Brighton and Sussex University Hospitals NHS Trust

Inspection report

Royal Sussex County Hospital
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We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Requires improvement
Are services well-led?	Good
Are resources used productively?	Requires improvement
Combined quality and resource rating	Good

Summary of findings

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Background to the trust

The trust has a history of long-standing and complex issues and was put into special measures for quality by the Care Quality Commission (CQC) following an inspection in August 2016. The current executive team were not in place at the time of that inspection. In October 2016, the trust was placed into financial special measures after it deviated from its planned savings targets. The trust exited financial special measures in July 2018.

Following the 2016 inspection an agreement between Brighton and Sussex University Hospitals NHS Trust, Western Sussex Hospitals NHS Foundation Trust and NHS Improvement was created.

The agreement included a partnership between the two trusts. The intention being that the chief executive and chair of Western Sussex Hospitals Foundation Trust would also carry out those roles for Brighton and Sussex University Hospitals from April 1, 2017.

The management contract between Western Sussex Hospitals Foundation Trust and Brighton and Sussex University Hospitals was that the trust would:

- Exit quality special measures
- Exit financial special measures
- Improve accident and emergency performance
- Improve culture
- Deliver 3Ts (Trauma, Teaching and Tertiary Care programme) building redevelopment on time and within budget

The trust was undergoing an extensive building programme at the time of our inspection as part of the 3Ts renovation project.

The trust was inspected in April 2017 within weeks of this agreement taking shape. Although we saw some improvement during the 2017 inspection the trust had not made enough improvement to exit quality special measure.

In October 2017, we conducted a focused, unannounced inspection to specifically review staff understanding of COSHH after CQC was notified of a patient death following a COSHH incident.

Overall summary

Our rating of this trust improved since our last inspection. We rated it as Good

What this trust does

Acute hospital sites at the trust

Brighton and Sussex University Hospitals is the regional teaching hospital working across two sites: The Royal Sussex County Hospital in Brighton and the Princess Royal Hospital in Haywards Heath. The Royal Sussex County site includes the Royal Alexandra Children's Hospital and the Sussex Eye Hospital.

Summary of findings

The trust provides district general hospital services to the local populations in and around the City of Brighton and Hove, Mid-Sussex and the western part of East Sussex. They also provide more specialised and tertiary services for patients across Sussex and the south-east of England.

Both hospitals provide many of the same acute services for their local populations. The specialised and tertiary services provided include: neurosciences, neonatal, paediatrics, cardiac, cancer, renal, infectious diseases and HIV medicine. The trust is also the major trauma centre for the region.

The trust provides urgent and emergency care services 24 hours a day seven days a week from two locations. The Royal Sussex County Hospital (RSCH) Brighton and the Princess Royal Hospital in Haywards Heath. The Royal Sussex County Hospital has a type one emergency department which is the regional major trauma centre and is co-located with an urgent care centre for patients with minor illnesses and minor injuries.

Emergency services for children are provided at the Royal Alexandra Children's Hospital and the Sussex Eye Hospital provides an eye casualty service. PRH has a type one emergency department.

The trust provides district general hospital services to local populations in and around Brighton and Hove, Mid-Sussex and the western part of East Sussex and more specialised and tertiary services for patients across Sussex and the south east of England. The trust primarily serves a population of over 539,500 people.

The Clinical Commissioning Group (CCG) is Brighton and Hove, which has lead commissioning responsibilities for the local CCGs. NHS England commissions significant specialist services from the trust. Musculo-skeletal services are commissioned by the Sussex MSK Partnership, who commission the musculo-skeletal pathways on behalf of local CCGs.

A list of the acute hospitals at the trust is below.

The trust also provides physiotherapy, dermatology and outpatients services out of Brighton General Hospital and are registered with CQC to provide services from the following locations:

- Lewes Victoria Hospital
- The Park Centre for Breast Care
- Hove Polyclinic
- Bexhill Haemodialysis Satellite Unit
- Worthing Dialysis Satellite Unit
- Newhaven ward
- Eastbourne Radiotherapy Unit

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

Summary of findings

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected the two of the acute services locations at this trust as part of our continual checks on the safety and quality of healthcare services. At our last comprehensive inspection of we rated the trust overall as requires improvement. The trust was in special measures to help it improve.

We also inspected the well-led key question for the trust overall. We summarise what we found in the section headed Is this organisation well-led?

What we found

Overall trust

Our rating of the trust improved. We rated it as good because:

- The trust had made huge improvements since the new executive team had introduced improved systems of working. The trust had a new strategy, vision and values which underpinned a culture which was patient centred. The 'Patient First Improvement System' had empowered front line staff by equipping them with the lean tools, methods and a structured process which had helped to build and promote a culture of continuous improvement across the whole trust.
- A new divisional structure had been created around the pre-existing directorate structure. This had strengthened the existing leadership and management arrangements of the clinical services.
- Quality was a 'golden thread' running through the trust Patient First Strategy. In all the interviews undertaken on inspection this was evident in the use of data both quantitative and qualitative and how this was triangulated and reported through the Quality Steering Group to the Quality Assurance Committee and the trust board.
- All staff we spoke with on inspection were clear about the trust's approach and priority to deliver high quality sustainable care to patients. Staff knew and understood the trust's vision, values and strategy and how achievement of these applied to the work of their team. To support the roll-out of Patient First across the trust, a communications plan was developed and implemented. The plan was tailored to different audiences to best reach staff in different parts of the organisation. Staff spoke about feeling that the Patient First Strategy had given them the ability to all speak the same language.
- The board received holistic information on service quality and sustainability. There was a programme of board visits to services and staff we spoke with told us that that leaders were approachable.
- Staff felt equality and diversity were promoted in their day to day work. We spoke with the newly formed Black and minority ethnicity working group. The trust had held an event in May where over 200 members of staff had come together to discuss equality and Black and minority ethnicity issues and start the forming of a new strategy. The output of this meeting was three workstreams; communication, recruitment, and education. The group we spoke with told us that they had seen a dramatic change in the past 6-9 months. They described this as powerful, positive and feeling included in the strategy and change. Staff told us that although they had not always felt supported in the past since the new executive team had arrived they now felt confident that they could raise any concerns about staff behaviours towards them with their line managers, and they felt assured that their concerns would be listened to and acted on appropriately.

Summary of findings

- Staff felt respected, supported and valued. The executive teams and divisional leaders told us how they felt that improving the experience and engagement of their staff was fundamental to delivering a culture of high sustainable care and trust strategic objectives.
- The trust's Patient First Improvement System empowered staff to make improvements and to be listened to and respected. In areas where 'Patient First' had been introduced the level of engagement and motivation had significantly improved as staff felt empowered to make improvements in their work. This was evident both on CQC engagement events at the trust and on inspection.
- A clear framework set out the structure of ward/service team, division and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to act as needed. The trust had governance and management arrangements had been strengthened significantly since the management agreement with Western Sussex Hospitals Foundation Trust and NHS Improvement. These arrangements enabled all clinical and management staff to function in an effective and efficient manner through both line management arrangements and governance arrangements.
- The board had invited the Good Governance Institute (GGI) carry out a review of the trust's quality governance structures, which resulted in 31 separate recommendations being made. The trust acted to address these issues and the Good Governance institute carried out a further review reporting on progress against these actions. A focus of this work has been to strengthen quality governance arrangements at divisional level.
- The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers. Leaders regularly reviewed these structures. The trust reported regularly through its governance arrangements on progress against delivery of its strategy to the board, Trust Executive Committee and to other relevant committees. However, the structure needed more time to become fully embedded.
- The trust executive team had worked hard to roll out Patient First Strategy across the trust. They had done this in a structured way by considering which areas of the trust would benefit the most from the methodology and training. There was no doubt that areas who had imbedded Patient first had made the largest impact on improvement. Although we were impressed at the speed and spread of improvement the trust needed more time to embed this methodology across the whole trust.

Are services safe?

Our rating of safe improved. We rated it as good because:

- We found a culture of openness and transparency about safety. Staff could raise concerns and report incidents, which were regularly reviewed to aid learning. Lessons learned were effectively shared and we saw changes implemented within the wards as the result of investigations.
- Substances subject to Control of Substances Hazardous to Health Regulations 2002 were stored securely and staff knew where to find safety information regarding these products. An inspection undertaken in October 2017 specifically in relation to these regulations had identified issues in the management and storage of products. At this inspection we saw the trust had taken effective action to address these concerns. For example, all cleaning cupboards had swipe card access so only authorised staff could access these areas.
- The trust had introduced several safety programmes to improve the monitoring of deteriorating patients and the reduction of potential harm. For example, the sepsis bundle and NEWS2, the availability of a clinical nurse specialist lead for sepsis, safeguarding huddles and safety huddles.

Summary of findings

- The sepsis bundle and NEWS2 scoring sheets had comprehensive sections on a full range of patient safety areas including pressure area monitoring, acuity, environment and equipment and risks and falls assessments. The huddles aided the sharing of patient information to ensure holistic, multidisciplinary care was provided. We saw that huddles were also an opportunity to focus on a topic of the week. The topic of the week during our inspection was sepsis, thus giving an opportunity to remind staff about the use of the sepsis bundle.
- The trust controlled infection risk well. Staff kept themselves, equipment and the premises clean through the use of effective control measures such as daily and weekly checklists, to prevent the spread of infection. All staff had a good understanding of control of substances hazardous to health regulations. The service had suitable premises and since the last inspection had introduced effective processes for managing fire risk assessments. Fire risk assessments were complete and mostly up to date and practice fire drills and evacuations had become routine
- The trust had adequate staff to keep people safe from avoidable harm and abuse and to provide the right care and treatment. Staffing levels and skill mix were planned, implemented and reviewed to keep people safe. While the lack of registered nurses remains a significant challenge, any staff shortages were responded to quickly and adequately. There were effective handovers and shift changes, to ensure staff managed risks to people who use services.
- Statutory and mandatory training compliance had improved since the last inspection. Staff understood how to protect patients from abuse and the service worked well with other organisations to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Managers made sure staff had the right skills to perform their role. They met with staff regularly to appraise performance and encouraged continued professional development. Practice educators on all wards and departments supported staff training within a positive learning environment.

However:

- The printed copies of NEWS2 and sepsis assessment sections showed different trigger scores for escalation. The NEWS2 form showed a trigger score of five or more and the sepsis form showed a trigger score of three or more. Managers we spoke with reported the trust was in the process of replacing the forms. Records we reviewed and staff we spoke with provided assurance that patients were not meanwhile put at risk as staff had escalated at the lower trigger score for escalation.
- In some areas some pieces of equipment that had not been serviced in line with the schedule. The trust had identified this as a risk and had a plan in place to mitigate this.

Are services effective?

Our rating of effective improved. We rated it as good because:

- The trust provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff carried out comprehensive assessments to meet people's needs and improve their health. This included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. They used special feeding and hydration techniques when required. They adjusted to patients' religious, cultural and other preferences.
- The trust monitored the effectiveness of care and treatment and used the findings to improve them. They participated in relevant local and national audits, and other monitoring activities such as service reviews, benchmarking, peer review and service accreditation. Staff shared up-to-date information about effectiveness internally and externally. Staff understood the information and used it to improve care and treatment and people's outcomes.

Summary of findings

- Staff had the right qualifications and skills to carry out their roles effectively and in line with best practice. Staff received timely supervision and appraisals of their work performance and they had access to learning and development, including mandatory training. The trust had a clear and appropriate approach for supporting and managing staff when their performance is poor or variable. We saw marked improvement of appraisal completion rate from the previous inspection. The continuing development of the staff's skills, competence and knowledge was recognised as being integral to ensuring high-quality care. Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice.
- There was effective multi-disciplinary team working across the trust. Staff of different disciplines worked together as a team to assess, plan and provide people coordinated care. Doctors, nurses and other healthcare professionals worked collaboratively to understand and meet the range and complexity of people's needs when planning people's discharge or transition. People were discharged at an appropriate time and when all necessary care arrangements were in place.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Staff understood and monitored the use of restraint and used less restrictive options where possible.
- Staff understood and recognised that the deprivation of a person's liberty only occurred when it was in that person's best interest, was a proportionate response to the risk and seriousness of harm to the person, and there was no less restrictive option that could be used to ensure the person got the necessary care and treatment. Staff used the Deprivation of Liberty Safeguards, and orders by the Court of Protection authorising deprivation of a person's liberty appropriately.
- The trust was working toward seven-day services in line with National Health Service Improvements (NHSI), Seven-day services in the NHS. We saw in the trust operational plan 2018-2019, that they plan to deliver the Seven Day Service standards for all admitting specialities by 2020.

Are services caring?

Our rating of caring improved. We rated it as outstanding because:

- The trust had a strong, visible person-centred culture. Despite staff and financial challenges, staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who use the service, those close to them and staff were strong, caring and supportive. These relationships were highly valued by staff and promoted by leaders.
- Staff had support to initiate improvements in quality of care. We saw a ward manager's innovation such as the 'blanket project' promoted people's dignity and individual needs for the care of the elderly. Individual blankets were used to allow patients to recognise their own bed space and protect them from falls.
- We saw staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Feedback from people who use the service, those who are close to them and stakeholders was continually positive about the way staff treat people. People described that staff "go the extra mile" and the care they received exceeds their expectations. We found many examples of this across all the services we visited on inspection
- Staff involved patients and those close to them in decisions about their care and treatment. We found people who use services were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person. Staff empowered people who use the service to have a voice and to realise their potential. They showed determination and creativity to overcome obstacles to delivering care. People's individual preferences and needs were always reflected in how care was delivered.

Summary of findings

- Staff provided emotional support to patients to minimise their distress. We also observed staff provided each other emotional support to ensure they received good health and wellbeing. Staff highly valued people's emotional and social needs and we saw these were not only embedded in their care and treatment, but they went over and beyond to innovate the "Small Acts of Friendship" programme to help elderly patients retain dignity, social activity, mobility and well-being whilst in hospital. Feedback from patients and staff were positive.
- There was a strong sense of togetherness amongst staff from all different grades despite facing challenges outside their control. Overall, we observed staff truly respected people and valued them as individuals, and empowered people as partners in their care. Staff recognised and respected the totality of people's needs. They always considered of people's personal, cultural, social and religious needs.
- We saw a significant number of plaudits from patients, relatives and loved ones describing how exceptional the care provided by trust staff had been both for the physical wellbeing of the patient and the emotional wellbeing of their loved ones.

Are services responsive?

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The trust was open and transparent about the issues they had and would continue to have with capacity until the new 3Ts building project was completed. This would give the trust additional capacity. The trust had effective strategies in place to address capacity, performance and flow challenges. However, they were dependant on building work completion to create more capacity within the emergency department and the creation of additional bed capacity within the hospital.
- Funding had been made available to secure the building of a new acute floor, which was expected to provide additional capacity to cope with the increased volume of patients who attend the emergency department. Building work was due to commence within the next couple of months.
- This meant that in the emergency department the service took account of patients' individual needs but was not always successful in meeting them. During busy times it was not always possible to manage individual needs if patients were cared for in 'the cohort area'. This was the same as our last inspection. Issues around the departments inability to meet surges during demand remained a concern. The service had undertaken a number of changes since our last inspection to improve efficiency and the performance against national standards. However, performance against national targets still required improvement.
- From June 2017 to June 2018 the trust's referral to treatment performance was consistently worse than the England average.
- Cardiology and gastroenterology medical specialties at the trust were below the England average for admitted RTT pathways (percentage within 18 weeks).
- Patients were staying longer than their required recovery time in theatre due to a lack of bed availability in critical care and some ward areas.
- Waiting times for referral to treatment within 18-weeks were below the England average in three out of the eight surgical specialities provided at the trust. Out of the remaining five, three were similar to the England average, and two were better. This was an improvement on the previous inspection when all specialties were below the England average.
- Patients could not always access the service when they needed it. Overall waiting times from referral to treatment were worse than the national average.

Summary of findings

- Patients referred on a cancer pathway were not always treated within 62 days of referral from their GP. The trust was performing worse than the England average in this area.
- The patient led assessment of the care environment audits for dementia and disability scored significantly worse than the national average across four outpatients areas that were assessed. The trust wide dementia strategy did not have any outpatient related actions.

However:

- Since our last inspection, we saw a range of implemented initiatives designed to improve referral to treatment times and the impact this had on patients.
- Staff provided coordinated care and treatment with other services and other providers.
- Staff made reasonable adjustments and removed barriers when people found it hard to use or access services.
- Managers planned and provided services in a way that met the needs of the local people. They were flexible and had made changes to improve services and support patients more effectively. The hospital had a significant redevelopment programme underway, directions to the surgical wards and departments were clear and easy to follow. Information about the building work and services was clearly available to visitors at the main entrances of the hospital.
- Initiatives had been taken to review all patients on the waiting list for specific bowel surgery which meant no patient was waiting 52 weeks. This was an improvement since the last inspection when there was a backlog of patients waiting for surgery. Theatre utilisation rates were monitored to make sure the theatre was used efficiently.
- Staff took account of patient's individual needs and had access to specialist nurses and other staff to support patient specific needs. Support was available for patients with dementia, learning disabilities and mental health problems with lead practitioners and link persons at department level.
- The trust had improved the provision of information for patients and visitors that did not speak English as a first language.
- Where people's needs, and choices were not being met we saw this was identified and used to inform how services were improved. An example of this was the development of a transgender and non-binary protocol. This included building the teams presence at relevant local events and working alongside local transgender support groups to encourage and support those who wished to have a family.
- Patients referred on a two week wait pathway for suspected cancer could expect to see a specialist within two weeks of referral from their GP and the trust was performing better than the England average in this area.
- Once a decision to treat had been made for a patient with a cancer diagnosis, they could expect to be treated within the operational standard of 31 days, and the trust was performing better than the England average in this area.

Are services well-led?

Our rating of well-led improved. We rated it as good because:

- The leadership team had the right skills and abilities to run a service providing high-quality sustainable care. We observed leaders working seamlessly together across departments. They were knowledgeable about clinical issues and about priorities for the quality and sustainability of the service. There was a clear management structure at directorate and departmental levels. Matrons and ward managers were visible, and ward managers told us they were well supported by the matrons, and divisional leads.

Summary of findings

- There was a systematic approach to continually improving the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. A robust governance system was in place with detailed information about performance this was discussed at regular governance meetings and used to demonstrate effectiveness and progress.
- The leadership team promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff morale had improved since our last inspection.
- There were effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. There was an up-to-date and detailed major incident plan. There had been a recent joint exercise with the ambulance service to assess the effectiveness of the plan.
- There was a commitment to improving services by learning from when things went well and when they went wrong, promoting training and innovation. There had been a significant number of improvements across the trust since our last inspection. Professional development and high levels of staff competency were priorities for the leadership team.
- Leaders across the trust promoted a positive culture that supported and valued staff. The staff survey showed that all questions relating to management had shown improvement since the 2016 survey. There was a significant change in the culture since the last inspection. Bullying and acceptance of poor behaviour was no longer recognised by staff. Since our last inspection the trust had introduced short monthly surveys in order that they could regularly monitor staff culture rather than waiting for the annual national staff survey. The trusts survey showed improvement in all areas. Management felt supported in dealing with under performance as there had been a focus on retraining Human Resource staff and ensuring they followed standardised policies and procedures in a timely manner.
- The trust engaged well with patients. Several wards organised regular carers groups, where family and friends could meet and support each other.
- The trust used a systematic approach to continually improve the quality of its services, by creating an environment in which clinical care would flourish. There were clear lines of accountability form the department to the board through the directorate governance structure. Staff we spoke with were clear about their roles and responsibilities and who or what they were accountable to or for.
- The department had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Departments maintained a risk register, which defined the severity and likelihood of risks in the department causing harm to patients or staff. It documented the measures to be taken to reduce the risk. We saw that the risks described accurately reflected the concerns described by staff.
- The service collected, analysed, managed and used information to support all its activities, using secure electronic systems with security safeguards. Staff had access to up to date information on patient care and treatment and were aware of how to use and store confidential information.
- The trust engaged with patients, staff and the public to plan and manage services. We saw the staff encouraged patients to complete the family and friends test on their care and treatment. They used social media mechanism for engaging with staff and patients, they also answered, complaints, concerns and compliments on the NHS choices website. At our previous inspection we required the trust should ensure the plan to improve staff engagement is fully implemented. We saw there was an upward trend in engagement with the most significant improvement in how likely staff would be to recommend the trust to friends and family as a place to work.
- The trust was committed to improving services by learning when things go well and when they go wrong, promoting training, research and innovations. The service and its staff demonstrated a willingness to develop and improve the service provided. The trust's strategy, was a process of continuous measurable improvement through existing pathways, to put patients first. The trust recognised and rewarded its staff for the work they did to improve quality.

