for staff reflected best practice and national guidance.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- SCT offered a Family Nurse Partnership programme which was an intensive, evidence based, preventative programme for vulnerable first time young mothers, from pregnancy to 2 years of age. Family nurses delivered a licensed programme, within a well-defined and structured service model.
- Health visitors and their teams delivered the Healthy Child Programme (HCP) to all children and families during pregnancy until 5 years of age. The Healthy Child Programme for the early life stages focused on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting.
- School Nursing services were delivered by the HCP to children aged 5-19 years of age, providing a core programme of evidence based preventative health care, with additional care and support for those who need it, such as supporting emotional and mental health, providing sexual health advice, tackling substance misuse and risk taking behaviours.
- The trust's Medical Director signed off any new guidance or change to practice and ensured there was a lead person identified to ensure the new guidance was implemented into clinical practice. The progress of the implementation was reported to the clinical effectiveness committee. The trust had identified that they had implemented the majority of NICE guidance however there were 14% where the cooperation of partner agencies was required.

Pain relief

- Patients told us that their pain was adequately controlled. They said pain relief was provided regularly or as needed. They told us they could request pain relief when they needed it. One patient said, "They always ask me if I am comfortable or if I'm in any pain". We looked at medicines administration records which confirmed patients received pain relief as prescribed on both a regular and as prescribed basis.
- We did not see any evidence of non-pharmacological approaches to pain relief, and staff told us these techniques were not routinely used. However in end of life care we saw evidence of complementary techniques such as massage being used
- Where appropriate patients had syringe drivers which delivered measured doses of drugs at pre-set times, all qualified nursing staff were trained in the use of syringe drivers.
- Nursing staff on the end of life care teams received a five day training course on pain management. We checked records at Martlets hospice which confirmed the training plan.
- Children's pain levels were appropriately assessed according to the age of the child. We saw that different methods were used, such as pictures and assessment of facial and body language, where verbal communication was not possible

Nutrition and hydration

- We observed that patients on wards were served a choice of foods and that therapeutic diets were managed well. Patients were assessed by a dietitian when screening suggested a risk of malnutrition, or if there were medical problems that compromised patients' nutrition.
- Dietary supplements were given to people when prescribed.
- Patient Led Assessments of the Clinical Environment (PLACE) assessments earlier in 2014 awarded scores averaging 96.6% which is above the national average for small community organisations of 91.4%.
- We observed patients being helped to eat and drink. The wards operated a protected mealtime policy and this was advertised on the ward, but in practice this was only partially implemented. For example we saw medicines rounds that clashed with mealtimes, and not all staff were focussed on making sure patients drinks were within reach. We saw various systems that identified those who required special help with feeding to staff, for example a knife and fork symbol on patient doors. We did not see any pictorial menus to help those with dementia or learning difficulties make food choices, in the adult inpatient wards.
- Where appropriate, children had a nutritional and hydration plan in place which reflected national guidance and demonstrated a multidisciplinary approach to meeting children's dietary needs.
- We saw staff following the feeding regime as prescribed, for those who were receiving enteral feeding.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Children who were at risk of obesity had access to a weight clinic to monitor their progress. The child and their parents had access to a dietitian who provided a regular review of their dietary requirement and provided dietary support for parents.
- Breastfeeding and Infant Feeding – teams supported well established peer supporters and health visiting teams to deliver breastfeeding drop-ins across Brighton and Hove and West Sussex, working in partnership with Children and Family Centres in West Sussex and with Children's Centres in Brighton and Hove