Summary of findings

- There was a culture of collective responsibility between teams and services. There were positive relationships between staff and leaders, where conflicts were resolved quickly and constructively, and responsibility was shared. The trust proactively engaged and involved all staff ensuring that the voices of all staff were heard and acted on to shape services and culture.

However:

- In the outpatient's department whilst the service had managers with the right skills and abilities to run a service providing high-quality and sustainable care, there were key vacancies in the division, and the management structure had not yet been embedded, nor was it known or understood to all staff. Staff did not feel that the divisional leadership team were visible.

Outstanding practice

We found examples of outstanding practice in urgent and emergency care, medicine, critical care and maternity.

For more information, see the Outstanding practice section of this report

Areas for improvement

We found areas for improvement including two breaches of legal requirements that the trust must put right. We found 64 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

Action we have taken

We issued two requirement notices to the trust. Our action related to breaches of legal requirements in one core service at one location.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will check that the trust takes the necessary action to continue to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

In Urgent and Emergency Care

- In October 2017, the service was the winner of RCEM Quality Improvement Project, Award in celebrating 50 years of Emergency Medicine.
- In November 2017, the service was highly commended in the Health Services Journal within the workforce category for work on innovative staffing solutions for medical staffing (clinical fellows) May 2018.
- In May 2018, the service achieved BMJ Award highly commended for Innovation team of the year for staffing solutions to emergency departments, where the self-rostering medical rota was highly commended for innovation
- In May 2018, the service was the winner for Health Services Journal Award, acute service redesign, single clerking project.

Summary of findings

- In July 2018, the service was Highly Commended in the Patient Safety Awards, Prompt Cards in the Emergency Department.

At the Royal Sussex County Site:

- A drug and alcohol worker from a local substance misuse service attended the department daily and reviewed the electronic patient system to identify patients with drug and alcohol support needs. Staff demonstrated to us how this would be identified on the electronic patient system.
- The service offered a clinical fellow programme. This allowed the opportunity for doctors to work in a part clinical (75%) and part research (25%) role for one year. This had created a flexible workforce to cover the needs of the service and provided the opportunity for the service to gain research and innovation projects. The clinical fellow programme had been replicated by other hospitals nationwide.
- As part of the trust wide Patient First Improvement plan staff identified there was a high haemolysis rate of blood samples. This resulted in a delay as the blood sample had to be taken from the patient again. Haemolysis of blood samples occurs when the red blood cells get damaged and therefore the results of the blood tests are inaccurate and need to be repeated. The service researched the best way to prevent haemolysis. For example, by mixing the blood tubes with anticoagulant additives gently first. Prior to making the changes in the process there was a haemolysis rate of 12% which has now reduced to 2% (the national average is 8%).
- There had been a significant positive change made in a relatively short space of time. One of the most significant was the culture which had changed, all staff had a 'can do attitude' and were committed to working together to drive further improvements in patient safety and experience.

In Medicine

At the Royal Sussex County Site:

- The service had shown falls reduction in four care of the elderly wards at the Royal Sussex County Hospital site as a result of the "picture blanket project" initiated by a ward manager. We saw staff used these as bedspreads which protected patients from falls as they could recognise their own beds. The ward manager had been nominated for a Health Service Journal award. Other providers had approached the service to explore the same initiation for their services.
- The service had introduced the "Small Acts of Friendship" scheme to support elderly patients retain their dignity, social activity, mobility and well-being whilst in hospital. Volunteers provide free-of-charge hair dressing, hand massage therapies, poetry reading, art classes and a mobile library service to the elderly care wards.
- The "Patient First" initiative had provided focus and a platform for staff to raise ideas. We saw these were well run as short and focused sessions by each ward, involving staff at all levels ranging from doctors, nurses, administrative staff to housekeepers who had contributed to those ideas. It gave staff the confidence and motivation to make continual improvements for patients.

At the Princess Royal Hospital Site:

- The culture of care that was found throughout medical services showed us that patients and their families were considered partners in their care. We heard numerous examples of staff going above and beyond to provide a supportive, caring environment with the Chaplain describing staff as "Emotional athletes".

In Critical Care

At the Princess Royal Hospital Site:

Summary of findings

- The patient journey poster board at the entry of the service showed all the stages of the critical care pathway. The pictures displayed could be understood by adults and children alike as well as those who did not speak English as a first language. Included in the picture were links to a wide variety of support groups and information sources. These could be directly accessed by using a smartphone to link to the QR code.

In Maternity

- Outcomes for people who use services are positive, consistent and regularly exceed expectations. The recent OASI Reduction at BSUH (ORB) project had made an immediate impact on reduced third and fourth degree tears.
- The trust's performance for the Maternal, Newborn and Infant Clinical Outcome Review Programme audit was much better than the national comparator group. It showed the trust was more than 10% lower than the average for the comparator group rate of 6.71.
- In July 2018 the trust was recognised as one of the top performing hospitals in the UK for helping diabetes patients control their glucose levels. The trust offered a diabetic clinic for women identified as at risk of gestational diabetes. Mothers had dedicated diabetes notes and a new diabetes protocol which aimed to reduce inductions of labour for women with gestational diabetes. In the two years since this was first developed there have been no diabetes birth defects experienced by mothers.
- Staff were consistent and proactive in supporting people to live healthier lives. There was a focus on early identification and prevention and on supporting people to improve their health and wellbeing.
- A women centred World Health Organisation checklist had been developed in obstetric theatres. The aim was to make the woman the centre of the checklist by making sure all staff introduced themselves by name and designation to the woman and her partner. Alongside this the maternity staff were in the process of filming in a simulation setting from the woman's perspective. They planned to use this both internally for training but also to promote best practice externally too.

Areas for improvement

The trust MUST take action to:

In Urgent and Emergency Care at the Princess Royal Hospital site:

- The trust must ensure that senior staff are monitoring any delays in the initial clinical assessment of self-presenting patients so that all patients are assessed in a timely manner. This particularly applies to children and to all patients arriving during the night.
- The trust must monitor nurse staffing levels using an acuity-based staffing tool to ensure there are always enough nurses in the emergency department.

The trust SHOULD take action to:

In Urgent and Emergency Care

- The trust should consider reviewing the length of nursing documentation.
- The trust should ensure that there is an effective process to check the expiry date of medicines.
- The trust should improve extended advanced life and trauma training for nurses.

At the Royal Sussex County Site:

Summary of findings

- The trust should ensure that patients identified at an increased risk of developing a pressure ulcer are given preventative equipment promptly.
- The trust should ensure mandatory training including Safeguarding adult training is improved amongst medical staff.
- The trust should ensure patients are aware of their right to have a chaperone.
- The trust should ensure intravenous fluids are prescribed in line with trust policy.
- The trust should consider the risk to patients who self-present to the hospital and the length of time until they receive an assessment.
- The trust should continue to improve efficiency and flow to improve performance and meet standards.
- The trust should consider how they align with the trusts strategy.

At the Princess Royal Hospital Site:

- The trust should should ensure that ambulance crews can handover their patients as soon as possible so that they can be released to respond to further emergency calls.
- The trust should ensure that all patients who require an early warning score have this calculated as part of their triage assessment and at the required frequency during their treatment.
- The trust should work with the neighbouring mental health trust to reduce the delays in admitting patients to specialist mental health units.
- The trust should ensure that patient safety checklists are completed hourly.
- The trust should maintain records of the number of doctors who have completed advance resuscitation training.

In Medicine

- The trust should improve their referral to treatment performance.
- The trust should ensure there are policies and procedures for patients to self-administer medicines if appropriate
- The trust should ensure that when developing or extending services, the pharmacy service is involved in planning and appropriate resources are provided
- The trust should ensure seven-day services were made available for the dietetic and speech and language therapy services.
- The trust should ensure the layout of all medication paperwork be clear for prescribers where they are required to record the date of each prescription to eliminate any potential confusion.
- The trust should ensure printed copies of NEWS2 and sepsis assessment sections showed consistent trigger scores for escalation to avoid any confusion for staff.
- The trust should continue their efforts to address the nursing and medical workforce challenges.
- The trust should ensure the vacancy for the clinical lead for specialty medicine in this division is filled.

At the Royal Sussex County Site:

- The trust should continue to carry out the actions they identified from the national audits such as the Lung Cancer Audit 2017 and National Audit of Inpatient Falls 2017.
- The trust should ensure staff followed trust standards to ensure name boards were completed.

Summary of findings

In Surgery

At the Royal Sussex County Site:

- The trust should complete all actions found in the fire risk assessments on wards Level 8a East and Level 8a West.
- The trust should ensure all equipment in use is serviced in line with service schedule.
- The trust should ensure staff record why medications are not administered.
- The trust should ensure that patients were not staying longer than their required recovery time in theatres.
- The trust should continue to work on reducing its referral to treatment times across all specialties.
- The trust should engage with patients in such a way as to develop their services.

At the Princess Royal Hospital Site:

- The trust should ensure the walls and fixtures and fittings meet the Department of Health's Health Building Note 00-09.
- The trust should ensure that consent to care and treatment is always sought in line with legislation, best practice and guidance.
- The trust should improve the signage for patients and visitors to navigate their way around the hospital.
- The trust should ensure that Local Safety Standards for Invasive Procedures (LocSIPPs) using the National Safety Standards for Invasive Procedures (NatSSIPs), are in place and staff are aware of their availability.
- The trust should make sure all locum doctors receive a local induction, to the hospital and ward they are working on.
- The trust should The trust should implement an effective system to ensure patients were not fasted for longer periods than clinically necessary.

In Critical Care

- The trust should continue to work with the rest of the hospital to reduce the length of time from a patient being identified as ward ready in the critical care unit to being discharged.
- The trust should review how it screens patients for dementia in the critical care environment.

At the Royal Sussex County Site:

- The trust should develop a system that ensures that patient diaries stay with the patient when they leave critical care.
- The trust should review the provision of psychological support provided to patients during their stay in critical care.
- The trust should look to provide training for all staff to better equip them when dealing with patients with mental ill health.
- The trust should continue the work that had already started to integrate the cardiac critical care unit with the general and neuro critical care units.
- The trust should continue the upward trend of completing pain assessments for all patients.
- The trust should continue to work to further reduce the number of out of hours discharges.

At the Princess Royal Hospital Site:

- The trust should develop stronger oversight of cleaning schedules and completion of cleaning rotas for staff and housekeeping.

Summary of findings

- The trust should strengthen and create more robust audit processes to obtain more reliable, valid and accurate data, particularly regarding hand hygiene and environmental cleanliness standards.
- The trust should have a centralised record of each staff's competencies and training.
- The trust should complete pain assessments for all patients even if they score 0.
- The trust should improve signposting throughout the hospital.
- The trust should continue to develop plans and policies to strengthen the provision of mental health services to patients in the critical care unit.

In Maternity

At the Princess Royal Hospital Site:

- The trust should ensure hand hygiene audits are consistently completed.
- The trust should ensure all staff adhere to bare below the elbows.
- The trust should ensure daily equipment checklists are completed.
- The trust should ensure room and fridge temperatures are recorded accurately and action taken when the readings are outside of expected range.
- The trust should have processes in place to review the quality and accuracy of patient records.
- The trust should ensure patient confidentiality is always protected.

In outpatients

- The trust should ensure that patient records are audited for quality.
- The trust should continue to develop the leadership and governance functions of outpatients. Staff should be appropriately involved in all areas of performance. Performance monitoring activities undertaken by staff should be meaningful and focused on improving performance.
- The trust should ensure that outpatient services are included as part of the dementia strategy.
- The trust should ensure that staff in outpatients receive training in the mental health act.
- The trust should ensure that action plans are implemented and monitored following poor performance in three areas of the Patient Led Assessments of the Care Environment scores.

At the Princess Royal Hospital Site:

- The trust should ensure that only registered nurses carry medicines keys.
- The trust should ensure that the waiting area and environment in phlebotomy is safe for staff and patients using it.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Summary of findings

We rated well-led at the trust as good because:

- The trust board had the appropriate range of skills, knowledge and experience to perform its role. From 1st April 2017 the entire Western Sussex Hospitals NHS Foundation Trust Board (rated outstanding by the CQC) entered into a three-year management contract with NHS Improvement and Brighton and Sussex University Hospitals. This new arrangement provided a level of stability that had be absent over several years (there had been more than five changes of chief executive in five years). One of the first objectives of the new executive team was to address the leadership and organisation's structural issues identified in the 2017 CQC report.
- From December 2017 a new divisional structure was created around the pre-existing directorate structure. The directorates were grouped under five clinical divisions and 15 new senior leadership posts were created to strengthen the existing leadership and management arrangements of the clinical services.
- Each division had a chief of service, divisional director of operations and head of nursing/profession. All appointees went through a formal process. The newly appointed divisional leaders undertook an initial three module personal development programme on appointment. All leaders in the new structure were required to go through a formal selection process to ensure that all the individuals appointed had the right skills, experience and behaviours to demonstrate that they met the ' Fit and Proper Person' criteria
- Leadership development opportunities were available, including opportunities for staff below team manager level. Succession planning was in place throughout the trust. The trusts leadership development strategy comprised of two activities. These were developing leaders through meeting learning needs in a timely and effective way and succession planning through understanding the trusts future needs and managing the talent within the trust so that they had ‘ready now’ people to fill key roles.
- Several other corporate functions were established across both organisations including service improvement, strategy, information technology and communications.
- The trust had a clear vision and set of values with quality and sustainability as the top priorities. The trust's clear vision and values was encapsulated in its 'Patient First' approach which was agreed by the board. This is summarised by the Patient First triangle, with 'the patient first and foremost' at the apex of the triangle.
- Patient First had four strategic themes - 'Our People' 'Quality Improvement' 'Sustainability' and 'Systems and Partnerships' The trust set out its strategic aims through its 'True North' which was the trust's key long term aims which aligned to its strategic themes which focused on quality and sustainability.
- The trust's Patient First approach provided the integrated framework for the development their strategy. The trust’s quality priorities were aligned with Patient First and set out in the trust’s ‘Quality Improvement Plan’. As part of planning and performance management each clinical division had identified how they contribute to True North and what areas of the strategic framework they would be driving delivery on. This process had set the divisional objectives for the financial year, with monitoring and reviewing of divisional priorities taking place in the monthly divisional Strategy Deployment Review meetings. We attended two of these meetings at divisional level during inspection and found that they steered the development of improvement initiatives.
- The trust’s strategy, vision and values underpinned a culture which was patient centred. Through the Patient First vision and values, the trust encouraged a culture which focused primarily on patients. The Patient First Improvement System had empowered front line staff by equipping them with the lean tools, methods and a structured process which had helped to build and promote a culture of continuous improvement across the whole trust. The divisional leads told us that front line staff often had the best ideas (as they are closest to the problem), and that Patient First helped them feel empowered to make change

Summary of findings

- The trust also made use of benchmarking for improvement through the 'Getting it right first-time programme'. The trust used a range of methodologies such as A3 thinking (a structured problem-solving approach), fishbone diagrams and improvement huddles, which aimed to understand and improve performance through fully engaging with staff.
- The board received holistic information on service quality and sustainability. Holistic performance management through a coaching style was witnessed in the strategic deployment meetings with the trust using data for performance targets and breakthrough objectives for True North. This approach used information for improvement as well as providing assurance in how the problem was being tackled with an evidence base.
- These meetings were held in a central point for the visual management of progress which the trust named their Strategy Deployment Room. Meetings were held monthly with the executive team, weekly at divisional level and locally at unit/ward level where improvement huddles were held three times a week.
- There was a programme of board visits to services and staff we spoke with told us that that leaders were approachable. Across the core service inspections and focus groups staff spoke with us about the improved visibility of the executive and divisional leaders. executives, non-executives and divisional leads regularly attended safety huddles on the wards and departments.
- We attended improvement huddles across all the core services we inspected and during CQC engagement events before the inspection. We found that these aligned clearly with the trust strategy and were supportive, effective and staff at all levels were engaged in the process.
- The trust was developing a fully refreshed clinical strategy, which was aligned to the trust's Patient First strategy at the time of the inspection. Therefore, we are unable to form a judgement on the effectiveness of this strategy in this inspection report. The trust was also developing a medium term financial plan, to fully understand the financial context of the trust and develop a programme of measures to address this.
- Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services. The trust had engaged with staff to communicate its Patient First Strategy through a range of engagement events. These included staff roadshows, leadership events, internal communications such as the CEO message and 'The Buzz', staff drop in sessions, trust briefs and Strategic Deployment Reviews.
- The trust also engaged staff in the patient first strategy at induction (850 staff to date). The trust patient first website provided staff with information about the strategy and has had 12,600 views since October 2017.
- All staff we spoke with on inspection were clear about the trust's approach and priority to deliver high quality sustainable care to patients. Staff knew and understood the trust's vision, values and strategy and how achievement of these applied to the work of their team. To support the roll-out of Patient First across the trust, a communications plan was developed and implemented. The plan was tailored to different audiences to best reach staff in different parts of the organisation.
- The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans. Progress on the trust strategy and improvement journey was reviewed regularly with external partners through various forums including Health Oversight Scrutiny Committee with the County and City councils, Integrated Assurance Meeting and System Assurance Meetings with NHS Improvement, 'Board to Board' with the Commissioning Alliance, the Quality Oversight Committee with the CQC, NHS Improvement, NHS England, Clinical Commissioning Groups, Healthwatch, Health Education England, and the various sustainability and transformation plans forums.

Summary of findings

- One of the trusts top strategic themes was their ambition is to be in the top 20% of all NHS employers for staff engagement. The strategic objective for their workforce was to value and respect all staff equably and to involve them in decisions about the services they provide and offer; and deliver training to ensure they develop the skills they need to fulfil their roles.
- Without exception all staff we spoke with both on inspection and engagement talked about a paradigm shift in culture across the whole trust. Staff described the culture as inclusive, empowering, and positive. Staff were described by inspectors and specialist advisors as energetic and enthusiastic. This mirrored what we found on engagement with the trust prior to inspection.
- Staff felt respected, supported and valued. The executive teams and divisional leaders told us how they felt that improving the experience and engagement of their staff was fundamental to delivering a culture of high sustainable care and trust strategic objectives.
- The trust's Patient First Improvement System empowered staff to make improvements and to be listened to and respected. In areas where 'Patient First' had been introduced the level of engagement and motivation had significantly improved as staff felt empowered to make improvements in their work. This was evident both on CQC engagement events at the trust and on inspection.
- We saw engagement of staff, from several disciplines, clinical and non-clinical during 'patient first' improvement huddles which enabled them to discuss and prioritise issues, challenge practice, and make improvements.
- The chief executive spoke about how by staff feeling that their contribution is valued they would want to do all they can to continue to propose new ideas, solve problems daily, "remove rocks from their shoes", and help to sustain change.
- In response to the 2017 NHS National Staff Survey the trust had developed trust and divisional level plans to improve staff experience and engagement. To measure any improvements, the trust had developed a monthly 'pulse survey '. The pulse surveys had shown staff agreeing that care is the top priority has risen from under 70% to over 80% in the past 12 months. Staff who recommend the trust as a place to work had risen from under 50% to over 70% in the past 12 months.
- The results of the 2017 staff survey highlighted increasing levels of violence and aggression being experienced by trust staff. Using the Patient First principles a diagnostic was completed by the trust which included representatives from ward leaders, strategic and operational security team members, team managers and representatives from the mental health and safeguarding. The trust had completed an initial deep dive into ward areas, completed a deep dive into security team and submitted a business case for a full personal protective equipment review for the security team and commencement of new equipment in the security team including body worn cameras.
- All staff had the opportunity to discuss their learning and career development needs at appraisal. This included agency and locum staff and volunteers. The trust had significantly improved their appraisal completion rates since our last inspection. The trust undertook audits to test the effectiveness and quality of the appraisal conversations.
- The trust had an education directorate that supported the learning needs of all staff and the trust held hold an annual multi professional conference. The trust had over 50 practice educators working clinically across the trust. On the core service inspection staff spoke positively about the input and learning they received from practice educators. A new 'Education and Knowledge Strategy' was being developed at the time of our inspection.
- The chief executive had taken advice from Yvonne Coghill OBE on how to address issues highlighted in the trust WRES data and how the trust could move forward on their race equality agenda. Yvonne is currently the Director of WRES Implementation in NHS England. Yvonne spoke with staff at the equality event in May 2018 and helped staff to understand the importance of WRES data and how this could help the trust with the forming of their new strategy.