Approach to monitoring quality and people's outcomes

- The community in-patient services all participated in the National Patient Safety Thermometer scheme, and this demonstrated that the patient outcomes measured were in line with national averages.
- The Wards all took part in auditing hand hygiene, and catheter care. They monitored the numbers of Urinary Tract Infections (UTI's) in patients with an indwelling catheter. Results of these audits were displayed on notice boards in Ward areas. The staff that we spoke with were aware of their progress with these audits.
- Do not attempt cardio pulmonary resuscitation (DNACPR or DNAR) forms were checked at a number of sites and were found to be completed appropriately. Patients had signed their consent, or where appropriate best interest meetings had been held with relatives or carers and medical staff. The DNACPR forms had been signed by GPs or hospital consultants. Staff at several inpatient locations described how they checked DNACPR forms if patients were transferred to them from acute settings, where appropriate forms were reviewed and amended or assessments in some cases assessments had been completed again to ensure that all interested parties fully understood the process.
- The trust collected data to monitor performance and used performance indicators to benchmark the outcomes for people using the service. The trust used an on-line reporting tool that collected information on operational performance, clinical performance and key performance indicators. Much of this information was displayed on notice boards around the trust. However we found that performance information across the trust was variable as although staff were collecting data and information, this was not always used to improve the service.
- We found that because of the different commissioning arrangements the care provided to patients varied. There was little analysis of the collected data available to support which of the various commissioning arrangements was most effective. Some of the specialist services were not recording data or using information to inform the service they provided. For example we found that because commissioners did not require performance indicators for leg ulcers none were available. Staff told us that although they aimed to heal most ulcers the commissioning arrangements did not allow for a follow up service to review their effectiveness.
- Data supplied by the trust for non-emergency pathways suggested that 100% of audiology referrals and 98.5% of Dentistry, Chronic pain and Child Development referrals were treated within the 18 weeks.
- During April 2013 and March 2014 the service saw 69.9% of referrals within 10 weeks of referral, with an average waiting time of 7.84 weeks. This is similar to the previous year. Nearly 90% of children are seen for their first definitive treatment within 18 weeks of referral.

Competent staff

- We found there were systems to ensure that qualified staff remained registered with the Nursing and Midwifery Council, or the Health Professions Council.
- Health Care Assistant competencies on The Horizon Unit were assessed and recorded by trained nurses. These included tasks such as taking a patients blood pressure.
- On The Horizon Unit at HorshamHospital and at the Kleinwort Centre 100% of staff had received their annual appraisal. All other hospitals reported that between 90% and 100% of staff had participated in an annual appraisal.
- In end of life care Consultants and doctors were available for advice to trust staff and to other healthcare professionals. Home visits were completed in support of district nurses and GPs to advise on practice. The end of life care teams were also called to assist with advice by staff in the trusts hospitals.
- Doctors told us they were supported to complete their revalidation. Revalidation for doctors was introduced in

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

2012; in order to maintain their licence to practise doctors were required to demonstrate on a regular basis that they were up to date and fit to practise. Study leave was provided and the service had a robust appraisal system which helped to support the revalidation process.

- In respect of the Midhurst Macmillan team, we saw evidence of how a healthcare worker had been supported to take a university course and had asked the team if they could complete a team protocol as part of their course project. The protocol had been assessed and discussed with the team and now formed part of their standard procedures. The staff member commented, "Everyone on the team is treated as an equal, there is no hierarchy".
- The 2013/2014 Quality Account stated that the trust has maintained high levels of participation in supervision and increased the proportion of teams demonstrating 100% compliance
- We saw that staff working in the minor injury and urgent treatment centre had strong links to local accident and emergency services (A&E) and accessed their services in order to maintain their A&E competencies. We were told that the staff on duty were all trained in emergency Paediatric Life Support (PLS) and Adult Life Support (ALS).
- Staff told us that when there was new equipment they had received relevant training. Managers kept records of staff competencies in using medical devices. We spoke with new staff who told us about their induction and the mentorship programme which helped them to find their feet quickly.
- Sussex Community Trust provided leadership support and development for its managers. An annual leadership conference and quarterly leadership exchange programme was in place for senior staff.

Multi-disciplinary working and and co-ordinatation of care pathways

- Within community hospitals we identified that there was a strong commitment to multi-disciplinary working. Each ward area had a multi-disciplinary team meeting on at least a weekly basis to plan the needs of patients with complex needs. We saw documentary evidence of a multi-disciplinary approach to discharge planning.
- Generally we saw that patients had timetables detailing when each therapist would be treating them that week. This ensured that patients, their families and nursing staff were aware what and when planned therapy sessions there would be.
- The Midhurst Unit held daily team meetings which involved all staff at the unit. The acuity of patients and their individual needs were discussed each day together with details and needs of any new patients who required visits. The team identified on a daily basis who was best able to support each patient and how care and support might best be delivered. Formal MDT meetings took place once per week.
- Across the trust staff told us they had a good relationship with specialist teams who were a good resource for other health services. During the inspection we observed good interteam working between the community and specialist nurses. For example community nurses took regular photographs of patients' wounds and sent these electronically to the tissue viability specialist nurse team who would advise on the best course of treatment. Staff told us this worked very well and helped to ensure patients received appropriate care and treatment promptly. The community nurses told us they received excellent support from the diabetic specialist nurses regarding caring for diabetic patients in the community.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of findings

All the staff we saw and spoke with demonstrated total commitment to safe, effective and caring relationships with their patients. We observed staff responding to patients, their families and carers with kindness in a compassionate and professional manner.

We also witnessed staff communicating with children with learning disabilities in a way which demonstrated outstanding communication skills and the positive relationships which had been developed with these children, for example in the way the children were asked for their opinions.

Staff were highly motivated in their roles and demonstrated a strong dedication and commitment to the Trust, despite the staffing challenges it was facing. Staff happily and willingly went the extra mile to ensure that the service was delivered regardless of the obstacles. We found examples of how teams constantly reviewed their ways of working.

Our findings

Dignity respect and compassionate care

- During our inspection we observed that patients were treated kindly and with respect. During conversations with each other staff talked positively and respectfully about patients and their circumstances.
- Patient Led Assessments of the Clinical Environment (PLACE) assessments earlier in 2014 awarded scores averaging 90.1% which was above the national average for small community organisations of 85.3%.
- The community in-patient services administered the 'Friends and Family' test to gauge patient satisfaction. Average percentage scores averaged 89%. However, caution is required in interpreting these results as often sample sizes were small.
- We visited the Arundel and District hospital as we had expected to find a patient receiving end of life care on the ward. Unfortunately the patient had passed away prior to our arrival. The patient had only been at the hospital for a very short period before passing away and we saw how this had affected the staff. It is importance for staff to establish a relationship with the patients and their families in order to help people understand and deal emotionally with the circumstances. We saw how the hospital used 'This is me' documents for patients receiving end of life care; similar to those used to help staff understand patients with memory issues. These enable staff to understand the wishes of patients and their families.
- In this instance the staff felt they had been unable to build a close relationship which they felt let down the patient and their family. They felt that the patient should not have been transferred if they were so ill. An incident report had been submitted and was being jointly investigated by the Sussex Community trust and the Acute trust from where the patient was transferred.
- The effect the incident had on the staff on the ward demonstrated the level of compassion they showed for their patients.
- We saw staff interact with hard to reach groups in a professional but understanding way.
- As part of the inspection we undertook a visit to two traveller's sites. This staff member demonstrated a very mature understanding of travelling culture which enabled them to meet the individual needs of this service user group.
- The home visits we observed and other interactions in clinical areas showed us that staff helped children and their families understand the care treatment and support available to them.
- The staff interactions with children and their parents we observed were noted as positive, respectful and centred on the child.
- The trust overall scored 90.21% for 'Privacy, Dignity & Wellbeing' in the latest PLACE assessment compared to the England average of 85.26%.
- We spoke with 34 patients or their carers across the trust from clinics, emergency care centres and out patients to visiting patients in their homes or contacting them by telephone. We looked at patient feedback and the complaints the trust had received. The information provided indicated that staff in the trust treated patients with care and compassion. We did see a few complaints in which staffing attitude was a factor but these issues had been dealt with promptly and appropriately.
- During the inspection all the patients we spoke with, without exception, told us how pleased they were with the care and treatment provided by Sussex Community

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Trust. We were told that the community nurse service was "Very good, they are extremely caring and professional" and the nursing staff and therapy staff were "Excellent".