Summary of findings

- Staff felt equality and diversity were promoted in their day to day work. We spoke with the newly formed Black and minority ethnicity working group. The trust had held an event in May where over 200 members of staff had come together to discuss equality and Black and minority ethnicity issues and start the forming of a new strategy. The output of this meeting was three workstreams; communication, recruitment, and education. The group we spoke with told us that they had seen a dramatic change in the past 6-9 months. They described this as powerful, positive and feeling included in the strategy and change.
- The relationship between the trust and the Black and minority ethnicity network (referred to in our previous report) had broken down and the trust no longer recognised this group. CQC facilitated a focus group with the previous BME representative group who chose not to attend to share their views with us. BME staff we spoke with that were working at the trust described the damage they felt had been done by the previous BME representative group. They told us that now they were not operating in the trust, "the fear had gone".
- As part of the 'Leadership Culture and Workforce programme' the chief executive directly led the Equality and Diversity Workstream. The trust had a dedicated 'Equality, Diversity and Inclusion Team' comprising of a head of equality, diversity and inclusion, deputy head, equality manager and adviser. This team provided expert advice on all equality issues for staff and patients. The team managed over half a million pounds contract for language support for patients who need additional support for example interpreting and British sign language, the deputy head of equality, diversity and inclusion advises on the equality issues for all service changes for example physical premises changes and signage.
- Staff networks were in place promoting the diversity of staff. The trust had established a 'Diversity Matters' Committee lead by the chief executive. They have entered Stonewell's Top 100 employers programme and have an LGBTQ+ conference planned for February 2019.
- We held a focus group for LGBTQ+ staff who told us that culture at the trust had improved. They told us that they had been encouraged by the workstreams that had been produced following the Black and minority ethnicity conference and were planning a similar event. They were planning to share best practice from the Black and minority ethnicity working group.
- Staff also described feeling pleased that the trust had a float at the Brighton PRIDE event and that the executive team had encouraged this and had been represented on the float. This was featured in "UK Pride Life Magazine" along with an interview with the Chair of the trusts LGBTQ+ network, and a description of how the trust is 'proudly diverse' in its support of the LGBTQ+ community through its policies and processes designed to support staff.
- Staff told us that although they had not always felt supported in the past since the new executive team had arrived they now felt confident that they could raise any concerns about staff behaviours towards them with their line managers, and they felt assured that their concerns would be listened to and acted on appropriately.
- The trust were members of the Equality and Inclusion Partnership and Transgender subgroup. This group was set up by Brighton and Hove City Council and has influenced the way equality was undertaken within the city and share best practice.
- The trust was a part of the 'Pronoun campaign' that was launched this year during Trans Pride. The trust now had a Mx. title on their patient administration system and gender fluid staff at the trust were able to wear two badges which identified their chosen name and identity at any time.
- In response to concerns raised by transgender staff the trust had delivered bespoke training for paediatric and general nursing staff. The training had helped to widen the knowledgebase of staff awareness of specific needs of the transgender community.

Summary of findings

- The board had invited the Good Governance Institute (GGI) carry out a review of the trust's quality governance structures, which resulted in 31 separate recommendations being made. The trust acted to address these issues and the Good Governance institute carried out a further review reporting on progress against these actions. A focus of this work has been to strengthen quality governance arrangements at divisional level.
- The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers. Leaders regularly reviewed these structures. The trust reported regularly through its governance arrangements on progress against delivery of its strategy to the board, Trust Executive Committee and to other relevant committees. However, the structure needed more time to become fully embedded.
- The effectiveness of the governance arrangements was observed on inspection at Strategy Deployment Review meetings. Each of the three leaders of each division owned and presented the data for their breakthrough objectives, had interrogated the data to find root causes where the objectives were behind plan and had devised action plans based on this knowledge to bring the objective back on track.
- The Chair of the Audit Committee explained that under the previous administration, assurance was not provided through reporting and they were not getting the information they needed. The new structures and approach put in place using improvement methodology now provided a joined-up approach that provided assurance on quality and delivery against the Patient First Strategy and breakthrough objectives and delivered quality improvement.
- Non-executive and executive directors were clear about their areas of responsibility. Performance against the trust's patient first strategy, true north and breakthrough objectives was focused and reinforced through the trust's strategic deployment review approach. There was clear ward to board line of sight through daily performance huddles, weekly driver meetings, Divisional Strategy Deployment Review, executive level Strategy Deployment Review and the board.
- The quality dashboard was aligned to the quality priorities along with the quality improvement plan with actions being taken and monitored at divisional, corporate and board level through the quality governance system, Quality Assurance Committee and board. The Audit Committee evaluated the effectiveness of the trust's structures and processes in relation to the management of risk, the management of performance and financial management and the management of quality and quality improvement.
- A clear framework set out the structure of ward/service team, division and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to act as needed. The trust had governance and management arrangements had been strengthened significantly since the management agreement with Western Sussex Hospitals Foundation Trust and NHS Improvement. These arrangements enabled all clinical and management staff to function in an effective and efficient manner through both line management arrangements and governance arrangements.
- Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person. Staff we spoke with on inspection understood how they fit within the organisational structure and how their respective roles impacted on the achievement of objectives. Through the trusts patient first strategy front line staff knew their department objectives, enabling support in achievement of the directorate, division and ultimately the trust overarching strategic objectives.
- Arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. Recorded risks were aligned with what staff said were on their 'worry list'. The trust board had sight of the most significant risks and mitigating actions were clear.
- The trust had recently updated and strengthened its Risk Management Strategy and Risk Management Policy and had reviewed and revised the Board Assurance Framework and all divisional and corporate directorate risk registers to ensure they accurately reflected the risks manifesting at all levels of the organisation from board to ward.

Summary of findings

- Where cost improvements were taking place, there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability. The trust had an efficiency plan focused on cost reduction, cost avoidance and income opportunities. Since April 2017, the programme management office had implemented and embedded governance and assurance processes to identify, monitor and report delivery of the trusts efficiency plans in a consistent approach and format. The programme management office worked with directorates to develop schemes to inform in year opportunities, and to develop mitigation for schemes at risk.
- Where cost improvements were taking place, they did not compromise patient care. Divisions were engaged in developing quality led efficiency schemes that recurrently reduce costs. 'Quality impact assessments' were undertaken as part of development of the project initiation document for each scheme. These were signed off by a lead clinician at divisional level and were submitted to the chief medical officer and chief nurse for approval. All quality impact assessments with a risk score of nine or above were submitted for review by the Quality Assurance Committee.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good ↑ Jan 2019	Good ↑ Jan 2019	Outstanding ↑ Jan 2019	Requires improvement ➔➔ Jan 2019	Good ↑ Jan 2019	Good ↑ Jan 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for Royal Sussex County Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Jan 2019	Good →← Jan 2019	Good →← Jan 2019	Requires improvement ↑ Jan 2019	Good ↑ Jan 2019	Good ↑ Jan 2019
Medical care (including older people's care)	Good ↑↑ Jan 2019	Good ↑ Jan 2019	Outstanding ↑ Jan 2019	Good ↑ Jan 2019	Good ↑ Jan 2019	Good ↑ Jan 2019
Surgery	Good ↑ Jan 2019	Good →← Jan 2019	Good →← Jan 2019	Good ↑ Jan 2019	Good →← Jan 2019	Good ↑ Jan 2019
Critical care	Good ↑↑ Jan 2019	Good ↑ Jan 2019	Outstanding ↑ Jan 2019	Good ↑ Jan 2019	Good ↑↑ Jan 2019	Good ↑↑ Jan 2019
Maternity	Good ↑ Jan 2019	Outstanding ↑ Jan 2019	Good →← Jan 2019	Good →← Jan 2019	Good →← Jan 2019	Good →← Jan 2019
Services for children and young people	Good Aug 2016	Outstanding Aug 2016	Outstanding Aug 2016	Good Aug 2016	Good Aug 2016	Outstanding Aug 2016
End of life care	Good Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Outpatients	Good ↑ Jan 2019	Not rated	Good →← Jan 2019	Requires improvement →← Jan 2019	Requires improvement →← Jan 2019	Requires improvement →← Jan 2019
Overall*	Good ↑↑ Jan 2019	Good ↑ Jan 2019	Outstanding ↑ Jan 2019	Requires improvement →← Jan 2019	Good ↑ Jan 2019	Good ↑ Jan 2019

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Princess Royal Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ➔➔ Jan 2019	Good ↑ Jan 2019	Good ➔➔ Jan 2019	Good ↑ Jan 2019	Good ↑ Jan 2019	Good ↑ Feb 2019
Medical care (including older people's care)	Good ↑ Jan 2019	Good ↑ Jan 2019	Outstanding ↑ Jan 2019	Good ↑ Jan 2019	Good ↑ Jan 2019	Good ↑ Jan 2019
Surgery	Good ↑ Jan 2019	Good ➔➔ Jan 2019	Good ➔➔ Jan 2019	Good ↑ Jan 2019	Good ➔➔ Jan 2019	Good ↑ Jan 2019
Critical care	Good ↑ Jan 2019	Good ↑ Jan 2019	Good ➔➔ Jan 2019	Good ➔➔ Jan 2019	Good ↑ Jan 2019	Good ↑ Jan 2019
Maternity	Good ↑ Jan 2019	Outstanding ↑ Jan 2019	Good ➔➔ Jan 2019	Good ➔➔ Jan 2019	Good ➔➔ Jan 2019	Good ➔➔ Jan 2019
End of life care	Good Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Outpatients	Good ↑ Jan 2019	Not rated	Good ➔➔ Jan 2019	Requires improvement ➔➔ Jan 2019	Requires improvement ➔➔ Jan 2019	Requires improvement ➔➔ Jan 2019
Overall*	Good ↑ Jan 2019	Good ↑ Jan 2019	Good ➔➔ Jan 2019	Good ↑ Jan 2019	Good ↑ Jan 2019	Good ↑ Jan 2019

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Princess Royal Hospital

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Key facts and figures

The trust provides district general hospital services to the local populations in and around the City of Brighton and Hove, Mid-Sussex and the western part of East Sussex. The trust primarily serves a population of over 539,500 people. They also provide more specialised and tertiary services for patients across Sussex and the south-east of England. Across the trust there are 830 general and acute beds, 80 critical care beds and 72 maternity beds. The Princess Royal Hospital provides 327 of these beds.

Princess Royal Hospital provides acute services for the local population. Services provided at the Princess Royal Hospital site include general elective surgery, orthopaedics, medicine (including elderly, dermatology and respiratory), critical care, maternity and rehabilitation. The hospital 's emergency department provides urgent and emergency care services 24 hours a day, seven days a week.

Princess Royal Hospital does not have a children's inpatient unit. Therefore any children requiring hospital admission are transferred to the Royal Alexandra Children's Hospital, the trust's dedicated hospital for children and young people.

We visited Princess Royal Hospital as part of a planned, comprehensive inspection of Brighton and Sussex University Hospitals NHS Trust on 25 and 26 September 2018. During our visit, we spoke with 152 members of staff and 45 patients on the Princess Royal Hospital site. We reviewed 67 sets of patient's records and a variety of policies and performance data.

Summary of services at Princess Royal Hospital

Good ↑

Our rating of services improved. We rated it them as good because:

- The service monitored safety and managed patient safety incidents well. Staff recognised incidents and reported them in line with policy. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- When things went wrong, staff apologised and gave patients honest information and suitable support. Staff were aware of their responsibilities regarding duty of candour and we saw current examples of duty of candour being used in practice.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Summary of findings

- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean through the use of effective control measures such as daily and weekly checklists, to prevent the spread of infection. All staff had a good understanding of control of substances hazardous to health regulations.
- There was significant improvement in training compliance since our previous inspection. The service provided mandatory training in key skills to all staff and made sure everyone completed it across most of the core services we inspected.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.
- The trust had introduced several safety programmes to improve multidisciplinary working and monitor deteriorating patients to respond promptly. This included the sepsis bundle and NEWS2.
- Care and treatment provided was based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- The service monitored the effectiveness of care and treatment and used the findings to improve them. Information about the outcomes of people's care and treatment were routinely collected and monitored.
- Managers made sure staff were competent for their roles and monitored the effectiveness of care and treatment. They usually compared local results with those of other services to learn from them.
- Staff at all levels worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The service managed patients' pain effectively and provided or offered pain relief regularly. Patients we spoke with told us staff offered pain relief quickly when they reported pain.
- Staff gave patients enough food and drink to meet their needs and improve their health. We saw staff prioritised mealtimes and there were enough staff to support patients that needed help eating and drinking. The service made adjustments for patients' religious, cultural and other preferences.
- The service was working toward seven-day services in line with National Health Service Improvements (NHSI), Seven-day services in the NHS. We saw in the trust operational plan 2018-2019, that they plan to deliver the Seven Day Service standards for all admitting specialities by 2020.
- Staff understood their roles and responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Staff knew the processes for ensuring deprivation of liberty safeguards documentation was complete and up to date as well as how to support those who lacked the capacity to make decisions about their care.
- Staff cared for patients with compassion. All staff we spoke with were very passionate about their roles and were dedicated to making sure patients received the best patient-centred care possible. Feedback from patients was positive about the care they received.
- Staff provided emotional support to patients to minimise their distress.
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted dignity. Staff were caring and supportive of patients which was encouraged by management.
- Patients were active partners in their care. Staff were committed to working in partnership with patients and their families. Staff empowered patients to reach their potential and we found this in particular on Lindfield ward.

Summary of findings

- The service took account of patients' individual needs. The trust employed specialist nurses to support the ward staff. The service made reasonable adjustments and took action to remove barriers for patients who found it hard to use or access services. This included interpreting services, services for patients living with dementia, those with sensory loss or impairment and facilities for bariatric patients.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care. There was a clear management structure at directorate and departmental levels.
- The trust had a strategy for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff and patients. All staff we spoke with were very aware of the 'Patient First' strategy and had 'bought in' to the initiative.
- The trust used a systematic approach to continually improve the quality of its services, by creating an environment in which clinical care would flourish. The department had systems for identifying risks, planning to eliminate or reduce them.
- The trust engaged with patients, staff and the public to plan and manage services. We saw the staff encouraged patients to complete the family and friends test on their care and treatment.
- The trust was committed to improving services by learning when things go well and when they go wrong, promoting training, research and innovations.
- There was a culture of collective responsibility between teams and services. There were positive relationships between staff and leaders, where conflicts were resolved quickly and constructively, and responsibility was shared. The service proactively engaged and involved all staff ensuring that the voices of all staff were heard and acted on to shape services and culture.
- The board and other levels of governance in the organisation functioned effectively and interacted with each other appropriately.

However:

- Risks to self-presenting patients in the emergency department were not always assessed in line with guidance when they first arrived.
- There was a risk that there were not always enough nurses to ensure the safe care of the patients that attended the emergency department.
- Patients could not always access the service when they needed it. For example, overall waiting times from referral to treatment and for those patients referred on a 62-day cancer pathway were worse than the national average.
- Patient flow through the hospital remained an issue in some areas. For example, the percentage of critical care bed days occupied by patients with discharge delayed more than 8 hours was 12.0% compared to the national aggregate of 4.9%.
- In outpatients, the patient led assessment of the care environment audits for dementia and disability scored significantly worse than the national average across four outpatients areas that were assessed. The trust wide dementia strategy did not have any outpatient related actions.
- The outpatients core service did not collect, analyse and action data to improve waiting times. Waiting times for individual clinics were not recorded or collected by the services.

Summary of findings

- The outpatients vision and strategy was not developed with involvement from key staff. Staff we spoke with in outpatients had no knowledge of, or involvement in developing these goals.
- A clinical pharmacist did not visit all wards daily; for example, Plumpton ward did not receive a regular pharmacy visit.

Urgent and emergency services

Good ↑

Key facts and figures

The Emergency Department (ED) at the Princess Royal Hospital (PRH). Haywards Heath provides urgent and emergency services to the local populations of Haywards Heath, Mid Sussex and the western part of East Sussex. It is one of four emergency departments in the trust and provides a full range of adult emergency services. The hospital does not have a children's in- patient unit and so seriously ill and injured children are stabilised and then transferred to the Royal Alexandra Hospital for Children in Brighton. Some adult patients requiring major surgical procedures are transferred to the Royal Sussex County Hospital in Brighton.

There were approximately 39,000 ED attendances at the Princess Royal Hospital in the year ending August 2018; 6,000 of which were children under 18 years old.

The department consists of;

- An ambulance assessment area with two cubicles for patients who arrive by ambulance,
- A walk-in triage assessment room.
- A three- bay resuscitation room.
- A major treatment area with room for 8 patients
- A children's examination area with space for two children and full resuscitation facilities.
- A mental health assessment room.
- Two examination rooms for patients with minor injuries
- Two consultation rooms for patients with minor injuries and illnesses.
- A six-bedded clinical decision unit.

We last inspected the emergency departments in April 2017 and rated them as Requires Improvement.

During this inspection we visited the emergency department at Princess Royal Hospital from 25 to 26 September 2018. We spoke with two patients and their relatives, approximately 22 staff at different levels and in different roles. We looked at 23 patients records and observed how the emergency department functioned and how patients were managed and cared for.

Summary of this service

Our rating of this service improved. We rated it as good because:

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

Urgent and emergency services

- The service monitored safety and managed patient safety incidents well. Staff recognised incidents and reported them in line with policy. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service had suitable premises and equipment and staff controlled the risks to infection well.
- Staff followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.
- The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.
- Care and treatment provided was based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Managers made sure staff were competent for their roles and monitored the effectiveness of care and treatment. They usually compared local results with those of other services to learn from them.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.
- Patients were cared for with compassion. Feedback from patients, and our own observations, confirmed that staff treated them well and with kindness.
- Most people could access the service when they needed it. There was a steady flow of patients through the department with few delays for diagnosis or treatment. Patients were consistently treated, admitted and discharged more quickly than most other hospitals in England. Staff were familiar with the hospital's full capacity protocol which gave guidance when the department experiences a surge in patient attendances.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.
- The emergency department leadership team promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

However:

- Risks to patients were not always assessed in a timely manner when they first arrived. We observed delays in the initial assessment of patients who had not arrived by ambulance. Information from the trust showed that almost half of patients, including children, waited more than 19 minutes for a nurse to assess them. Early warning scores were not always calculated as often as they needed to be to detect patients who were at risk of deterioration.
- There was a risk that there were not always enough nurses to care for the number of patients that attended the emergency department. No acuity-based review of nurse staffing had taken place since the department had been enlarged. There was only one nurse looking after patients in the resuscitation room and there were sometimes no nurses in the ambulance assessment area.
- Patient's records were not always easy to follow, and some of them did not contain all the information required. The records of patients who had who had been admitted rarely contained copies of observation charts or admission documents.
- Staff did not always assess and monitor patients regularly to see if they were in pain. Pain scores were not always recorded when patients first arrived or after pain relief had been given.

Urgent and emergency services

- Although the service provided mandatory training in key skills to staff it did not make sure everyone completed it. Not all nurses had received training in immediate life support for adults and children.
- Senior staff told us that the ambulance service was not always able to arrive quickly when needed to transfer patients to hospitals in Brighton.

Is the service safe?

Requires improvement

Our rating of safe stayed the same. We rated it as requires improvement because:

- Risks to patients were not always assessed in a timely manner when they first arrived. We observed delays in the initial assessment of patients who had not arrived by ambulance. Information from the trust showed that almost half of patients, including children, waited more than 19 minutes for a nurse to assess them. Early warning scores were not always calculated as often as they needed to be to detect patients who were at risk of deterioration.
- There was a risk that there were not always enough nurses to ensure the safe care of the patients that attended the emergency department. Although a review of staffing levels had taken place it was not clear whether it was evidence-based. There was only one nurse looking after patients in the resuscitation room and there were sometimes no nurses in the ambulance assessment area.
- Patient's records were not always easy to follow, and some of them did not contain all the information required. The records of patients who had who had been admitted rarely contained copies of observation charts or admission documents.
- Although the service provided mandatory training in keys skills to all staff, it did not ensure that everyone completed it. 65% of nurses had been trained in immediate life support for adults and children. This did not meet the trust target of 85%.

However:

- Staff we spoke with understood how to protect patients from abuse and the service worked well with other agencies to do so. Nursing staff had received advanced training on how to recognise and report abuse although only 58% of doctors had received the same training.
- The department controlled the risk of infection well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- Premises and equipment were suitable and well maintained. Staff checked equipment regularly to make sure that it was ready to use.
- There were enough medical staff, with the right mix of qualifications, to keep patients safe and provide the right care and treatment.
- Staff followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.
- Safety information was monitored. Staff collected safety information and managers used this to improve the service.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Urgent and emergency services

Is the service effective?