Patient understanding and involvement

- Patients told us they were involved in planning their care and understood what was happening to them. Patient comments included, "I've been told about my treatment and how long I'm going to be here".
- We saw that each hospital had patient information packs available both in booklet format and on the trust website. Staff told us that patients received a copy on admission.
- We saw many examples of how staff had introduced initiatives to support patients, their supporters and family. Examples of this were the regular Matrons surgery for relatives to help their understanding at Salvington Lodge and the patient and family meetings on admission introduced at Arundel Hospital. One relative said "As far as I know this place does not need any improvement – it's top work here"
- We were able to observe a patient receiving treatment from a healthcare worker. The treatment consisted of application of creams and massage. The patient was able to ask about the creams and the different techniques involved. They asked about other therapies and how these might assist with mobility, pain relief and relaxation. The care worker described the techniques and benefits of different techniques.
- Patients told us that their medication and treatment had been explained to them including any possible side effects and the benefits they might see from taking medication. On one inpatient ward we visited the ward manager explained how they had completed an audit with patients regarding self-medicating whilst in hospital. The results showed that all the patients at the time of the audit had preferred to have staff take control of their medicines; none had wanted to retain their drugs and self-medicate. The ward manager explained that patients were able to self-medicate if they wished to do so.
- The home visits we observed and other interactions in clinical areas showed us that staff helped children and their families understand the care treatment and care support available to them.
- The people we talked to told us, they felt understood the care and support offered by the trust and their local authority because staff had taken the time to explain.
- We joined community and specialist nurses on their home visits to assess the care of patients in their own homes. We found that staff ensured that patients understood the care and treatment they received and obtained consent before starting the treatment. For example we saw a patient who required a bladder washout and the community nurse asked permission before starting the procedure and constantly checked if the patient was comfortable and happy to proceed. This demonstrated that staff were aware of the principles for obtaining valid consent at all stages of a patient's treatment.
- We spoke with the staff from the trust's 'Homeless Project' who told us of the work they undertook in engaging with hard to reach groups. This included making sure they were engaging with the patients in a way they found it easy to understand in locations where they did not feel threatened or intimidated.

Emotional support

- Within patient notes we saw mood assessments/care plans but not all clearly identified objectives or supporting information to support the patients' care. An example of this was a low mood care plan viewed at The Kleinwort Centre that simply stated "anxious re health and continence issues".
- Staff could refer patients to a mental health liaison service. Staff were clear about how to access these services and how important such a referral would be if they detected a patient needed an appropriate mental health assessment to be performed
- All end of life care patients were allocated a named nurse so that they had a single point of contact. In reality patients told us that they had found all the staff either in person or on the telephone to be equally as helpful and friendly. Some patients did say that having a named nurse was reassuring to them.
- When we spoke with staff they told us how they involve carers and relatives in discussions about care and support and how this involves helping them as well as the patient to understand and come to terms with their condition. We saw evidence of this involvement and support when we observed members of the team during

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

home visits where patients, carers and other family members were present. We saw how staff were friendly and exchanged banter with patients and their relatives but were professional and caring in their practice

- We saw that chapels were available at Crawley and Zachary Merton hospitals for patients, visitors and staff. We saw that the rooms were predominantly Christian but subtle enhancements had been made to encompass other faiths. For example at Crawley we saw that a symbol had been placed on the ceiling indicating the direction of Mecca, and washrooms were available nearby for those whose customs involved washing prior to and after prayer. Staff at Zachary Merton hospital had contact details for ministers and religious leaders; we were told how the hospital is regularly visited by clergy of all denominations.
- We found parents had an understanding of their children's care and treatment that the service provided. This was supported in all areas we inspected, but was especially commendable at Chailey Heritage Centre. Examples included the staff response to a medical emergency during the inspection
- The trust had in place services to provide patients, their families and carers with emotional support. We spoke with staff who provided services such as support for carers, Time 2 Talk, learning disability support and sexual health services. They told us of the support that was available to patients and their families and carers. This included home visits in a place of their choice, help in accessing caring and health services and expert patients' programmes where patients volunteered to help other patients or staff with long term conditions.

Promotion of self-care

- We observed that there was a strong ethos of promoting independence and rehabilitation throughout the in patient services. We saw that staff encouraged patients with patience and kindness to undertake tasks for themselves where this would aid their recovery.
- In end of life care we observed how patients were encouraged to complete tasks for themselves and take an active part in monitoring and reporting their own health and wellbeing. One patient described to staff how they had been unwell and had needed assistance from a relative to complete certain tasks, staff spoke with them about the issues and encouraged them to persevere and described how their ability would improve as treatment progressed. The patient clearly understood their long term prognosis but was anxious to remain independent for as long as they could.
- We visited the Sussex Rehabilitation Centre and went on home visits with the technicians. We observed how the staff provided kind and compassionate care with meticulous attention to detail throughout which gave the patient confidence to use the equipment on their own. The technicians provided a follow up service to ensure that the patient continued to cope on their own and had not developed any problems such as pressure areas.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary of findings

End of life care was found to be outstanding in its responsiveness to patients needs

We found that the trust was responsive in meeting the complex needs of the people of Sussex, Brighton and Hove together with the commissioners of services. However the differing models of care commissioned by the CCGs and historic differences in the provision of care meant that across the county patients experienced different models of care and treatment.

There were arrangements to meet the specific needs of patients, including those with learning disabilities and bariatric needs. We found some weaknesses in the care of people living with dementia but saw there was an organisation wide action plan to address this.

Patients were informed how they could raise a concern or complaint. We saw that complaints were investigated and that agreed timescales were met most of the time. We found there were systems to ensure that learning from complaints was shared within the organisation.

Our findings

Service planning and delivery to meet the needs of different people

- The Musculoskeletal service at Crawley was collecting data on patients not attending clinics, appointments not being filled, and cancelled appointments in order to make improvements to the service. The demand on the service had increased with non urgent appointments having a waiting time of 14 weeks.The department had a high level of patients not taking up the appointments offered to them. For example, between September 2013 – July 2014 the service had received 110 referrals 68 of which had come from General Practitioners (GPs) 48 of these referrals had not taken the appointments that the service offered to them. We were told that the service on average had 29 missed appointments over a four week period. Staff felt that the reasons for this were patients not being prepared to wait, patients not receiving appointment letters, and the high volume of calls to the service which meant patients said that they struggled to get through to talk to staff.
- The Sussex Community NHS Trust had two defined services for end of life care patients dependent upon where they reside. The Midhurst Macmillan specialist palliative care service supports patients in the North West of the region and were commissioned to take patients from parts of Surrey and Hampshire. The service is part funded by Macmillan Cancer although staff were employed and managed by the trust. Patients in other areas were cared for by end of life care teams funded and managed by the trust. We saw that patients in all areas of the trust received excellent care and support.
- The trust does not have a dedicated end of life care ward although they worked closely with independent hospice services. Patients who were admitted to hospital either due to the end of life needs or through co morbidities were supported by the general ward staff. Patients with end of life care needs may be referred by their GPs or from an acute hospital setting.
- We found that service planning in the trust was complex due to the differing demands of the various CCGs and historical service provision. We found that across the trust different models of care were provided to the same patient group. Some teams did little cross location working across the trust to promote best practice and provide equity of service.
- Other specialist services, such as the respiratory nurses, told us how their services had been subject to redesign and there had been sharing of tools, administration, knowledge and protocols. They told us how there had been significant workforce planning to ensure that patients' needs were met.
- Children and Young peoples services went to great lengths to address the care needs of hard to reach groups, for example, travellers, refugees, asylum seekers and ethnic minorities groups.It also provided support group (Rainbow group) for LGBT parents and had outstanding facilities for children who had a neuro developmental disorder at Chailey - described by staff as a "one stop shop".