Good

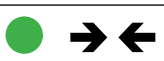
Our rating of effective improved. We rated it as good because:

- Care and treatment was based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Patients were given enough food and drink to meet their needs and improve their health.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They often compared local results with those of other services to learn from them although they had not taken part in national audits of the treatment of children.
- The service provided structured in-house training for staff and regular assessment took place to make sure that staff were competent for their roles. Managers appraised staff's work performance to provide support and discuss development opportunities.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Essential services were provided seven days a week, in line with NHS Seven Day Services Clinical Standards.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We observed staff asking for patient's consent before they carried out care or treatment. They followed the trust policy and procedures when a patient could not give consent.

However:

- Staff did not always assess and monitor patients regularly to see if they were in pain. Pain scores were not always recorded when patients first arrived or after pain relief had been given.

Is the service caring?

Good 

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

- We observed compassionate care for patients and their families. Feedback from patients we spoke with during the inspection told us that the care was "marvellous" and that staff were friendly and helpful. 93% of patients said that they would recommend the department to friends and family.
- Emotional support was provided to patients to minimise their distress. Staff understood the impact that a patient's diagnosis could have on their wellbeing and on those close to them, both emotionally and socially. We observed two members of staff discussing the best way to break bad news to a patient and their family.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients confirmed that they felt involved in decision-making and medical and nursing staff shared enough information to support this. We observed staff checking that what they had said had been understood by patients and if there were further questions that patients, relatives or carers wanted to ask.

Urgent and emergency services

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good because:

- The trust planned and provided services in a way that mostly met the needs of local people. Extensive modernisation of the department in the last year had made it safer and had improved the patient experience.
- The department took account of patients' individual needs although it was not always successful in meeting them. There was wheelchair access to all clinical areas although the design of the reception area made it difficult for wheelchair users to register. Discharge arrangements for patients with complex health and social needs were individually tailored to their specific needs.
- Most people could access the service when they needed it. There was a steady flow of patients through the department with few delays for diagnosis or treatment. The percentage of patients who were treated and admitted or discharged within four hours was consistently better than most other departments in England.
- Concerns and complaints were treated seriously. They were thoroughly investigated and lessons were learnt from the results. Learning was shared with all staff.

However:

- Senior staff told us that the ambulance service was not always able to arrive quickly when needed to transfer patients to hospitals in Brighton.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good because:

- The leadership team had the right skills and abilities to run a service providing high-quality sustainable care. We observed them working seamlessly together in the department. They were knowledgeable about clinical issues and about priorities for the quality and sustainability of the service.
- There was a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. A robust governance system was in place with detailed information about the department's performance discussed at regular governance meetings and used to demonstrate effectiveness and progress.
- The emergency department leadership team promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff morale had improved since our last inspection.
- There were effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. All staff were aware of the departmental risk register and of the measures taken to reduce those risks. There was an up-to-date and detailed major incident plan. There had been a recent joint exercise with the ambulance service to assess the effectiveness of the plan.
- Information was collected, analysed, managed and used well to support departmental activities. All staff were familiar with the new computer systems and the security safeguards necessary to use it.

- The department engaged with patients, staff, the public and local organisations to plan and manage appropriate services.
- There was a commitment to improving services by learning from when things went well and when they went wrong, promoting training and innovation. There had been a significant number of improvements to the service since our last inspection. Professional development and high levels of staff competency were priorities for the leadership team.

However:

- Although leaders in the emergency department had a clear vision of what they wanted to achieve, there remained some confusion about the strategy for the department.

Outstanding practice

We found examples of outstanding practice in this service:

- In May 2018 the self-rostering medical rota was highly commended for innovation by the British Medical Journal.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Actions the trust MUST take to improve:

- The trust must ensure that senior staff are monitoring any delays in the initial clinical assessment of self-presenting patients so that all patients are assessed in a timely manner. This particularly applies to children and to all patients arriving during the night.
- The trust must monitor nurse staffing levels using an acuity-based staffing tool to ensure there are always enough nurses in the emergency department.

Actions the trust SHOULD take to improve:

- The trust should ensure that ambulance crews can handover their patients as soon as possible so that they can be released to respond to further emergency calls.
- The trust should ensure that all patients who require an early warning score have this calculated as part of their triage assessment and at the required frequency during their treatment.
- The trust should work with the neighbouring mental health trust to reduce the delays in admitting patients to specialist mental health units.
- The trust should ensure that patient safety checklists are completed hourly.

Medical care (including older people's care)

Good ↑

Key facts and figures

The Princess Royal Hospital is part of Brighton and Sussex University Hospitals NHS Foundation Trust located in Haywards Heath in West Sussex. The hospital provides a full range of general and specialist medical services including specialist dementia and endoscopy services.

Acute stroke services are based at RSCH whereas specialist inpatient rehabilitation takes place at the rehabilitation centre at PRH.

Across the trust there are 371 medical inpatient beds located across 24 wards. A site breakdown can be found below:

- Royal Sussex County Hospital: 245 beds are located within 16 wards and units.
- Princess Royal Hospital: 108 beds are located within seven wards and units.
- Hurstwood Park Hospital: 18 beds located on Plumpton Ward.

The trust had 47,921 medical admissions from May 2017 to April 2018. Emergency admissions accounted for 20,270 (42.3%), 2,180 (4.5%) were elective, and the remaining 25,471 (53.2%) were day case. The chart below shows how the number of medical admissions at the trust relates to other NHS trusts in England.

Admissions for the top three medical specialties were:

- Gastroenterology - 8,864 admissions
- Geriatric medicine - 7,847 admissions
- General medicine - 6,952 admissions

We visited eight medical wards as well as the pharmacy and discharge lounge. We reviewed 10 patient records, 25 medicine charts and checked 15 items of equipment. We spoke with 11 patients, two visitors and 33 members of staff. Staff included consultants, ward managers, nurses, student nurses, health care assistants, housekeeping staff, volunteers, porters and therapists.

Medical care (including older people's care) service at the Royal Sussex Hospital is outlined in a separate report specific to that location.

Summary of this service

Our rating of this service improved.

This reflects the improvements made since our inspection in 2017. At this inspection we saw positive changes to the culture with a workforce that felt engaged and able to contribute, the 'Patient First' improvement strategy was embedded and staff had bought into the premise, management at all levels was praised and the caring culture was outstanding.

The main concerns from our previous inspection included:

- Mandatory training compliance did not meet trust standards
- There were insufficient fire plans and risk assessments to ensure patients and visitors were able to evacuate safely

Medical care (including older people's care)

- Staff did not regularly receive an appraisal and appraisal completion rates were below the trust standard
- Patient flow through the hospital did not expedite the timely discharge of patients which impacted capacity and length of stay at the hospital
- There was a culture of silo working that impacted on learning from incidents
- Poor behaviour amongst staff was unchallenged and managers were not sufficiently supported by the human resources department.

At this inspection we saw many improvements.

- We saw there had been a concerted effort to improve mandatory training compliance rates in order to meet trust targets. The trust provided comprehensive training. Ward managers were aware of which staff members were up-to-date with their training and those who were out-of-date were closely monitored. The introduction of e-learning enabled staff to complete online training in their own time, which had helped increase completion rates. Service leads were assured that there were sufficient numbers of staff with the right qualifications, training and experience to meet the needs of patients.
- Fire safety improvements had been made with staff at all levels aware of the content and location of fire plans and risk assessments. Evacuation practices had become the norm, and staff were confident they knew what to do in case of a fire.
- The trust had ensured staff had received an appraisal within the last 12 months. Staff we spoke with advised us that they were given adequate time to complete their appraisal, they were given the opportunity to discuss personal development and that the appraisals were useful and not just a tick box exercise.
- The trust had implemented a number of initiatives to support the flow of patients through the hospital. We had previously found the discharge lounge to be inconsistently used with issues around to-take-home medication and planning of transport. At this inspection, we saw the service had a comprehensive plan to support staff to ensure these measures were organised and in place before the expected date of discharge.
- The culture across the department was more positive and there was a sense of openness and transparency. The trust had reviewed human resource training to ensure all staff and managers received the same level of support and that there was consistency in how policies were applied. Staff felt empowered to challenge poor behaviour. The culture had also improved in terms of incident reporting and shared learning, as there was no longer a blame culture.
- The trust had introduced several safety programmes to improve multidisciplinary working and monitor deteriorating patients in order to ensure quick response times. For example, the sepsis bundle and NEWS2, the availability of a clinical nurse specialist lead for sepsis, safeguarding huddles and safety huddles. We saw health care assistants led safety huddles which also demonstrated the improved culture within the trust, as there was no evidence of a 'them and us' culture.

Is the service safe?

Good

Our rating of safe improved.

This reflects the significant improvements made to patient safety and risks as well as environmental improvements regarding fire safety.

We rated it as good because:

Medical care (including older people's care)

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and used safety huddles to share lessons learned with their team. Improvement information was communicated to the wider service through the various governance meetings.
- There was one never event reported at the hospital between June 2017 and May 2018. Since the incident staff competencies had been monitored, policies and procedures were updated to ensure they followed national guidelines and a programme of auditing had been introduced.
- When things went wrong, staff apologised and gave patients honest information and suitable support. Staff were aware of their responsibilities regarding duty of candour and we saw current examples of duty of candour being used in practice.
- The trust had introduced several safety programmes to improve the monitoring of deteriorating patients and the reduction of potential harm. For example, the sepsis bundle and early warning system (NEWS2), the availability of a clinical nurse specialist lead for sepsis, safeguarding huddles and safety huddles. The sepsis bundle and NEWS2 scoring sheets had comprehensive sections on a full range of patient safety areas including pressure area monitoring, acuity, environment and equipment and risks and falls assessments. The huddles aided the sharing of patient information to ensure holistic, multidisciplinary care was provided. We saw that huddles were also an opportunity to focus on a topic of the week. The topic of the week during our inspection was sepsis, thus giving an opportunity to remind staff about the use of the sepsis bundle.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean through the use of effective control measures such as daily and weekly checklists, to prevent the spread of infection. All staff had a good understanding of control of substances hazardous to health regulations. The service had suitable premises and since the last inspection had introduced effective processes for managing fire risk assessments. Fire risk assessments were complete and up to date and practice fire drills and evacuations had become routine.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date, stored safely and available to all staff providing care.
- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it. The introduction of unit practice educators, who monitored staff training records and scheduled training dates had improved compliance of statutory and mandatory training from 72% to 89%.
- The service prescribed, gave, recorded and stored medicines well. We saw bedside patient lockers, which had fob operated patient drug dispensing compartments. This facilitated safe and effective personal drug dispensation. Patients received the right medication at the right dose at the right time.

However:

- A clinical pharmacist did not visit all wards daily; for example, Plumpton ward did not receive a regular pharmacy visit. The prescription charts for these patients were not reviewed on the wards by the pharmacy team, they would only be seen if the chart was sent to the pharmacy if a medicine was needed.
- We could not find evidence that during planning for opening new beds, for example for winter pressures, the impact on the pharmacy had been considered and no extra pharmacy resources had been provided. The patients on any new services would not receive a clinical pharmacy service. Their medicines would not be reviewed unless a prescription chart was sent to pharmacy and there was a risk of increased medicine interactions and adverse reactions to medicines.

- There was no policy/procedure for self-administration of medicines, although we did see evidence of auditing of self-administration of insulin.

Is the service effective?

Good ↑

Our rating of effective improved.

This reflects the improvements made in relation to the increased number of staff receiving an appraisal and the introduction of a seven-day pain service.

We rated it as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff at all levels worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. The 'Patient First' programme had enhanced teamwork among differing grades of staff which was evidenced during ward rounds a safety huddles where all staff were encouraged to participate in patient centred discussions. Any member of the team was able to lead a huddle.
- Staff gave patients enough food and drink to meet their needs. We saw staff prioritised mealtimes and there were enough staff to support patients that needed help eating and drinking. The service made adjustments for patients' religious, cultural and other preferences.
- The service made sure staff were competent for their roles. Managers appraised staff performance to provide support, and personal development and monitor the effectiveness of the service. The number of staff who had up to date appraisals had improved since our last inspection.
- The service provided an effective, seven-day pain service. Staff had access to a pain management service including a dying patient care algorithm for the management of pain for terminally ill patients. Pain management was part of the 'Patient First' strategy that included assessing and providing pain relief within 30 minutes of arrival on a ward, which had improved from 15% to 50% since commencing the initiative.
- Seven-day services/cover was available to pharmacy, physiotherapy and occupational therapy. Access to dieticians or speech and language therapists was provided Monday to Friday, 9am to 5pm with an out of hours telephone advice line to support staff. Nurses were trained to carry out assessments for patients on the stroke ward where dietary advice and support with eating affected recovery were required out of hours.
- Staff understood their roles and responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Staff knew the processes for ensuring deprivation of liberty safeguards documentation was complete and up to date as well as how to support those who lacked the capacity to make decisions about their care.

However:

- The trust did not perform well in the 2017 Lung Cancer Audit in relation to the proportion of patients seen by a Cancer Nurse Specialist. This data was not broken down by site. In the National Audit of Inpatient Falls 2017, the Princess Royal Hospital performed poorly. We noted the trust had action plans to improve performance.

Is the service caring?

Outstanding ☆ ↑

Medical care (including older people's care)

Our rating of caring improved.

This reflected the culture staff had built which empowered patients and made them partners in their care. Examples of staff going above and beyond are included in our evidence appendix for this service.

We rated it as outstanding because:

- Patients were respected and valued as individuals and staff empowered patients to be partners in their care.
- Patients, their family and friends who used the service gave overwhelmingly positive feedback about the way staff treated patients. We were provided with numerous examples of staff going the extra mile and patients stated the care they received exceeded expectations.
- There was a strong, visible person-centered culture. Staff were highly motivated and inspired to offer care that was kind and promoted dignity. Staff were caring and supportive of patients which was encouraged by management.
- Staff recognised and respected patients' opinions, taking their personal, cultural, social and religious needs into account.
- Patients were active partners in their care. Staff were committed to working in partnership with patients and their families. Staff empowered patients to reach their potential and we found this in particular on Lindfield ward.
- Staff showed determination in delivering outstanding care. For example, staff came in on their day off to provide hair and nail services to patients.
- Staff highly valued patients' emotional and social needs and embedded these within their care and treatment.
- The Friends and Family Test showed the recommendation rate for medicine at the Princess Royal Hospital site to be above 90% from June 2017 to May 2018. Staff provided continual high-quality care. This was supported by all patients and relatives we spoke with who were consistently positive about the care which they described have exceeded their expectations.

Is the service responsive?

Good ↑

Our rating of responsive improved. This reflected the improvements around patient flow

We rated it as good because:

- The trust planned and provided services in a way that met the needs of local people. Although the hospital was not meeting referral to treatment times we saw numerous examples of initiatives to improve this. For example, the Hospital Rapid Discharge Team (HRDT) reviewed short stay patients. These patients stayed under the care of the HRDT in order that ward staff were freed up to focus on longer term patients and to expedite the discharge of patients only needing a few days hospital care. The hospital also had a Rapid Access Medical Unit where GPs could directly refer patients to the hospital. This was used to reduce referral to treatment times. Transfers and discharges were discussed at the huddles and occupational therapists ensured community care was in place prior to the patients' discharge. Patient transport services were arranged two days in advance in order to ensure transport teams had the capacity to include the patient. Where possible discharges took place at 10am to allow beds to become available sooner in the day. To-take-home medication was ordered the day before discharge to prevent delay in being transferred to the lounge or patients not receiving medication.

Medical care (including older people's care)

- The service had done everything within their remit to improve access and flow. Initiatives such as discharging patients at 10am, regular and effective monitoring and managing of medical outliers and daily board rounds and huddles. The service used data to manage any delayed transfers of care and worked with system partners to improve the position.
- Between April 2017 and March 2018, the average length of stay for medical elective patients was better than the national average and for non-elective patients the average length of stay was similar to the national average.
- The service took account of patients' individual needs. The inspection team were impressed with Hurstpierpoint ward's reminiscence room that was used for therapy, as well as the regular use of the occupational therapy kitchen on Lindfield ward, which was praised by patients.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- There was an improvement on the referral to treatment times, compared to the previous inspection, where six of the eight specialties (geriatric medicine, neurology, rheumatology, thoracic medicine, dermatology and general medicine) were better than the England average. Two specialties (cardiology and gastroenterology) were below the England average.

Is the service well-led?

Good

Our rating of well-led improved.

This reflected the significantly improved culture and the implementation of the trusts strategy.

We rated it as good because:

- The trust had managers at all levels with the right skills and abilities to run a service. There was now a permanent matron following a number of interim appointments and staff appreciated the stability this provided. Managers at all levels within the trust were praised by staff.
- Managers across the trust promoted a positive culture that supported and valued staff. The staff survey showed that all questions relating to management had shown improvement since the 2016 survey. There was a significant change in the culture since the last inspection. Bullying and acceptance of poor behaviour was no longer recognised by staff. Management felt supported in dealing with under performance as there had been a focus on retraining Human Resource staff and ensuring they followed standardised policies and procedures in a timely manner.
- The trust engaged well with patients. Several wards organised regular carers groups, where family and friends could meet and support each other.
- The service engaged well with staff. Since our last inspection the trust had introduced short monthly surveys in order that they could regularly monitor staff culture rather than waiting for the annual national staff survey. The trusts survey showed improvement in all areas.
- The trust had a strategy for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff and patients. All staff we spoke with were very aware of the 'Patient First' strategy and had 'bought in' to the initiative.

However:

- The trust values were not as well embedded as its strategy. Two wards at the hospital had seen a great deal of change over the previous 12 months, therefore staff were focused on building a coherent team rather than trust values.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

- The culture of care that was found throughout medical services showed us that patients and their families were considered partners in their care. We heard numerous examples of staff going above and beyond to provide a supportive, caring environment with the Chaplain describing staff as "Emotional athletes".

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Actions the trust SHOULD take to improve:

- The trust should ensure there are policies and procedures for patients to self-administer medicines if appropriate.
- The trust should ensure that when developing or extending services, the pharmacy service is involved in planning and appropriate resources are provided.
- The trust should ensure seven-day services were made available for the dietetic and speech and language therapy services.
- The trust should continue to work on improving its referral to treatment performance in all specialties.

Surgery

Good ↑

Key facts and figures

Brighton and Sussex University Hospitals NHS Trust (BSUH) provides surgical services to the local populations in and around the city of Brighton and Hove and some tertiary services to the wider South East of England region.

It provides surgical services across two sites, the Royal Sussex County Hospital (RSCH) at Brighton and the Princess Royal Hospital (PRH) at Haywards Heath.

The Surgical division is made up of four directorates which encompass; head & neck, abdominal surgery and medicine, musculoskeletal (MSK), and perioperative.

Each Directorate is led by a Clinical Director, Lead Nurse and Directorate Manager. The Division is led by a triumvirate team of Chief of Surgery, Chief Nurse and Director of Operations.

The Princess Royal Hospital (PRH) has five main theatres, one-day surgery theatre and four theatres in the Sussex Orthopaedic Treatment Centre (SOTC). These cover emergency, elective inpatient and day case surgery. There are 114 inpatient surgical beds across three wards (Ansty 31 beds, Newick 31 beds and Twineham 37 beds), a day case ward with 22 beds and the SOTC.

(Source: Acute Provider Information Request (RPIR) – Acute context tab)

The trust had 34,848 surgical admissions from May 2017 to April 2018. Emergency admissions accounted for 7,465 (21%), 21,874 (63%) were day case, and the remaining 5,509 (16%) were elective.

(Source: Hospital Episode Statistics)

During our inspection, we visited all areas of the surgical services, including theatres, wards, pre-operative assessment unit, Sussex Orthopaedic Treatment Centre (SOTC), and day surgery.

We spoke with 32 staff of all grades, including, nurses, doctors, healthcare assistants, therapists, and housekeeping, other healthcare professionals as well as the management team for the division.

We reviewed 18 sets of patient records. We spoke with 12 patients and relatives about their experience, and observed care and treatment being delivered. We observed nursing, doctor and multi-disciplinary team handovers, nursing safety huddles and ward rounds. We reviewed performance data before, during and after the inspection. We also took into account views and feedback provided at staff focus groups and drop-in sessions, which we facilitated before the inspection.