Access to the right care at the right time

- The north and south of the region used different processes for accepting admission into their services from the two local Acute trusts. The North of the region was able to evidence a robust system where discharge

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

teams in the acute Trusts acted as gatekeepers for admissions to ensure that admissions were appropriate for the rehabilitation and environment that the wards were offering. In the South of the region this was managed by 'One Call' staff in the South had experienced problems with patients being admitted to the wards who were not suitable for rehabilitation

- The end of life care team engage with patients as early in their treatment as they were able making initial assessment and liaising closely with GPs, district nursing teams and other health providers in an advisory and support capacity. They provide a range of interventions both in people's homes and at community settings enabling patients to receive treatments which historically might have meant a hospital stay; these include blood and blood product transfusions, scans and medicines management.
- We saw how arrangements were made in respect of two patients who required blood transfusions. Day beds were booked to enable the patients to receive their treatments in a clinical setting but without the need for admission to hospital. Staff at Midhurst also provided transfusion services in people's homes and where this was done overnight sitters were arranged to monitor the patient following the procedure.
- A school nurse told us they recently discovered a high level of tooth decay in one school. They contacted the BDCA for support and ran clinics where children had access to dental reviews, free toothbrushes, toothpaste and oral hygiene.

Discharge, referral and transition arrangements

- Although we found many examples of good multi-disciplinary working both within the trust and with outside organisations, many staff told us about the poor discharge and transfers from the local acute hospital trusts.
- Staff told us that although there were regular MDT meetings and processes in place to prevent unsafe discharges these were still happening. They gave examples where patients were discharged home without appropriate support being in place, with incomplete discharge drugs and poor information exchange. For example we heard of a patient who was discharged from the local acute hospital with advice that a district nurse would call to take their stitches out. However a referral was not made and only when the patient called in to the district nursing office to request help did the situation come to light. We were told this type of issue was not unusual.
- Each end of life care team included a social worker. Nursing staff told us that having the social workers as part of the team had increased the teams' efficiency as they had the knowledge to engage directly with local authorities or other agencies and arrange for equipment, financial support or other services to become involved with patients, making it easier for them to remain at home
- Staff described how the rapid discharge process had enabled people to return home from hospital during their final hours or days if it had been their wish to die at home. We saw evidence to show that a bed and specialist mattress had been requested the previous evening and had been delivered to the patient's home that morning together with a hoist. Another example we were told about involved arranging the discharge and transport home within a few hours for a patient who had requested that they be able to return home to die. The patient's family subsequently wrote expressing their appreciation for how the team had managed the process.
- We found appropriate handover arrangements in place for those children and young people moving between services.
- The Trust offered a transition clinic where children were assessed by a paediatricians and a physiotherapist prior to leaving the service.

Responding to and learning from complaints and concerns

- We found there were clear procedures for receiving, handling, investigating and responding to complaints.
- We saw literature and posters were displayed advising patients and their supporters how they could raise a concern or complaint formally or informally. Patients told us they all knew how to raise a concern and were confident that their concerns would be acted upon.
- We meeting minutes that showed concerns, complaints and plaudits were discussed at team meetings, and that action plans were formulated and implemented in

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

response to these. We saw how the learning from complaints was shared at staff meetings and clinical governance meetings and staff told us they found this useful.

- We saw that 92 complaints were upheld from the 204 complaints received. The majority of the complaints involved aspects of clinical care, staff attitude and delay or cancellation of outpatient appointments.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

Instructions

The Trust provided very good executive and board leadership and were highly visible across the various services.

The trust encouraged and supported staff to take responsibility and ownership of their service. This encouraged innovation with staff taking pride in the service they offered. Staff from all levels in the organisation felt valued and listened to. They told us that the executive team actively sought their opinions and where possible acted upon them. Although caseloads and workloads were high, staff across the organisation spoke of the positive working environments and told us how proud they were to work for the trust.

Staff we spoke with told us they felt supported by their immediate managers to provide good quality care, with managers being approachable and visible.

Our findings

Instructions

Vision and strategy for this Provider

- Sussex Community Trust had a detailed vision and strategy in place to meet the needs of the communities it served across Sussex, Brighton and Hove. The trust had recently approved a five year transformation plan to provide a sustainable business base to secure the future of the Trust. This involved reducing costs and developing clinical expertise, service design, and health intelligence and reporting. This information was communicated to staff and the public through the trust's website and in leaflets and brochures.
- The trust covered wide and disparate communities from busy cities and ports to isolated rural settlements and we noted the difficulties in providing parity of services across the county with the differing requirements of the various CCGs.
- We spoke with senior members of the trust who told us of their five year strategic plan for all agencies and disciplines to work together to provide integrated care and support for adults in the community. We were told of the organisational redesign to develop a "Hub and spoke" model of care with specialist clinical teams providing all necessary care in the community setting. .
- The trust's vision to provide 'Excellent care at the heart of the community' was underpinned by three strategic goals;
  - To provide excellent care every time to reinforce wellbeing and independence.
  - To work with partners to personalise services.
  - To be strong and sustainable, grounded in the communities and led by excellent staff.
- We found that all the staff we spoke with were working towards these goals and were aware of the trust's strategic vision. From discussions with staff and patients, observation of practice and review of documentation we found that the trust board and senior managers were aware of the areas which presented the most significant challenges and had plans in place to address them. For example, recruitment and retention of staff particularly in the community nursing teams together with the introduction of new technology to improve record keeping and data collection across the county.
- There was a 'Living Room to Board Room' cultural change programme underway at SCT.Staff spoke highly of their local management and members of the board. They felt much supported by their teams and service managers. However, we did receive some concerns about the management above clinical director level which the trust may wish to review. Staff reported feeling proud of the open, involved and progressive culture at SCT and unanimously told us that they "loved their jobs". Staff also told us that they felt involved in the service and could make suggestions or bring solutions to management which would be listened to and, if appropriate, incorporated into the service to improve it.

Governance, risk management and quality measurement

- We found evidence of an effective governance structure and reporting culture in SCT.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- Key performance indicators, workforce issues and learning from incidents, complaints and patient experience were discussed at team meetings and reported through to the Board.
- There was also a Quality Committee who were responsible for delivery and assurance of all quality issues and detailed reviews in key areas of harm have been undertaken.
- We saw from the monthly quality performance report and risk register that there were clear lines of responsibility and communication.
- At community in-patient service level we found there were robust governance arrangements. We saw minutes of ward meetings where there was a standing agenda that covered areas such as risks, incidents, complaints and audits. Clear actions were described and previous actions were evaluated. Staff were able to access these minutes and they were displayed on staff notice boards.
- We were also told about the Quality Risk Panel meeting which ensure that quality and safety matters received due consideration, and that actions were agreed and progress monitored.
- We saw that there was clear clinical oversight and involvement with patients throughout their care. Systems were in place which ensured that managers understood their workforce and their workload. Audits were completed and information shared with teams to show performance and highlight targets. One such area was mandatory training. The trust had set itself a target of 90% of staff across the trust to attend mandatory training.
- Weekly and monthly team meetings took place in all the teams we met with. Standing agenda items included incidents, complaints, plaudits and policy updates. Staff at all levels told us the meetings were a useful source of information and encouraged staff to engage with issues and enabled learning to be passed across the teams and the trust. We checked minutes of meetings and saw that what staff had told us was reflected in the notes.

Leadership

- Staff across the trust told us that how visible the trust's board were. They held walkabouts in various locations across the trust and that several all staff leadership events had been held.
- Staff told us that it would not be unusual for a member of the executive team to visit their hospital in the evening and have had a night visit from the chief executive. Another told us that the Director of Nursing was "a breath of fresh air with a passion for nursing".
- The executive team led by example, and regarded the care of patients their number one priority. For example, the Director of Nursing worked in the clinical environments regularly and the Director of Finance worked one shift a month as a healthcare assistant. All other Directors, the Chair, and the non exectuives all spent time meeting with staff and talking to patients in the core services.
- Managers told us that Sussex Community Trust was "A fabulous trust to work for". They told us that the executive team and senior managers allowed them to take ownership of their service which encouraged innovation and pride in what they were doing. They told us that together with the dedicated staff groups and support from the trust they were making a real difference for patients. They gave examples of looking for ways to make sure that patients had a positive experience over the Christmas period and ways to take pressure off the acute sector.
- We found that because of the differing commissioning arrangements and historical differences in providing specialist services across the county there were differences in the way specialist services were provided. This included differences in the leadership and management of the services such as the tissue viability and diabetic specialities. Staff working in these services told us that it was difficult to make their voices heard because of the differing managers and models of service provision. However specialist staff told us "Although we still have all the pressures, staffing issues and time constraints that are common to all our roles, the team and senior management are so supportive that it helps us to cope with it".