Summary of this service

Our rating of this service improved. We rated it as good because:

- The service provided statutory and mandatory training in key skills to all staff and made sure everyone completed it. Staff understood how to protect patients from abuse and the service worked well with other agencies.
- Staff assessed risks to patients and monitored their safety, so they were supported to stay safe. There were effective systems in place to report incidents. Incidents were monitored and reviewed and staff gave examples of learning from incidents. Staff understood the principles of Duty of Candour regulations, were confident in applying the practical elements of the legislation.

Surgery

- The service controlled infection risk well. There were policies in place to manage effective infection control and hygiene processes. The service had suitable premises and systems were in place to ensure equipment was well looked after.
- Staff kept appropriate records of patient care and treatment. Records were available to all staff providing care, however, we did find some inconsistencies. The service prescribed, gave, recorded and stored medicines well.
- Theatres complied with the minimum staffing as per Association of Perioperative Practice (AfPP) safe staffing recommendations (2014). Planned staffing levels on the wards were not always met. Data supplied to us by the trust showed as of July 2018, the vacancy rate for the surgical division was 9.9%, and was on track to meet the March 2019 target. Patients told us they felt safe, on the ward, and there were adequate numbers of staff on the wards to meet their needs.
- The service provided care and treatment based on national guidance. Staff had access to up to date policies, procedures and clinical guidelines.
- The service monitored the effectiveness of care and treatment and used the findings to improve them. Information about the outcomes of people's care and treatment were routinely collected and monitored. Staff gave patients enough food and drink to meet their needs and improve their health. The service managed patients' pain effectively and provided or offered pain relief regularly.
- The service made sure staff were competent for their roles. Staff training and professional development needs were identified, we saw 94% of staff had an up to date appraisal.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The service was working toward seven-day services in line with National Health Service Improvements (NHSI), Seven-day services in the NHS. We saw in the trust operational plan 2018-2019, that they plan to deliver the Seven Day Service standards for all admitting specialities by 2020.
- Staff supported patients to manage their own health, care, and well-being and to maximise their independence following surgery and as appropriate.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with dignity and respect. Staff involved patients and those close to them in decisions about their care and treatment. Staff communicated well with patients and those close to them in a manner so they could understand their care, treatment and condition.
- The service planned and provided services in a way that met the needs of local people. The service had systems and staff in place to aid the delivery of care to patients in need of additional support, such as initiative to support patients with learning disabilities or those living with dementia.
- People could mostly access the service when they needed it. The service took account of patients' individual needs. The trust employed specialist nurses to support the ward staff.
- The service treated patient's concerns and complaints seriously and investigated them, we saw lessons were learned from complaints and shared with all staff.
- The service had managers at all levels with the right skills and abilities to run the service, and provide quality care. Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The trust had a vision for what it wanted to achieve and workable plans to turning it into actions. The trust vision and strategy focused upon quality and sustainability.

Surgery

- The trust used a systematic approach to continually improve the quality of its services, by creating an environment in which clinical care would flourish. The department had systems for identifying risks, planning to eliminate or reduce them.
- The service collected, analysed, managed and used information to support all its activities, using secure electronic systems with security safeguards.
- The trust engaged with patients, staff and the public to plan and manage services. We saw the staff encouraged patients to complete the family and friends test on their care and treatment.
- The trust was committed to improving services by learning when things go well and when they go wrong, promoting training, research and innovations.

However:

- Some wards such we visited, we found some of the walls, fixtures, and fittings were not intact. For example, we saw sink surrounds, which were damaged with exposed wood, this is not in line with the Department of Health's Health Building Note (HBN) 00-09: infection control in the built environment. Non-intact surfaces, flooring and walls can harbour dirt and dust and make the cleaning difficult.
- Patient consent to care and treatment was not always sought in line with legislation and guidance. Not all consent forms we looked at for elective surgery were signed before the day of surgery, this is not with guidance from the Royal College of Surgeons Good Surgical Practice 2014.
- Not all staff had the correct information or competencies to do their role. Although all staff we spoke with told us they had an attended the trust wide induction, we found three locum doctors who had not had a local induction to the hospital or ward they were working on.
- Signposting around the hospital was poor, and made it difficult for people who were unfamiliar with the hospital to find their way around. We saw multiple visitors, and patients lost or unable to locate the ward or department they needed to find. This was an issue we highlighted in our previous inspection in 2017.
- The trust was in the process of developing Local Safety Standards for Invasive Procedures (LocSIPPs) using the National Safety Standards for Invasive Procedures (NatSSIPs), some of which were available to staff on the trust intranet. For example, we saw the local safety standards for invasive procedures for surgical and procedure site verification was available on the trust website. We found not all staff were aware of local safety standards for or their availability.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- The service provided statutory and mandatory training in key skills to all staff and made sure everyone completed it. The overall statutory and mandatory training rates for nursing staff was 95% and medical staff was100%, which was better than the trust target of 90%. We saw all statutory and mandatory training modules were above 90%, except manual handling – patients for nursing staff which was 86%.
- Staff understood how to protect patients from abuse and the service worked well with other agencies. Both nursing and medical staff were above the trust target for training on how to recognise and report abuse. Staff demonstrated a good understanding of the different types of abuse, and knew the process for reporting a safeguarding concern, and were able to give examples of safeguarding concerns they had raised.

Surgery

- The service controlled infection risk well. There were policies in place to manage effective infection control and hygiene processes. We saw staff cleaned their hands at the correct times and were bare below the elbow, in line with trust policy. All areas on the wards, department and theatres we visited were found to be visibly clean. Equipment was visibly clean and staff had a good understanding of responsibilities in relation to cleaning.
- The service had suitable premises and systems were in place to ensure equipment was well looked after. Equipment used in the event of an emergency was constantly checked daily to make sure it was present and in working order. The cleaning cupboards inspected on the wards and theatres were locked at the time of inspection.
- Staff assessed risks to patients and monitored their safety, so they were supported to stay safe. Assessments were in place to alert staff when a patient's condition deteriorated, such as the use of National Early Warning System, which we found to be fully completed and scored correctly.
- Risk based pre-operative assessments were carried out in line with national guidance from the Modernisation Agency. We saw the surgical service met the Association for Perioperative Practice (AfPP) guidance, for making sure surgical instruments and gauze swabs were checked before, during and at the end of patients' operations.
- Patients were assessed for their risk of developing a blood clot, or falling in line with national guidance. The trust used the five steps to safer surgery, World Health Organisation (WHO) surgical safety checklist, in line with National Patient Safety Agency (NPSA) guidelines.
- Theatres complied with the minimum staffing as per Association of Perioperative Practice (AfPP) safe staffing recommendations (2014). Planned staffing levels on the wards were not always met. The leadership team told us the trust recruitment of staff particularly for the Princess Royal Hospital site remained a challenge. Data supplied to us by the trust showed as of July 2018, the vacancy rate for the surgical division was 9.9%. This had improved from the previous year's vacancy rate which was 15%, and was on track to meet the March 2019 target. Rotas were planned, this allowed for adjustment to make sure of the correct skill mix. Staffing shortfalls were always escalated and covered by bank or agency staff. Patients told us they felt safe, on the ward, and there were adequate numbers of staff on the wards to meet their needs.
- Surgery was consultant delivered and led, with consultant ward rounds happening seven days a week. Planned medical staffing levels on the wards were not always met. Locum staff were used to fill shortfalls in shifts, but the number of shifts that were filled had decreased by 4% on the previous year. The leadership team, told us they had challenges for recruiting across junior and middle grade staff. Recruitment campaigns were being planned to encourage medical staff to work for the trust. Junior doctors told us they felt supported by consultants and included in decision making.
- Staff kept appropriate records of patient care and treatment. Records were available to all staff providing care, however, we did find some inconsistencies. We looked at 18 patient records and found they contained patient reviews, referrals to and from other clinicians and clear treatment plans. All entries of patient's recent admissions were signed, dated and timed by staff. There was clear recording from physio therapists and occupational therapists. We found up to date and completed risk assessments and saw they were reviewed regularly. We did find some inconsistency with filing across the wards, which meant patients records were not always straightforward to read.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time. Medicines were stored in locked rooms, and cupboards. Where medicine trolleys were used these were locked and secured to the wall when not in use. There were systems in place to check for out of date medicines. Controlled drugs were kept secure and accurate records maintained. Prescriptions charts we looked at were legible, signed and dated, and allergies were recorded. In addition, where antimicrobials were used, all had the clinical indication, dose and duration documented. Fridge and room temperatures were recorded and within range, to make sure drugs maintain their function and safety.

Surgery

- There were effective systems in place to report incidents. Incidents were monitored and reviewed and staff gave examples of learning from incidents. Staff understood the principles of Duty of Candour regulations, were confident in applying the practical elements of the legislation. Regular mortality and morbidity meetings were held to discuss patient deaths and other adverse events in an open manner, review care standards and make changes if needed.
- Safety thermometer information was prominently displayed on notice boards. The information was kept up to date to keep staff, patients and visitors informed about the ward's performance. This data was also included in the metrics dashboard for each ward, so they could see how they were performing in each area, and where they were in comparison to the trust average for the month, monitor trends and improve and make changes to practice.

However:

- On some wards we visited, we found some of the walls, fixtures, and fittings were not intact. For example, we saw sink surrounds, which were damaged with exposed wood, this is not in line with the Department of Health's Health Building Note (HBN) 00-09: infection control in the built environment. Non-intact surfaces, flooring and walls can harbour dirt and dust and make the cleaning difficult.

Is the service effective?

Good

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

- The service provided care and treatment based on national guidance. Staff had access to up to date policies, procedures and clinical guidelines. We saw they were evidence based guidance from organisations such as Royal College of Surgeons and the National Institute for Health and Care excellence.
- Staff gave patients enough food and drink to meet their needs and improve their health. The service adjusted for patient's dietary requirements. Protected mealtimes were in place, which meant patients could eat their meals without being interrupted, and allowed staff to assist those who needed it. During our inspection, we saw staff assisting patients with their meals, or helping to position them in chair, to make them more comfortable to be able to eat. Nursing staff completed a nutritional risk assessment when patients were admitted to hospital, this is in line guidance.
- The service was pro-active in preventing post-operative pain. The service managed patients' pain effectively and provided or offered pain relief regularly. Patients we spoke with told us staff offered pain relief quickly when they reported pain.
- The service monitored the effectiveness of care and treatment and consistently used the findings to improve them. Information about the outcomes of people's care and treatment were routinely collected and monitored. The service participated in national audits to enable its practice to be compared and action was taken to improve areas identified from audit that were not at the required level. Overall, performance in national audits was broadly in line with national averages. The service completed local audits, but the results did not drive the necessary improvements.
- We saw the service participated in the reducing the impact of serious infection Commissioning for Quality and Innovation (CQUIN) and that the trust had an action plan in place to ensure patient care was delivered in line with evidence-based guidance, standards and best practice. The surgical division had a local audit programme and reviewed their progress against the action plans to improve their service.
- The service made sure staff were competent for their roles. Staff training and professional development needs were identified, we saw 94% of staff had an up to date appraisal. Staff had the skills, knowledge, and experience to deliver

safe care and treatment. Training and educational development was embedded in the surgical division. Staff we spoke with told us they completed competency assessment to make sure they had the skills and knowledge to carry out the roles they were employed to do. Staff had training, skills, knowledge and experience to identify and manage and care for patients living with dementia or a learning disability.

- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. Staff respected their colleagues' opinions and staff at all levels could contribute to the discussion and were prepared to challenge each other.
- The service was working toward seven-day services in line with National Health Service Improvements (NHSI), Seven-day services in the NHS. We saw in the trust operational plan 2018-2019, that they plan to deliver the Seven Day Service standards for all admitting specialities by 2020. There was a consultant ward round seven days a week. Diagnostic services were available 24 hours a day, seven days a week, in line with the NHS Services, Seven Days a Week, Priority Clinical Standard Five (2016). The seven-day services programme is designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital.
- Staff supported patients to manage their own health, care, and well-being and to maximise their independence following surgery and as appropriate for individuals.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

However:

- Patient consent to care and treatment was not always sought in line with legislation and guidance. Not all consent forms we looked at for elective surgery were signed before the day of surgery, this is not in line with guidance from the Royal College of Surgeons Good Surgical Practice 2014.
- Not all staff had the correct information to do their role. Although all staff we spoke with told us they had attended the trust wide induction, we found three locum doctors who had not had a local induction to the hospital or ward they were working on.

Is the service caring?

Good

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

- Staff cared for patients with compassion. All staff we spoke with were very passionate about their roles and were dedicated to making sure patients received the best patient-centred care possible. We saw staff introduced themselves, and asked patients how they wanted to be addressed.
- All wards displayed their friends and family feedback showing a response rate between 24 and 53 per cent. Staff gave patients a card on discharge asking them to feedback about their experience. All wards had an annual positive performance of 90% or above.
- Staff members showed an understanding and a non-judgemental attitude when talking about patients who had mental ill health or a learning disability. Staff responded to patients who might be frightened, confused or have a phobia about a medical procedure or any aspect of their care in a respectful and understanding way.
- Patients were satisfied with their care. Patients consistently gave positive feedback about their experience in the emergency department. Patients told us staff were brilliant helpful and caring.
- Staff provided emotional support to patients to minimise their distress.

Surgery

- Staff involved patients and those close to them in decisions about their care and treatment. Patients confirmed that they felt involved in decision-making and medical and nursing staff shared enough information to support their decision-making; we observed that staff asked if what they said had been understood by patients and if there were further questions the patients, relatives or carers had.
- Staff communicated well with patients and those close to them in a manner so they could understand their care, treatment and condition. Staff had accessible ways to communicate with people when their protected equality or other characteristics make this necessary.

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good because:

- The service planned and provided services in a way that met the needs of local people. The service had systems and staff in place to aid the delivery of care to patients in need of additional support, such as initiatives to support patients with learning disabilities or those living with dementia. The trust was investing in the facilities and premises to make sure they were appropriate for the services that were being delivered.
- The service took account of patients' individual needs. The trust employed specialist nurses to support the ward staff. The service made reasonable adjustments and took action to remove barriers for patients who found it hard to use or access services. This included interpreting services, services for patients living with dementia, those with sensory loss or impairment and facilities for bariatric patients.
- The inspection did not highlight any concerns relating to the admission, transfer, or discharge of patients from the ward, theatres or recovery.
- People could mostly access the service when they needed it. During our inspection the theatre lists ran mostly on time. The patients we spoke with did not have any concerns in relation to their admission, waiting times, or discharge arrangements. Waiting times for referral to treatment within 52-weeks had improved from the previous inspection, with no patients waiting longer than 52-weeks or more. Theatre utilisation rates were monitored to make sure the theatre was used efficiently.
- There was an improvement on the referral to treatment, compared to the previous inspection, where all specialities were below the England average. Two specialities (Trauma and orthopaedics and ophthalmology) were better than the England average and three were similar (ear, nose and throat, urology, and oral). However, we found three specialities (neurosurgery, general surgery and cardiothoracic) were greater than 5% below the England average.
- The service treated patient's concerns and complaints seriously and investigated them, we saw lessons were learned from complaints and shared with all staff.

However:

- Signposting around the hospital was poor, and made it difficult for people who were unfamiliar with the hospital to find their way around. We saw multiple visitors, and patients lost or unable to locate the ward or department they needed to find. This was an issue we highlighted in our previous inspection in 2017.

Is the service well-led?

Good →←

Surgery

Our rating of well-led stayed the same. We rated it as good because:

- The service had managers at all levels with the right skills and abilities to run the service, and provide quality care. There was a clear management structure at directorate and departmental levels. Matrons and ward managers were visible, and ward managers told us they were well supported by the matrons, and the surgical divisional leads. Staff felt supported by their line manager and matron, and felt there was a clear management structure within the team and leaders and senior staff were very approachable.
- The trust had a vision for what it wanted to achieve and workable plans to turning it into actions. The trust vision and strategy focused upon quality and sustainability. Staff were able to explain the vision and strategy and what it meant to them.
- Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Both theatre and nursing staff reported a good culture, and felt supported and valued by all members of the multidisciplinary team.
- The trust used a systematic approach to continually improve the quality of its services, by creating an environment in which clinical care would flourish. There were clear lines of accountability form the department to the board through the directorate governance structure. Staff we spoke with were clear about their roles and responsibilities and who or what they were accountable to or for.
- The department had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The department maintained a risk register, which defined the severity and likelihood of risks in the department causing harm to patients or staff. It documented the measures to be taken to reduce the risk. We saw that the risks described accurately reflected the concerns described by staff in the department. There were processes in place for the stewardship of antimicrobials.
- The service collected, analysed, managed and used information to support all its activities, using secure electronic systems with security safeguards. Staff had access to up to date information on patient care and treatment, and were aware of how to use and store confidential information.
- The trust engaged with patients, staff and the public to plan and manage services. We saw the staff encouraged patients to complete the family and friends test on their care and treatment. They used social media mechanism for engaging with staff and patients, they also answered, complaints, concerns and compliments on the NHS choices website. At our previous inspection we required the trust should ensure the plan to improve staff engagement is fully implemented. We saw there was an upward trend in engagement with the most significant improvement in how likely staff would be to recommend the trust to friends and family as a place to work.
- The trust was committed to improving services by learning when things go well and when they go wrong, promoting training, research and innovations. The service and its staff demonstrated a willingness to develop and improve the service provided. The trust's strategy, was a process of continuous measurable improvement through existing pathways, to put patients first. The trust recognised and rewarded its staff for the work they did to improve quality.

However:

- The trust was in the process of developing Local Safety Standards for Invasive Procedures (LocSIPPs) using the National Safety Standards for Invasive Procedures (NatSSIPs), some of which were available to staff on the trust intranet. For example, we saw the local safety standards for invasive procedures for surgical and procedure site verification was available on the trust website. We found not all staff were aware of local safety standards for or their availability.

Surgery

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Actions the trust SHOULD take to improve:

- The trust should ensure the walls and fixtures and fittings meet the Department of Health's Health Building Note 00-09.
- The trust should ensure that consent to care and treatment is always sought in line with legislation, best practice and guidance.
- The trust should improve the signage for patients and visitors to navigate their way around the hospital.
- The trust should ensure that Local Safety Standards for Invasive Procedures (LocSIPPs) using the National Safety Standards for Invasive Procedures (NatSSIPs), are in place and staff are aware of their availability.
- The trust should make sure all locum doctors receive a local induction, to the hospital and ward they are working on.
- The trust should implement an effective system to ensure patients were not fasted for longer periods than clinically necessary.

Critical care

Good ↑

Key facts and figures

The Intensive Care Unit was identified by the trust as the location "where we care for patients who are extremely sick and need constant close monitoring and support from staff, machines and medicine to keep normal body functions going". The critical care team supported the care of inpatients across all the hospitals specialities.

We inspected the following service:

- Eight bedded level 3 Intensive Care Unit (ICU) at Princess Royal Hospital

We also spoke to the critical care outreach team who provided a supportive role to the wards, medical, surgical and nursing staff when caring for deteriorating patients and supporting patients discharged from critical care. This team was available 24 hours a day, seven days a week.

During our inspection we spoke with 17 staff members who included all grades of medical and nursing staff, senior managers, clinical support workers and allied health professionals. We also spoke with two patients on the ward.

We observed the care and treatment patients were receiving, attended multi-disciplinary team meetings and ward meetings and reviewed three patient records including medicine prescription charts.

Before our inspection we reviewed performance information from and about the trust and data from the Intensive Care National Audit and Research Centre (ICNARC).

The trust was part of the South East Critical Care Network.

Summary of this service

Our rating of this service improved. We rated it as good because:

- The service improved its mandatory training compliance since the last inspection. Overall compliance rates for mandatory training where above the 90% target identified by the trust.
- Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times.
- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Staff felt supported when doing so. We also saw that the service had addressed the significant backlog of incidents that had not been investigated.
- Staff managed medicines consistently and safely. Medicines were stored correctly, and disposed of safely. Staff keep accurate records of medicines. This was an improvement on the findings from our previous inspection
- People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.
- Mortality rates were within expected limits. This assured us that the intended outcomes for people using this service were being achieved.
- Staff were competent and the service provided good opportunities for learning and professional development. An example of this was the advanced critical care practitioner course and preceptorship programme. We saw evidence how staff appraisal rates had gone up to 96% in August 2018.