Culture across the provider

- The culture of the Trust was one of openness and caring, staff were proud to work at SCT.
- We found that staff were passionate about their work and the difference it made to patients. They displayed positive attitudes and said they were supported by their

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

managers to provide excellent care and services. There was a commitment to a multi-disciplinary approach to care and an ethos that promoted autonomy and independence.

- Staff we spoke with told us they felt the matrons and Ward Managers provided strong leadership that focussed on the needs of patients. They were visible in the hospital wards and when we spoke to patients they told us could recognise them and knew what their roles were.
- We were told that the trust Chief Executive and members of the executive team held meetings in the localities and were approachable and interested in their roles and showed a keen interest in their work.
- We found that although the trust had been through a sustained period of organisational change and was implementing challenging financial targets, they had managed to engage with the majority of staff during this difficult time.
- The inspection process uncovered what was perceived as a north- south divide in the trust. This gave a sense of a fragmented service due to the geographical restraints and the recent amalgamation of the trust. However, we found a culture of positivity, commitment, dedication, and an abundance of good will in this childrens Services.
- There was a clear sense of pride and belonging amongst staff at all levels within the end of life care teams. Each person's role was seen as being equally as important as the next. Staff appeared to have a genuine respect for each other which allowed them to concentrate on their role within the team.

Public and staff engagement

- The Trust board met every other month and at each meeting the board heard a patient's story. For example at the July Board meeting issues relating to the Community Phlebotomy Service were delivered by a patient with a follow up review of the issues raised in the September board meeting.
- The trust engaged with the public through patient surveys various patient forums and feedback through the trust website and comments made via the Patients Advice and Liaison Service (PALS). We noted high levels of patient satisfaction for those services surveyed. Patients and carers were encouraged to contact the Patient Experience Team to share their experience of the services they had received.
- The trust collated information from patients, families, carers and staff using the friends and families test, we also saw evidence of public engagement a trust level, in relation to changes to services, however these had not included provision of end of life care.

Innovation, improvement and sustainability

- The trust was financially stable with systems in place to enable growth and development of services depending on the needs of the commissioning groups. Staff across the trust told us how they were encouraged to find creative solutions and were helped to implement trials and new ways of working.
- We heard examples from teams of how innovation and improvement to services was encouraged. For example:

We heard from staff about the successful trial of an early warning trigger tool that alerted the trust of teams that were struggling with staffing levels, sickness, absence and increased activity. The success of the trial meant that this information would be included in the trust's Quality Dashboard.

- Staff throughout the community in-patient facilities were very positive about the inspection and we saw how the Ward Manager at Arundel had used the opportunity to maximum benefit, creating an improvement and positive attitude notice board. The main focus of the board was to highlight and involve staff in identifying all the benefits of a CQC visit giving them an opportunity to "shine at what you do best – looking after patients" .
- Staff at Midhurst, including some managers, told us that they do spend a lot of time completing administrative tasks. This had been identified and a volunteer with appropriate skills now worked regularly at the unit as opposed to with patients in order to reduce the burden. A new member of staff was due to start working with the admin team from January 2015.
- The Midhurst Specialist End of life Care programme had been subject to a rigorous two year independent review. It had been shown to provide exemplary care and in addition provides cost savings of up to 20% over similar

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

in hospital care. Patients were referred earlier and receive support more timely, patients experience far fewer emergency A&E visits and hospital admissions, the programme maximises patient choice.