Critical care

- Feedback from patients we spoke with was consistently positive and praised staff's care and availability. People were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive.
- A large poster board that showed all the stages of the critical care pathway had been placed at the entry of the unit. The pictures displayed could be understood by adults and children alike as well as those who did not speak English as a first language. Included in the picture were links to a wide variety of support groups and information sources. These could be directly accessed by using a smartphone to link to the QR code.
- The service had recorded zero non-clinical transfers between April 2018 and August 2018. Additionally, the service did not record any patients being readmitted to critical care within 48 hours of discharge.
- There was a clear statement of vision and values, driven by quality and sustainability. The vision and strategy were aligned to the trust's true north objective where the patient is at the heart of everything that is done. We saw that progress against delivery of the strategy and local plans was monitored and reviewed.
- There was a culture of collective responsibility between teams and services. The service proactively engaged and involved all staff ensuring that the voices of all staff were heard and acted on to shape services and culture.
- We heard from a variety of staff how the arrival of the new executive team and the move to a new structure, in which critical care was its own directorate in the specialist services division, had shown real benefits to critical care.

However:

- We found dirty and cluttered storage cupboards during inspection. The service did not have cleaning schedules in these rooms to assess when the cleaning rota was last completed and there were no records easily available. There were also no checklists to show that clinical staff made a daily check of their clinical area and cleaned the equipment in use. Once our concerns were raised the service was proactive in addressing the cleanliness issues and we saw that floors and cupboards had been cleaned and reorganised.
- We found that staff missed opportunities to comply with the hand hygiene standards. This in association with the cleaning issues we encountered in storage areas led us to question the accuracy of audit reporting with the hand hygiene audit and environmental cleanliness standards audit. These issues were raised with the matron and leadership team and we were assured immediate action would be taken to strengthen the reliability and validity of the auditing process being undertaken
- At the time of inspection critical care rehabilitation and pharmacy support did not meet the Guidelines for the Provision of Intensive Care Services (GPICS) standards 2015; The service was aware of this and had listed improving rehabilitation as a driver for their patient first programme. There were arrangements in place to minimise the impact of not having a permanently allocated pharmacist on the critical care ward.
- Patient records, we reviewed, did not have any formal assessments for dementia undertaken in the critical care unit.
- Patient flow remained a significant problem for the service. This was also an issue as it was a potential source for mixed sex breaches in the critical care unit.
- Signposting at PRH was not clearly visible or presented in dementia or visual deficit friendly colours. Additionally, there was no different colouring for different services and all indications were written in brown letters.
- The critical care directorate did not have a specific lead for mental health within the service. Additionally, we were not made aware of any senior staff members required to regularly report on aspects of patients' mental health or emotional well-being.

Critical care

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- The service improved its mandatory training compliance since the last inspection. Overall compliance rates for mandatory training where above the 90% target identified by the trust.
- Safeguarding of people at risk was given sufficient priority. Staff took a proactive approach to safeguarding and focused on early identification.
- Staffing levels and skill mix were planned, implemented and reviewed to keep people safe. This included the outreach team. We saw effective handovers and shift changes to ensure that staff could safely manage risks to people who used the service. We saw there was less reliance on agency staff to fill rotas.
- Staff could access information they needed to assess, plan and deliver care, treatment and support to people in a timely way. Records were accurate and kept up to date
- Staff managed medicines consistently and safely. Medicines were stored correctly, and disposed of safely. Staff keep accurate records of medicines. This was an improvement on the findings of our previous inspection
- Monitoring and reviewing activity enabled staff to understand risks and gave a clear, accurate and current picture of safety. We heard how improvement and safety huddles in the critical care service shared and promoted good practice regarding safety thermometer measurements. We also heard how themes and trends were being identified from incidents at trust level. This led to further staff training, changes in processes and improvements in patient safety.
- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Staff felt supported when doing so. We also saw that the service had addressed the significant backlog of incidents that had not been investigated.
- Cleanliness and hygiene audits were achieving trust targets in the last five months prior to our inspection. We also saw staff adhering to the bare below the elbow policy as well as using personal protective equipment correctly.

However:

- We found dirty and cluttered storage cupboards during inspection. The service did not have cleaning schedules in these rooms to assess when the cleaning rota was last completed and there were no records easily available. There were also no checklists to show that clinical staff made a daily check of their clinical area and conducted cleaning to the equipment in use. Once our concerns were raised the service was proactive in addressing the cleanliness issues and we saw that floors and cupboards had been cleaned and reorganised.
- We found that staff missed opportunities to comply with the hand hygiene standards. This in association with the cleaning issues we encountered in storage areas led us to question the accuracy of audit reporting with the hand hygiene audit and environmental cleanliness standards audit. These issues were raised with the matron and leadership team and we were assured immediate action would be taken to strengthen the reliability and validity of the auditing process being undertaken.

Is the service effective?

Good ↑

Critical care

Our rating of effective improved. We rated it as good because:

- We saw that people had good outcomes because they received effective care and treatment that meets their needs.
- People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.
- The service was looking at ways to improve patient care and treatment. The critical care service was actively engaged in the patient first improvement programme to maximise patient care and treatment.
- There was good monitoring of pain and patients' nutrition, and a care plan to support this.
- Information about people's care and treatment, and their outcomes, was routinely collected and monitored. The trust participated in relevant local and national clinical audits, such as ICNARC, and other monitoring activities such as reviews of services and benchmarking.
- Mortality rates were within expected limits. The risk adjusted hospital mortality ratio was 0.9 in 2016/17. This was within the expected range. Additionally, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.3 in 2016/17. This was also within the expected limits. This assured us that the intended outcomes for people using this service were being achieved.
- Staff were competent and the service provided good opportunities for learning and professional development. An example of this was the advanced critical care practitioner course and preceptorship programme. We saw evidence how staff appraisal rates had gone up to 96% in August 2018.
- There was good teamwork and communication within the multidisciplinary team. This ensured coordinated care and collaborative working to understand and meet the range and complexity of people's needs.
- Staff supported patients in actively achieving healthier lifestyles.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Deprivation of liberty was recognised and only occurred when it was in a person's best interests as a proportionate response to the risk and seriousness of harm to the person.

However:

- At the time of inspection critical care rehabilitation and pharmacy support did not meet the Guidelines for the Provision of Intensive Care Services (GPICS) standards 2015; The service was aware of this and had listed improving rehabilitation as a driver for their patient first programme. With regards to pharmacy support there were arrangements in place to minimise the impact of not having a permanently allocated pharmacist on the critical care ward.
- There was no central log identifying staff's competencies. Equipment competencies and training was recorded on a personal and individual level and recorded on individual appraisals.
- Patients with a pain score of 0 did not always have their score recorded and could not be benchmarked. This was actively being addressed by the critical care unit as part of their improvement huddle and staff were looking to address this issue by ensuring pain scores of 0 were recorded at regular intervals.
- Patient records we reviewed did not have any formal assessments for dementia undertaken in the critical care unit.

Is the service caring?

Good

Critical care

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

- Feedback from patients we spoke with was consistently positive and praised staff's care and availability. People were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive.
- Staff took time to interact with people who used the service and those close to them in a respectful and considerate way. There was a culture of empathy and humanity in the service particularly regarding their response to people's emotional needs including support for bereavement.
- Staff had a good understanding of the impact that a person's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially.
- Staff used the patient diaries to document the patients' journey through critical care and how these were used during patients' rehabilitation and recovery. We heard how the diaries supported families, friends and carers in understanding what had happened to the patient whilst in hospital.
- There was a holistic approach to care with patient and family involvement. All patients we spoke with told us they felt part of the team

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good because:

- People's needs and preferences were considered and acted on to ensure that services were delivered in a way that was convenient to them. The service had improved the provision of information for patients and visitors that did not speak English as a first language.
- A large poster board that showed all the stages of the critical care pathway had been placed at the entry of the unit. The pictures displayed could be understood by adults and children alike as well as those who did not speak English as a first language. Included in the picture were links to a wide variety of support groups and information sources. These could be directly accessed by using a smartphone to link to the QR code.
- The service had recorded zero non-clinical transfers between April 2018 and August 2018. Additionally, the service did not record any patients being readmitted to critical care within 48 hours of discharge.
- People who used the service, their family, friends and other carers felt confident that if they complained, they would be taken seriously and treated compassionately. The service had not recorded any formal complaints within the last five months prior to our inspection.

However:

- Patient flow remained a significant problem for the service. This was evidenced as the percentage of bed days occupied by patients with discharge delayed more than 8 hours was 12.0% compared to the national aggregate of 4.9%. This was also an issue as it was a potential source for mixed sex breaches in the critical care unit. The trust was actively addressing this issue.
- Signposting at PRH was not clearly visible or presented in dementia or visual deficit friendly colours. Additionally, there was no different colouring for different services and all indications were written in brown letters.
- There were no shower or private wash facilities for ward ready patients.

Critical care

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good because:

- Leaders were knowledgeable about issues and priorities for the quality and sustainability of services. They understood what the challenges were and had developed plans to address them.
- There was a clear statement of vision and values, driven by quality and sustainability. The vision and strategy were aligned to the trust's true north objective where the patient is at the heart of everything that is done. We saw that progress against delivery of the strategy and local plans was monitored and reviewed.
- Leaders were responsive to the concerns raised by the inspection team.
- Leaders modelled and encouraged compassionate, inclusive and supportive relationships among staff so that they felt respected, valued and supported. There had been a significant culture shift where staff described critical care as a more cohesive unit.
- There was a culture of collective responsibility between teams and services. There were positive relationships between staff and leaders, where conflicts were resolved quickly and constructively, and responsibility was shared. The service proactively engaged and involved all staff ensuring that the voices of all staff were heard and acted on to shape services and culture.
- The leadership team provided all staff at every level with the development they need, including high-quality appraisal and career development conversations.
- The board and other levels of governance in the organisation functioned effectively and interacted with each other appropriately.
- We heard from a variety of staff how the arrival of the new executive team and the move to a new structure, in which critical care was its own directorate in the specialist services division, had shown real benefits to the provision of critical care services at PRH.

However:

- The critical care directorate did not have a specific lead for mental health within the service. Additionally, we were not made aware of any senior staff members required to regularly report on aspects of patients' mental health or emotional well-being.
- The critical care team did not have a wide range of service level agreements with organisations that could assist with patients leaving the critical care environment.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

- The patient journey poster board at the entry of the service showed all the stages of the critical care pathway. The pictures displayed could be understood by adults and children alike as well as those who did not speak English as a first language. Included in the picture were links to a wide variety of support groups and information sources. These could be directly accessed by using a smartphone to link to the QR code.

Critical care

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Actions the trust SHOULD take to improve:

- The trust should develop stronger oversight of cleaning schedules and completion of cleaning rotas for staff and housekeeping.
- The trust should strengthen and create more robust audit processes to obtain more reliable, valid and accurate data, particularly regarding hand hygiene and environmental cleanliness standards.
- The trust should should have a centralised record of each staff's competencies and training.
- The trust should complete pain assessments for all patients even if they score 0.
- The trust should review how it screens patients for dementia in the critical care environment.
- The trust should improve signposting throughout PRH.
- The trust should continue to work with the rest of the hospital to reduce the length of time from a patient being identified as ward ready in the critical care unit to being discharged.
- The trust should continue to develop plans and policies to strengthen the provision of mental health services to patients in the critical care unit.

Maternity

Good

Key facts and figures

The trust has 73 maternity beds across two sites. The Royal Sussex County Hospital and the Princess Royal Hospital. Of these beds 40 are located within two wards at Royal Sussex County Hospital. The other 33 beds are located within two wards at Princess Royal Hospital.

Brighton and Sussex University Hospitals Trust (BSUH) provides maternity services on the Royal Sussex County Hospital (RSCH) and Princess Royal Hospital sites. This report focuses on the Princess Royal Hospital (PRH). From April 2017 to March 2018 there were 5,056 deliveries at the trust of these approximately 2,500 babies were delivered at PRH per annum. There is a community maternity service which achieves a high rate of 9.1% for home deliveries. The trust also provides antenatal services at Hove Polyclinic.

The number of deliveries at the trust has fallen slightly over the last two years (January 2016 to March 2018). In the most recent quarter of available data (January 2018 to March 2018) there were 1,218 deliveries at the trust, down from 1,349 deliveries in the same period of the previous year (January 2017 to March 2017).

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk with was available. We carried out our inspection on 25 and 26 September 2018 and reviewed all areas where maternity patients received care and treatment. These included the antenatal clinic (including the day assessment unit), antenatal, antenatal and post-natal ward, the triage service, labour ward, obstetric theatres and recovery.

We spoke with 27 staff from across the department including the obstetric consultant, the consultant anaesthetist, junior doctors, a clinical fellow, senior house officers, the maternity governance team, lead midwives, screening midwives, sonographers, a volunteer, an imaging administrator, a community matron and maternity care assistants.

We also spoke with 8 patients and relatives and reviewed five sets of maternity records. Before, during and after our inspection we reviewed the hospitals performance and quality information. This information included meetings minutes, policies and performance data.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The trust had managers at all levels with the right skills and abilities to run the service.
- The service controlled infection risk well and had suitable premises and equipment.
- Staffing levels were much improved and one to one care labour was achieved 99-100% of the time. Staff were competent with high appraisal rates and opportunities for further training were identified and supported.
- Risk was well managed within maternity and when incidents did occur they were investigated and lessons learnt were shared among the team and wider directorate. Risk was reviewed through a series of local and trust wide meetings.
- Outcomes for people who use services are positive, consistent and regularly exceeded expectations. Audit had been used effectively to show improvement and high performance was recognised by credible external bodies.

Maternity

- The department used maternity specific tools throughout the department as women's maternity needs were different to that of other patients within the hospital.
- Women were supported in a caring and compassionate way, with their dignity and privacy maintained. Staff supported women in making their own choices and accommodating these where ever possible.
- Where people's needs and choices were not being met we saw this was identified and used to inform how services were improved.
- A range of specialist midwives were available to support women. This included mental health, teenage pregnancy, homeless and substance abuse specialist midwives.
- Community teams worked cohesively with the department and a separate homebirth team worked across the trust ensuring a better than national homebirth rate.
- Discharge of patients was well managed and planned. Women undergoing caesarean section were given an estimated discharge date on arrival and recovered under an enhanced recovery protocol.
- All staff we spoke with felt supported by their line manager. Midwifery staff spoke positively about the leadership of the department and the support they were offered.
- The trust had systems for identifying risks and planning to eliminate or reduce them. There was a demonstrative commitment to best practice performance and risk management.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action. These were often developed with involvement from staff and patients.

Is the service safe?

Good

Our rating of safe improved. We rated it as good because:

- Maternity staff received effective training in safety systems, processes and practices. There was a significant improvement to compliance with mandatory training for all healthcare professionals.
- Staff could identify signs of abuse and knew how to escalate their concerns. There were effectiveness systems to protect people from abuse, neglect, harassment and breaches of their dignity and respect. The service collaborated effectively with local authorities and agencies.
- During our previous inspection, we highlighted concerns around fire safety. At this inspection, we saw all areas had up to date risk assessments and clear evacuation plans displayed. Several midwifery staff acted as fire wardens and one was allocated on every shift
- Risks to people who used the services were assessed, monitored and managed on a day to day basis. These included signs of deteriorating health, medical emergencies and challenging behaviour.
- One to one care in labour was being achieved 99-100% of the time which was much better than the previous time we inspected. Between May 2017 and April 2018, the trust reported an average vacancy rate of 4.4% for midwifery and nursing staff in maternity which was better than the trust target of 10.5%.
- The maternity service met the recommended 40 hours of obstetric consultant staffing levels as recommended by Safer Childbirth (2007). Between September 2017 and August 2018, the trust reported an average vacancy rate of 4.3% for medical staffing in maternity which was better than the trust target of 10.5%.

Maternity

- Staff had the information they needed to deliver safe care and treatment. All records contained completed risk assessments, past medical history and patient preferences. Management and treatment plans for women were clearly recorded.
- The service managed patient safety incidents well. Staff recognised incidents and reported them in line with trust policy. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service monitored safety effectively. Safety thermometer results from September 2017 to August 2018 showed 99.3% of patients across the women's and children's division received harm free care. This was better than the trust average of 95%.

However:

- Hand hygiene audits were not consistently completed by all departments which provided limited assurance of compliance to good hand hygiene.
- The service had stopped using 'I am clean' stickers which identified equipment that was clean and safe to use. This meant there was a risk equipment might be used without being cleaned.
- Not all staff were bare below the elbows. This meant staff did not have access to the wrist for good hand washing and so reduce the spread of germs.
- Staff did not always complete the daily equipment checklist. This meant the ward did not have assurances that the equipment was calibrated, if applicable, and its contents safe to use
- Not all records were comprehensive and accurate. We found inconsistencies between the midwifery and medical documentation and insufficient documentation to describe the events in theatre.
- Room temperature checks were not always completed or actions documented when the temperature was outside of the normal range. Staff did not have assurance medicines stored in these rooms were safe to use.
- Although compliance to mental capacity act training was similar to the trust target for nursing staff, only 53% of medical staff had completed mental capacity act training. This is significantly lower than the trust target of 90%.

Is the service effective?

Outstanding ☆ ↑

Our rating of effective improved. We rated it as outstanding because:

- Maternity services holistically assessed and consistently delivered treatment in line with legalisation, standards and evidence based guidance. There were systems to monitor the effectiveness of care and treatment and the service used the findings to make improvements. They compared local results with those of other services to learn from them.
- Women received support to breastfeed after birth and this continued on the post-natal ward. Breastfeeding initiation was consistently above the trust target of 85% with figures averaging 87%.
- The department had been recently identified as an outlier for third and fourth degree tears. These tears are referred to as Obstetric Anal Sphincter Injuries (OASI). The department had undertaken a piece of work called the 'ORB', which

stands for OASI reduction at BSUH. The project encompassed research and evidence from other trusts and focused on position, guidance, protection and pace of delivery. Since the introduction of the project the rates of OASI had reduced significantly with rates of 2.3%. This is much better than the previous high of 7.7% and was also better than the trust target of 5%.

- The department had an awareness that maternity specific tools were needed throughout the department as women's maternity needs were different to that of other patients within the hospital. For example, the maternity department had a separate sepsis screening tool that was completed and placed in all women's notes. This had maternity specific questions such as if a woman may be suffering with mastitis (infection of the milk ducts).
- The maternity department was involved with the trusts 'Learning from Deaths Programme'. The trust appointed the chief medical officer and a non-executive director to oversee any learning from deaths across the trust. The deputy medical director for safety and quality presented to the Grand Round about learning from deaths, this included case presentations on neonatology mortality. For neonatal mortality BSUH was the 6th best level three unit (with surgery) out of 26 in the country.
- The trust was taking part in the Maternal and Neo-Natal Health Safety Collaborative. This was a national initiative to reduce the rates of maternal deaths, stillbirths and brain injury. The introduction to this scheme was attended by the matron, obstetric lead and labour ward leads. The obstetric consultant at the trust was the lead for the county on this initiative. This showed a commitment to achieve better rates of intrauterine foetal death and stillbirth.
- The trust took part in the 2017 Maternal, Newborn and Infant Clinical Outcome Review Programme audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 5.72. The trust's performance for this audit was much better than the national comparator group. It showed the trust was more than 10% lower than the average for the comparator group rate of 6.71.
- Staff had the correct skills, knowledge and experience to deliver effective care, support and treatment. There were comprehensive training and education opportunities available to staff. For example, staff had been involved in developing regional teaching for nursery nurses and extended training in advanced neo-natal life support.
- From May 2017 to May 2018, 81.2% of staff within maternity at the trust received an appraisal compared to a trust target of 78%.
- Staff, teams and services within maternity services worked together to deliver effective care and treatment. Staff worked across health care disciplines and with other agencies when caring for women with mental health or safeguarding needs.
- Consultant and midwife support was available 24 hours a day, seven days a week at the hospital. The community midwife team also ran a homebirth team, 24 hours a day, seven days a week.

Is the service caring?

Good

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

- Staff took the time to interact with women and their families in a respectful and considerate way. Staff understood and always respected the privacy and dignity needs of women in their care.
- Staff responded in a compassionate, timely and appropriate way when women experienced physical pain, discomfort or emotional distress.
- Staff introduced themselves and made women and their families aware of their role and responsibilities.

- Staff displayed understanding and a non-judgemental attitude when talking about women who had mental health needs.
- The eight patients we talked with were all very complimentary about the care and attention they had received.
- The trust's maternity friends and family test performance for antenatal, labour and postnatal wards was generally similar to the England average between June 2017 and June 2018.
- In 2018, all midwives received mandatory bereavement education and attended specialist training provided by a stillbirth and neonatal death charity. This training covered supportive listening skills, breaking bad news and creating memories. This meant staff were able to provide women and their families with appropriate emotional support and information following a bereavement.
- Maternity staff provided advice and explanations tailored to women' needs about the benefits and risks of each location for birth without bias. Women we spoke with said midwifery staff involved them in decision making and women felt they had made an informed decision about their birthing plans.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good because:

- The service provided women with personalised care that was responsive to their needs.
- Information leaflets were available throughout the maternity unit and on the trust's website which were available in a variety of languages upon request. There were virtual tours available on the trust website of the maternity facilities at PRH to help women prepare for their arrival.
- Where people's needs and choices were not being met we saw this was identified and used to inform how services were improved. An example of this was the development of a transgender and non-binary protocol.
- The service took account of patients' individual needs. Reasonable adjustments were made and action taken to remove barriers when people find it hard to use or access services.
- Women with specific needs or care needs due to physical disabilities or wheelchair access were referred by their community midwife to the labour ward leads who met with the woman. They discussed the women's needs and developed a plan to best support the women.
- Women had access to a perinatal mental health clinic which provided advice, assessment and treatment for women with a past or current history of severe mental illness.
- There was a system in place to signal to healthcare professional that a parent had experienced a bereavement. Staff told us they placed a pink tear sticker at the front of patient records to signal to healthcare professionals that a woman has experienced a bereavement.
- Women could access care and treatment in a timely way. Women had access 24 hours, seven days a week to a triage phone line for advice. The triage system for all women went through a dedicated triage midwife on the labour ward.
- Midwives managed women's expectations at initial booking. Women were told that the maternity service was a one hospital trust which provided maternity care over two sites.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

However:

- The services provided did not always reflect the needs of the population served. The maternity unit was consultant led, the hospital did not have a midwife led birth unit. This restricted choice over place of birth for low risk women planning a normal birth in their local area.

Is the service well-led?

Good ➔➔

Our rating of well-led stayed the same. We rated it as good because:

- The trust had managers at all levels with the right skills and abilities to run the service.
- Staff reported a big difference in the leadership of the maternity unit. They reported an open culture and felt able to escalate concerns as leaders operated an open-door policy and were visible.
- The department had direct access to the trust board every month through the divisional governance board meeting. This allowed information to be fed up to the board and back to the frontline staff.
- The division had a clear vision and a credible strategy to deliver high quality sustainable care. It had robust plans to help achieve and deliver this. The division was working with the trust to contribute to a revised BSUH clinical strategy.
- Staff felt more connected, more involved in decision making and able to raise concerns without fear of reprisal.
- The service had met the 10 strict national safety criteria including clear and effective plans for staffing levels, training, and ensuring that patients had effective ways to give feedback.
- All staff we spoke with knew about risk and governance issues and were fully engaged in receiving this feedback.
- The trust had systems for identifying risks and plans to eliminate or reduce them. There was a commitment to best practice performance and risk management.
- The service held mortality and morbidity meetings monthly which was not previously occurring at our last inspection.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

However:

- Not all members of staff could name the head of midwifery, although they reported an open culture and felt able to escalate concerns.
- Although midwives had good working relationships with the consultants, some staff told us there were historic issues between midwives and middle grade doctors. There was on going actions to address these issues including a meeting between midwives and middle grade doctors.
- The IT systems used in maternity were not effective at collecting data efficiently.
- Patients confidentiality was not always protected and there was a risk unauthorised people could gain access to confidential information.

Maternity

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

- Outcomes for people who use services are positive, consistent and regularly exceed expectations. The recent OASI Reductionproject had made an immediate impact on reduced third and fourth degree tears.
- The trust's performance for the Maternal, Newborn and Infant Clinical Outcome Review Programme audit was much better than the national comparator group. It showed the trust was more than 10% lower than the average for the comparator group rate of 6.71.
- In July 2018 the trust was recognised as one of the top performing hospitals in the UK for helping diabetes patients control their glucose levels. The trust offered a diabetic clinic for women identified as at risk of gestational diabetes. Mothers had dedicated diabetes notes and a new diabetes protocol which aimed to reduce inductions of labour for women with gestational diabetes. In the two years since this was first developed there have been no diabetes birth defects experienced by mothers.
- Staff were consistent and proactive in supporting people to live healthier lives. There was a focus on early identification and prevention and on supporting people to improve their health and wellbeing.
- A women centred World Health Organisation checklist had been developed in obstetric theatres. The aim was to make the woman the centre of the checklist by making sure all staff introduced themselves by name and designation to the woman and her partner. Alongside this the maternity staff were in the process of filming in a simulation setting from the woman's perspective. They planned to use this both internally for training but also to promote best practice externally too.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Actions the trust SHOULD take to improve:

- The trust should ensure hand hygiene audits are consistently completed.
- The trust should ensure all staff adhere to bare below the elbows.
- The trust should ensure daily equipment checklists are completed.
- The trust should ensure room and fridge temperatures are recorded accurately and action is taken when the readings are outside of expected range.
- The trust should have processes in place to review the quality and accuracy of patient records.
- The trust should ensure patient confidentiality is always protected.

Outpatients

Requires improvement

Key facts and figures

The outpatient department at the Princess Royal Hospital is part of the Brighton and Sussex University Hospitals Trust.

Between May 2017 and April 2018 there were 192,492 appointments at the Princess Royal Hospital, which equated to 20% of the overall appointments across the trust during the same period.

Outpatient services at the Princess Royal Hospital are located throughout the site, with the main outpatient clinics and physiotherapy and occupational therapy located on the ground floor, and the neurology outpatients building which was behind the main hospital building.

As part of our announced inspection we visited the main outpatients' department; neurology outpatients; physiotherapy; the fracture clinic; phlebotomy (taking blood for testing) and the outpatients pharmacy.

The hospital provides outpatient services covering a range of specialities including but not limited to: medicine, cardiology, neurology, rheumatology, diabetes, respiratory and dental.

The service provided both consultant and nurse led outpatient clinics across a range of specialities. Outpatient clinics were held between 08:30am and 5:30pm with some additional ad-hoc clinics on a Saturday dependent on speciality.

During our inspection we spoke with ten patients and their relatives. We spoke with 21 members of staff including nurses, health care assistants, therapists, phlebotomists and managers. We reviewed eight patient records. We reviewed performance information about the department and the trust.

The service was previously inspected in 2017. That inspection also included diagnostic imaging services. Diagnostic imaging services are now inspected separately and have a separate report and therefore we cannot directly compare ratings. During this inspection, we only looked at services provided within outpatients.

The last inspection rated the service as requires improvement overall. On this inspection we maintained this rating, however the rating for safe improved from requires improvement to good.

Summary of this service

Our rating of this service stayed the same, although we saw that improvement had been made. We rated it as requires improvement because:

- The service did not always share feedback from patient safety incidents. We did not see evidence of incidents being discussed in team meeting minutes. There were daily staff huddles but these did not have incidents as a set part of the agenda.
- Patients could not always access the service when they needed it. Overall waiting times from referral to treatment and for those patients referred on a 62-day cancer pathway were worse than the national average.
- The service did not always take account of people's individual needs. The patient led assessment of the care environment audits for dementia and disability scored significantly worse than the national average across four outpatients areas that were assessed. The trust wide dementia strategy did not have any outpatient related actions.
- The service did not collect, analyse and action data to improve waiting times. Waiting times for individual clinics were not recorded or collected by the services.

Outpatients

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results. However, trust wide not all complaints were responded to within the timeframe set in the trust guidelines.
- The service leads could describe a vision for what it wanted to achieve with clear priorities for delivering good quality and sustainable care. However, this was in a draft format that we were not able to view, and was not developed with involvement from key staff. Staff we spoke to in outpatients had no knowledge of, or involvement in developing these goals.
- There was a plan to implement systems and processes to ensure the governance of the department, but these were not embedded. There was no evidence that governance issues such as incidents were discussed at local level or fed into the overarching divisional or trust governance meetings.
- The service had managers with the right skills and abilities to run a service providing high quality, sustainable care, however there were key vacancies at the time of our inspection which left some staff without formal line management or face to face supervision. Visibility of the service senior leadership team was poor.

However:

- The service provided mandatory training to all staff and made sure everyone completed it. We saw a significant improvement in training compliance since our previous inspection, with training compliance better than the trust target.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. All areas we visited appeared visibly clean and cleaning audits were consistently at a high standard.
- The service responded appropriately when things went wrong. Staff apologised and gave patients honest information and suitable support.
- Staff cared for patients with compassion. Feedback from patients via the Friends and Family Test and from patients we spoke with at our inspection was positive regarding the care they received from staff.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients confirmed that they felt involved in decision-making and medical and nursing staff shared enough information to support this.
- Patients referred on two-week wait and 31-day cancer pathways could access the service when they needed it. The trust was performing better than the national average in these areas.
- A change in the structure of the service enabled better oversight of staff and management of key performance indicators. Since our previous inspection where outpatient services were within the head and neck directorate, a divisional restructuring had taken place across the trust. Since April 2018 general outpatients and central administration services had operated within the central clinical services division.
- The service demonstrated a commitment to improvement and innovation. There had been a significant improvement in the friends and family response rates and the successful roll out of the e-referral system.

Is the service safe?

Good

Our rating of safe improved. We rated it as good because:

- Staff recognised incidents and serious incidents and reported them in line with the trust policy. When things went wrong, staff apologised and gave patients honest information and suitable support. Root cause analysis reports were completed to identify areas for improvement.

Outpatients

- The main outpatient areas and the neurology (treatment of the nerves and nervous system) outpatient area had suitable premises to provide the service.
- The service had enough staff with the right skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. Cleanliness of the environment audits consistently met or were better than the trust compliance target and patients we spoke with told us the hospital felt clean. This had improved from the previous inspection.
- Patient records were stored securely and ensured patient confidentiality was maintained. This had improved since our last inspection where patient notes were sometimes left unattended. At this inspection we saw that all notes were in locked cupboards or trolleys that were secured to walls.
- Outpatient staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and we saw that all members of the outpatient team within the Central Clinical Services division had received this training which had improved since the previous inspection.
- The service provided mandatory training and key skills to all staff and made sure everyone completed it. This had improved since our last inspection and the rate of training compliance across outpatient staff was better than the trust target.
- The service had systems which promoted patient safety and we saw staff following these. Daily huddles were held where safety issues such as staffing, premises and patient care were discussed. Where patients had minor procedures such as dental extractions, World Health Organisation surgical safety checklists were completed to ensure risks to were minimised.

However:

- Learning from incidents was still not embedded within the service. At our last inspection we found that learning from incidents was not discussed at team meetings. This had not improved at this inspection and we saw no evidence that incidents were discussed at team meetings.
- The service did not monitor or audit the quality of patient records. During our previous inspection, records audits indicated that the quality of patient records had decreased. Since then, no further audits had been completed which meant that the service could not be assured of the quality of the records.
- The phlebotomy environment was crowded and the storage area was accessible to patients and visitors. We raised this with the trust at the time of our inspection and following the inspection, the trust had drafted a risk for addition onto the divisional risk register.
- It was not clear whether third party provider staff working for the trust understood how to protect patients from abuse. The phlebotomy service was provided by a third-party company who treated both adults and children. Whilst they were trained to level two safeguarding children, they were not aware of the process to follow when a parent did not bring their child to a phlebotomy appointment.
- Medicines were not always managed in line with national guidance. An audit had identified that the medicines cupboard keys were not always held by a registered professional and we observed this to be the case on our inspection.
- Not all equipment was looked after well. We were shown an audit where over 100 electrical items were overdue their electrical safety testing date. The trust was aware of the backlog and this was on the risk register.

Outpatients

Is the service effective?

Not sufficient evidence to rate

We do not rate outpatients service for effective. Our findings are as follows:

- The service provided care and treatment based on national guidance. There were policies and procedures in place that staff knew how to access. All policies and procedures were kept electronically and all staff had access to these.
- The service made sure staff were competent for their roles. Staff that were new to the department had an appropriate induction and trust wide the compliance for outpatient staff completing an appraisal in the last 12 months was better than the trust target.
- Staff of different kinds worked together to benefit the patient. Multidisciplinary meetings were held in various specialities including cancer, to ensure a holistic view of the patient's needs were taken into account.
- Staff gave patients enough food and drink, where appropriate, to meet their needs whilst in the outpatient department.
- The service ensured that consent was taken from patients in line with the trust policy. We reviewed patient records and saw that consent forms were signed and dated by both the consultant and patient and risks of the procedures were documented as part of this process.
- Staff understood their roles and responsibilities regarding the Mental Capacity Act 2005 and received training on this as part of their safeguarding level two training.

However:

- Although there was a trust wide programme for providing training to staff regarding the Mental Health Act 1983, no staff in outpatients had received Mental Health Act training. However, staff told us that they knew how to escalate issues

Is the service caring?

Good ➔➔

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

- Staff cared for patients with compassion. We observed staff interacting with patients in a kind and caring manner. Feedback from patients we spoke with on inspection told us that the care was "excellent" and that staff were "pleasant and helpful".
- The Friends and Family Test results for patients had a consistently high recommend rate and the response rate had improved over the last six months. Between February and June 2018, the rate was similar to or better than the national average recommend score.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients confirmed that they felt involved in decision-making and medical and nursing staff shared enough information to support their decision-making.

However:

Outpatients

- The patient led assessment of the care environment result for dignity, scored significantly worse than the national average in two of the outpatient areas assessed.

Is the service responsive?

Requires improvement

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Patients could not always access the service when they needed it. Overall waiting times from referral to treatment were worse than the national average.
- Patients referred on a cancer pathway were not always treated within 62 days of referral from their GP. The trust was performing worse than the England average in this area.
- The service did not always take account of people's individual needs. The patient led assessment of the care environment audits for dementia and disability scored significantly worse than the national average across four outpatients areas that were assessed. The trust wide dementia strategy did not have any outpatient related actions.
- Department waiting times for individual clinics were not recorded or collected by the services. This meant that the service did not have oversight of patient waiting times within the department.
- Clinics were sometimes cancelled with less than six-weeks' notice. This was not in line with the trust's Patient Access Policy and the amount of cancellations had increased since our last inspection.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results. However, trust wide, not all complaints were responded to within the timeframe set in the trust guidelines.

However:

- Patients referred on a two week wait pathway for suspected cancer could expect to see a specialist within two weeks of referral from their GP and the trust was performing better than the England average in this area.
- Once a decision to treat had been made for a patient with a cancer diagnosis, they could expect to be treated within the operational standard of 31 days, and the trust was performing better than the England average in this area.
- The service took account of patients' individual needs. The main outpatient departments were signposted, and volunteers were situated in the main hospital entrance and offered patients assistant to find a clinic if required.
- The service received more compliments than complaints over the previous 12 months.

Is the service well-led?

Requires improvement

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Whilst the service had managers with the right skills and abilities to run a service providing high-quality and sustainable care, there were key vacancies in the division, and the management structure had not yet been embedded, nor was it known or understood to all staff. Staff did not feel that the divisional leadership team were visible on this site, and some had never met face to face.

Outpatients

- There was a new governance structure in place across the trust which indicated that governance fed from the departments up through the divisions and to board level. However, there were no discussions of governance at the team meetings within the outpatient department, which meant that governance issues may be missed at a divisional and senior level.
- The service had a vision for what it wanted to achieve. A new clinical strategy had been created since our last inspection and we were told that this had involved in depth discussions with divisions and services and had been aligned to the trust strategic objectives. However, we were unable to see the strategy due to it not being approved or ratified, and staff we spoke with had not been involved or engaged with this process.
- There were improvement projects being run within the department, however key staff from the departments were not included as part of this.
- Action plans were not in place following poor performance in three areas of the Patient Led Assessment of the Care Environment audits and no evidence to suggest the service was going to make any changes in response to the audits.

However:

- Since our last inspection, the central administrative service and outpatients had been merged as a standalone directorate. This meant that the majority of outpatient services were under one directorate, which would enable better oversight and management of key performance figures such as mandatory training.
- Staff felt well supported at a local level by the department manager and individual line managers.
- The culture of the staff in the department was positive and open. Staff put patients at the centre of their work.
- The service demonstrated a commitment to improvement and innovation. There had been a significant improvement in the friends and family response rates and the successful roll out of the e-referral system.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Actions the trust SHOULD take to improve:

- The trust should ensure that patient records are audited for quality.
- The trust should ensure that only registered nurses carry medicines keys.
- The trust should ensure that the waiting area and environment in phlebotomy is safe for staff and patients using it.
- The trust should ensure that staff in outpatients receive training in the Mental Health Act.
- The trust should ensure that outpatient services are included as part of the dementia strategy.
- The trust should ensure that action plans are put in place and monitored following poor performance in three areas of the Patient Led Assessments of the Care Environment scores.
- The trust should continue to develop the leadership and governance functions of outpatients. Staff should be appropriately involved in all areas of performance. Performance monitoring activities undertaken by staff should be meaningful and focused on improving performance.

Royal Sussex County Hospital

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Key facts and figures

The trust provides district general hospital services to the local populations in and around the City of Brighton and Hove, Mid-Sussex and the western part of East Sussex. The trust primarily serves a population of over 539,500 people. They also provide more specialised and tertiary services for patients across Sussex and the south-east of England. Across the trust there are 830 general and acute beds, 80 critical care beds and 72 maternity beds. The Royal Sussex County Hospital provides 565 of these beds.

The Royal Sussex County Hospital provides acute services for the local population. The specialised and tertiary services provided include: neurosciences, neonatal, paediatrics, cardiac, cancer, renal, infectious diseases and HIV medicine. The hospital is also the major trauma centre for the region.

The hospital provides urgent and emergency care services 24 hours a day, seven days a week. The Royal Sussex County Hospital has a type one emergency department which is the regional major trauma centre and is co-located with an urgent care centre for patients with minor illnesses and minor injuries. Emergency services for children are provided at the Royal Alexandra Children's Hospital and the Sussex Eye Hospital provides an eye casualty service.

The Royal Sussex County Hospital site is currently undergoing a major redevelopment. Major building works are in progress as part of the "3Ts" (trauma, teaching and tertiary care) programme.

We visited the Royal Sussex County Hospital as part of a planned, comprehensive inspection of Brighton and Sussex University Hospitals NHS Trust on 25 and 26 September 2018. During our visit, we spoke with over 268 members of staff and over 66 patients at the Royal Sussex County Hospital site. We reviewed over 64 sets of patients' records and a variety of policies and performance data.

Summary of services at Royal Sussex County Hospital

Good ↑

- Our rating of this service improved. We rated it as good because:
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.

Summary of findings

- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to monitor and prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well. Staff carried out risk management strategies in unsuitable premises and kept patients safe. The service had systems to provide assurance that information relating to Control of Substances Hazardous to Health (COSHH) was available, complete and accurate, and staff understood it.
- The service gave, recorded and stored medicines safely. Patients received the right medication at the right dose at the right time.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- Staff understood how to protect patients from abuse and the service worked well with other organisations to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- We found staff responded well to the deteriorating patient and there was effective sepsis management.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff carried out comprehensive assessments to meet people's needs and improve their health. This included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. They used special feeding and hydration techniques when required. They adjusted to patients' religious, cultural and other preferences.
- Staff of different professions worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Outcomes for patients were good. The service performed well in audits such as the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade A in the latest audit, August 2017 to November 2017.
- The service made sure staff were competent for their roles. Staff had the right qualifications and skills to carry out their roles effectively and in line with best practice. Staff received timely supervision and appraisals of their work performance and they had access to learning and development, including mandatory training.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to information they need to assess, plan and deliver care to people in a timely way. When there are different systems to hold or manage care records, these were coordinated.
- Staff in most areas we inspected understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Staff understood and monitored the use of restraint and used less restrictive options where possible.
- The service had a strong, visible person-centred culture. Despite staff and financial challenges, staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who use the service, those close to them and staff were strong, caring and supportive. These relationships were highly valued by staff and promoted by leaders.

Summary of findings

- We saw staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Feedback from people who use the service, those who are close to them and stakeholders was continually positive about the way staff treat people. People described that staff "go the extra mile" and the care they received exceeds their expectations.
- Staff provided emotional support to patients to minimise their distress. Staff were aware of the impact on patients and carers of the care and treatment they provided.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients were satisfied with the information they had been given and was explained in a way they could understand.
- Staff highly valued people's emotional and social needs and we saw these were not only embedded in their care and treatment, but they went over and beyond to innovate the "Small Acts of Friendship" programme to help elderly patients retain dignity, social activity, mobility and well-being whilst in hospital.
- The service planned and provided services in a way that met the needs of local people. We saw flexibility, choice and continuity of care were reflected in the services.
- The service had done everything within their remit to improve access and flow. Initiatives such as discharging patients before midday, regular and effective monitoring and managing of medical outliers and the service had recruited a new manager to help with the flow. The service also monitored delayed transfers of care and worked with system partners to improve the position. Capacity to deal with the demand could be fully realised once the trust's 3Ts project is completed.
- Staff provided coordinated care and treatment with other services and other providers.
- The service took account of patients' individual needs. Staff accounted the needs of different people when planning and delivering services. For example, on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation.
- Staff made reasonable adjustments and removed barriers when people find it hard to use or access services.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. It was easy for people to complain or raise a concern and they were treated compassionately when they did so. There was openness and transparency in how complaints were dealt with. Complaints and concerns were always taken seriously, listened to and responded to in a timely way. The service made improvements to the quality of care as a result of complaints and concerns.
- The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. The leadership structure was clear and staff knew their reporting lines and responsibilities.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action with involvement from staff and patients. Staff could clearly explain what the vision was and were actively engaged in training for the strategic patient first approach to working. Staff could clearly explain why they thought this was a positive initiative to improve patient care.
- The trust used a systemic approach to continually improve the quality of its services and safeguarding its standards of care by creating an environment in which clinical care would flourish.
- The culture was significantly different to previous inspections. Staff displayed a 'can do' attitude to any challenges they faced. All disciplines of staff had a shared focus and purpose to ensuring patients received the best possible care and experience. Staff morale was good, and staff were positive about the overall leadership of the trust.

Summary of findings

- We saw good local ward and department leadership. Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff we spoke with described they were valued and how they felt there was a culture of collective responsibility between teams and services.
- Staff were engaged, supported and felt valued by senior staff. There was a supportive culture of learning and education and staff told us that this was a real focus and they felt invested in.
- The service engaged with patients, staff, the public and local organisations to plan and manage appropriate services.
- Staff understood candour, openness, honesty and transparency and challenged poor practice. The service had mechanisms to support staff and promote their positive wellbeing. Behaviour and performance inconsistent with the values were identified and dealt with swiftly and effectively, regardless of seniority.
- The service had an effective process to identify, understand, monitor and address current and future risks. They escalated performance issues to the relevant committees and the board through clear structures and processes. We saw clinical and internal audit processes functioned well and had a positive impact on quality governance, with clear evidence of action to resolve concerns.
- The trust managed financial pressures so that they did not compromise the quality of care.

However:

- Patients could not always access services when they needed them. Data provided to us by the trust showed there was 902 black breaches as Royal Sussex County hospital between September 2017 and August 2018. A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. The trust accounted the black breaches to challenges with hospital capacity and flow.
- The percentage of patients in the emergency department waiting between four and 12 hours from the decision to admit until being admitted was worse than the national average.
- Patients referred on a cancer pathway were not always treated within 62 days of referral from their GP. The trust was performing worse than the England average in this area.
- The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 64.6%, which did not meet the aspirational audit standard of 90%. The figure had improved since 2016 when it was 60.0% and we saw the trust had an action plan to address this issue. The trust worked with another NHS provider to roll out a streamlined rapid access pathway for new referrals in late 2018/early 2019. The pathway was compliant with National Optimal Lung Pathway.
- Surgical patients sometimes stayed longer than their required recovery time in theatre due to a lack of bed availability in critical care and ward areas.
- In outpatients, critical care and surgical wards and theatres, there were some pieces of equipment that had not been serviced in line with schedule. Fire risk assessment in wards level 8a East and 8a West had identified actions and on both wards, these actions were only partially complete.
- In the surgery core service, there was some inconsistency in recording why medications were not administered. Out of eight charts checked, four showed no documentation of reasons for not administering drugs by using the suggested code, which meant a lack of information when reviewing treatment.
- The trust did not comply with all elements of Guidelines for the Provision of Intensive Care Services, 2015. Coverage from the critical care outreach team was not provided 24 hours a day, seven day a week and there was not a critical care pharmacist.

Summary of findings

- No staff in outpatients had received training in the Mental Health Act 1983.
- The patient led assessment of the care environment audits for dementia and disability scored significantly worse than the national average across four outpatients areas that were assessed. The trust wide dementia strategy did not have any outpatient related actions.
- The leadership and governance structures did not provide consistent and visible support to staff working in outpatients, although arrangements were in place to appoint to key management vacancies and address this moving forward.

Urgent and emergency services

Good ↑

Key facts and figures

Brighton and Sussex University Hospitals is an acute teaching hospital working across two main sites, the Royal Sussex County Hospital in Brighton and the Princess Royal Hospital in Haywards Heath. The Brighton campus includes the Royal Alexandra Children's hospital and the Sussex Eye Hospital and is also the Major Trauma Centre for the region. The Sussex Eye Hospital has a self-contained emergency department. We did not inspect the emergency services at the Royal Alexandra Children's Hospital on this occasion.

The trust provides district general hospital services to the local populations in and around the Brighton and Hove, Mid Sussex and the western part of East Sussex and more specialised and tertiary services for patients across Sussex and the south east of England.

Both hospitals provide many of the same acute services for the local populations. The Royal Sussex County hospital is the centre for emergency and tertiary care. Children are treated at the Royal Alexandra Children's hospital, occasionally a child is cared for in the adult resuscitation area whilst waiting a transfer to a specialist hospital.

The emergency department at Royal Sussex County hospital sees approximately 86,000 patients each year.

Urgent and emergency care services at the Royal Sussex County Hospital consists of four main areas:

- Clinical decisions unit
- Emergency department
- Urgent care centre
- Short stay ward

The emergency department is part of the Medicine Division and is within the Acute Floor Directorate.

The emergency department has a five-bedded resuscitation suite; two majors areas consisting of 20 majors cubicles, three side rooms, two assessment cubicles, a dedicated minor injury area with 12 cubicles, a six-bedded bay with one side room in the clinical decisions unit and six beds and two chairs in the short stay ward. There is an emergency nurse practitioner and GP service for minor injuries. There are also four rapid assessment cubicles and two triage bays located near the ambulance entrance. The GP service is run by a different healthcare provider seven days a week between 7am and 10pm. The emergency department works closely with the ambulatory department, and patients who do not require urgent care are referred to the ambulatory care department.

Summary of this service

Our rating of this service improved. This reflects the improvements made to patient safety, education and development of staff, improved medical and nursing leadership and oversight of risk. Positive changes were a result of the trust wide Patient First Improvement System, an empowered and engaged workforce, quality management, maintaining the dignity and respect of patients and a change in culture.

We rated it as good because:

- Staff worked in a culture that empowered them to report incidents. Learning from incidents had improved since our last inspection.

Urgent and emergency services

- Staff confirmed they received feedback and learning from incidents was shared. The service managed patient safety incidents well. Staff knew what they would need to report and how to do it.
- The service was delivered by staff that were competent, trained and supported by their managers, and in sufficient numbers, to provide safe and effective care.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Mandatory training and appraisal compliance amongst the nursing staff had improved since our last inspection.
- Staff kept themselves, equipment and the premises clean. They used control measures available to prevent the spread of infection.
- Equipment, including emergency equipment was in working order and was checked daily to ensure it was available. Records we reviewed confirmed this. This was an improvement since our last inspection when records were incomplete.
- The room used for assessing patients with mental health needs was compliant with the Psychiatric Liaison Accreditation Network standard. The room had been refurbished since our last inspection to ensure it was compliant with the standard.
- Substances subject to Control of Substances Hazardous to Health Regulations 2002 were stored securely and staff knew where to find safety information regarding these products.
- Staff had embedded and strengthened the systems and processes relating to the management of deteriorating patients since our last inspection.
- Medical staffing provided 24-hour consultant cover, this met the Royal College of Emergency Medicine guidelines.
- The majority of records we reviewed were clear, up-to-date and available to all staff providing care. Patient records were kept securely and confidentially. This was an improvement since our last inspection
- Monitoring of fridge and room temperature readings where medicines were being stored were carried out regularly in line with trust policy. This was an improvement since our last inspection when we found an inconsistent approach to medicine fridge temperature checks.
- The services provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- There was good evidence of multi-disciplinary team work to make sure patients were transferred or discharged to the appropriate location at the right time and with the correct support and involvement of carers and relatives. The mental health liaison team facilitated communication with the community mental health teams and home-based treatment team, enabling people to be discharged from hospital with more intensive mental health support.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. We saw staff reassuring patients who were anxious or upset, with specialist support available if this was needed.
- The divisional and service level leadership, culture and overall governance structure had the capacity, capability and integrity to ensure that the challenges could be resolved and risks to performance addressed.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

Urgent and emergency services

- There was a consistent quality of care given to all patients who attended the department regardless of their health needs.
- In the main, patients received treatment within one hour of arrival in line with the best practice guidance.

However:

- Due to limited space within the department, the risk of infection was not always controlled well during busy periods. We observed that during busy periods, patients were on trolleys next to each other in the 'cohort area' which did not minimise the risk of the spread of infection. This was consistent with our last inspection, however, we observed it happening less frequently during this inspection.
- Patient's privacy and dignity was not respected whilst in the 'the cohort area.' Mixed sex patients were cared for there with only a privacy screen separating them.
- The number of black breaches remained a concern as patients were delayed in receiving their treatment. Data provided to us by the trust showed there was 902 black breaches as Royal Sussex County hospital between September 2017 and August 2018. A "black breach" occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. The trust accounted the black breaches to challenges with hospital capacity and flow.
- The service was closely monitoring reasons for black breaches and performance was reviewed weekly and discussed at daily huddles. The service was using Patient First Improvement System to address challenges surrounding delays in handovers, triage and assessment of patients. Delays in ambulance handovers was identified as a key driver in the Patient First Improvement System. Each delay was reviewed and discussed at daily huddles. The service had plans on how to address the delays for example, having a senior nurse where the ambulances arrive who could receive handover make an initial assessment and direct the patient to the most appropriate location. A training programme to ensure the nurses had the correct skills and knowledge to undertake this was being developed.
- Mandatory training compliance amongst doctors was 77% which was below the trust target. Only 81% of doctors had completed Safeguarding Adults at Risk training and 81% had completed level 3 Safeguarding Children and Young People training.
- Compliance with advanced life and trauma training amongst nurses was low. Sixty-seven percent of eligible staff had up to date training which was worse than the trust target, this was due to funding of the courses However, the service had an effective plan in place to ensure all nurses had undertaken advanced life and trauma training.
- The department took part in national audits to compare treatment results with other hospitals. However, their data was combined with that of the Princess Royal Hospital and so it was not possible to be specific about the effectiveness of treatment at the Royal Sussex County hospital. The service had addressed this issue and we saw ongoing audits and planned audits were separated by hospital site.
- Intravenous (into a vein) fluids were not prescribed in line with trust policy. The prescription prostration for the intravenous fluid did not include a time frame for it to be given. Giving intravenous fluids either too quickly or too slowly could have an adverse effect on the patient.
- Patients may not have been aware of their right to have a chaperone when being examined as there were no posters advising patients of this.
- The trust strategy remained confused. The strategy the leaders described to us did not match the trust strategy.

Urgent and emergency services

- Data provided to us showed there was regular delays in assessing the risk for patients who brought themselves to the emergency department. The median time patients waited for assessment at Royal Sussex County hospital was longer than best practice. However, all patients were streamed by an experienced nurse and were directed either to the emergency department or the emergency ambulatory care unit. Streaming is the process of allocation of patients to the most appropriate physical areas of a hospital, and the most appropriate clinical pathways.
- If a self-presenting patient booked in at reception with a serious condition such as chest pain, reception staff escalated this immediately to the streaming nurse.
- The service did not have an effective process which ensured medicines were checked to ensure they were still in date. We checked 20 different medicines and found four were past the expiry date.
- The percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was worse than the national average.

Is the service safe?

Good

Our rating of safe improved.

This reflects the significant improvements made to ensure patient safety, appropriate management of patient risk, medical staffing and nurse staffing levels.

We rated it as good because:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.
- The service had not reported any never events in the last twelve months and only one serious incident, (a patient fall resulting in harm) other than 12-hour wait breaches.
- Substances subject to Control of Substances Hazardous to Health Regulations 2002 were stored securely and staff knew where to find safety information regarding these products. An inspection undertaken in October 2017 specifically in relation to these regulations had identified issues in the management and storage of products. At this inspection we saw the trust had taken effective action to address these concerns. For example, all cleaning cupboards had swipe card access so only authorised staff could access these areas.
- The department had effective processes for managing fire risk assessments. We saw the department had six actions following the last fire risk assessment, all of which had been completed.
- The department had changed the triage process of patients since our last inspection. Streaming is the process of allocation of patients to the most appropriate physical areas of a hospital, and the most appropriate clinical pathways. The service had changed to a new model which was based on national guidance. This model was based on streaming and priority assessment and treatment of patients. Priority assessment and treatment involves a senior doctor seeing and assessing patients as soon as possible after their arrival. The purpose of the model is to quickly determine the most appropriate place for a patient who walks through the front door of an urgent and emergency care department.
- There were excellent resources regarding sepsis recognition within the department. Staff awareness of sepsis was embedded in the department with continuous monitoring for improvement. Up to date and evidence-based guidelines for the management of sepsis were visible in all areas in the department. Sepsis is a life-threatening blood infection. One hundred-percent of patients within the emergency department were screened for sepsis between April 2017 and March 2018.

Urgent and emergency services

- The single clerking assessment process had become embedded since our last inspection. Single clerking is when one doctor takes a comprehensive history and full examination of a patient and avoids repetition.
- Both medical and nursing staffing had increased after a staffing review since our last inspection. There was the correct amount and experience of doctors to meet the needs of the department twenty-four-hours a day. However, staff told us that whilst staffing could be a challenge in busy periods, but it had improved since our last inspection.
- Overall, staff kept clear accurate records of patients care and treatment. We reviewed 22 sets of patient records and found four were incomplete. For example, safety checklists or falls risk assessment were not fully completed. In all cases the incomplete documentation occurred during a night shift.
- Mandatory training compliance was better than at our last inspection but still required improvement amongst doctors to achieve the trust target.
- The Royal Sussex County Hospital Friends and Family Test performance (% recommended) was about the same as the England average (86%) October 2017 to September 2018.

However:

- Data provided to us showed there was regular delays in assessing the risk for patients who brought themselves to the emergency department. The average time patients waited for assessment at Royal Sussex County hospital was 25 minutes which was worse than the best practice time of 15 minutes. Therefore, a patient's condition was at risk of deteriorating during this time. However, if a patient booked in at reception with a serious condition such as chest pain reception staff escalated this immediately to the streaming nurse who assessed the patient immediately.
- Patients who presented themselves to the department with a minor injury where treated in the urgent care centre. Staff had oversight of patients waiting in the waiting area and therefore could monitor any deterioration in a patient's condition. The computer system tracked the length of time a patient was in the department, so staff knew had been waiting the longest.
- The service closely monitored the time taken to assess patients who took themselves to the emergency department. The service was using Patient First Improvement System to address delays in assessment. Delays in assessment of self-presenting patients had was identified as a key driver in the Patient First Improvement System. Performance and delays were reviewed and discussed at daily huddles. The service had plans on how to address the delays for example, fully implementing the streaming process. Streaming is when a senior nurse undertakes a quick initial assessment of the patient and then directs them to the most appropriate location.
- More recent data supplied to us showed an improvement in the initial assessment of patients at Royal Sussex County hospital. Between 01 July 2018 and 09 September 2018 93% of patients had an initial assessment within 15 minutes of arrival. This was similar to the national target of 95%.
- The service did not have an effective process which ensured medicines were checked to ensure they were still in date. We checked 20 different medicines and found four were past the expiry date.
- The number of black breaches remained a concern as patients were delayed in receiving their treatment. Data provided to us by the trust showed there was 902 black breaches as Royal Sussex County hospital between September 2017 and August 2018. A "black breach" occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. The trust accounted the black breaches to challenges with hospital capacity and flow.
- The service was closely monitoring reasons for black breaches and performance was reviewed weekly and discussed at daily huddles. The service was using Patient First Improvement System to address challenges surrounding delays in handovers, triage and assessment of patients. Delays in ambulance handovers was identified as a key driver in the

Patient First Improvement System. Each delay was reviewed and discussed at daily huddles. The service had plans on how to address the delays for example, having a senior nurse where the ambulances arrive who could receive handover make an initial assessment and direct the patient to the most appropriate location. A training programme to ensure the nurses had the correct skills and knowledge to undertake this was being developed.

- Intravenous (into a vein) fluids were not prescribed in line with trust policy. The time period to give the fluid had not been documented. Giving intravenous fluids too quickly or too slowly can have an adverse effect.
- When a patient was assessed as a high risk for developing a pressure ulcer, preventative equipment was not obtained quickly. We saw a patient who was at high risk of developing a pressure ulcer had not been placed on a specialist pressure relieving mattress.
- Due to limited space within the department, the risk of infection was not always controlled well during busy periods. We observed during busy periods patients were on trolleys next to each other in the 'cohort area,' which did not minimise the risk of the spread of infection. This was consistent with our last inspection, however, we observed less patients waiting in this area during our inspection and they were moved out of this area quicker.
- Mandatory training compliance amongst doctors was 77% which was worse than the trust target. Only 81% of doctors had completed Safeguarding Adults at Risk training and 81% had completed level 3 Safeguarding Children and Young People training.

Is the service effective?

Good

Our rating of effective stayed the same.

This reflects the improvements made in relating to ensuring pain relief is given within 30 minutes of arrival and excellent multi-disciplinary working.

We rated it as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff of different professions worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- There was a reduction in the number of patients who waited more than 12 hours from the decision to admit in the four months prior to inspection.
- Staff understood their roles and responsibilities under the Mental Health Act 1983. They knew how to support patients experiencing mental ill health.
- In the main, patients received treatment within one hour of arrival in line with the best practice guidance.
- There was good evidence of working together to treat and care for patients who frequently attended the department.
- Appraisal completion rates had historically been low but were improving.
- The service introduced emergency prompt cards in April 2017. They allowed the essentials of clinical practice and safety to be readily available to all. The emergency prompt cards were based on national guidance and local guidance and set out a standardised approach to undertaking certain procedures such as inserting a chest drain.
- Sepsis screening and management was carried out effectively in line with national guidance such as the Sepsis 6.

Urgent and emergency services

- Sepsis screening and management was carried out effectively in line with national guidance such as the Sepsis 6. Trust wide data showed that 100% of patients within the emergency department were screened for sepsis between April 2017 and March 2018.
- There was an extensive teaching and assessment programme which included competencies required for nurses working in emergency departments.
- Patients were routinely assessed for venous thromboembolism in line with best practice guidance.
- The latest Trauma, Audit and Research Network data showed (Quarter 4 2017/18) that the department delivered a consultant-led trauma team within 30 minutes for triage positive patients 98% of the time. This was better than the national average of 92%.

However:

- Senior staff monitored the effectiveness of care and treatment and used the findings to improve them. The department took part in national audits to compare treatment results with other hospitals. However, their data was combined with that of the Princess Royal Hospital and so it was not possible to be specific about the effectiveness of treatment at the Royal Sussex County hospital. The service had taken action to address this and we saw recent ongoing and planned audits were separated by hospital site.

Is the service caring?

Good

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

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. We saw staff reassuring patients who were anxious or upset, with specialist support available if this was needed.
- Staff provided emotional support to patients to minimise their distress. Staff were aware of the impact on patients and carers of the care and treatment they provided.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients were satisfied with the information they had been given and was explained in a way they could understand.
- The Royal Sussex County Hospital Friends and Family Test performance (% recommended) was about the same as the England average (86%) October 2017 to September 2018. Quotes from the friends and family test included: “A fabulous, friendly service, well done. Friendly staff, very efficient, nothing too much trouble, great all-round service, keep doing what you’re doing.”
- Dignity and privacy for patients waiting in “the cohort area” was not ideal however, there were systems and processes which ensured no procedures were undertaken whilst in this area. If patients required, an examination or treatment they were moved to a dedicated cubicle.

Is the service responsive?

Requires improvement

Our rating of responsive improved. We rated it as requires improvement because:

Urgent and emergency services

- The service took account of patients' individual needs but was not always successful in meeting them. During busy times it was not always possible to manage individual needs if patients were cared for in 'the cohort area.' This was the same as our last inspection. Issues around the departments inability to meet surges during demand remained a concern. The service had undertaken a number of changes since our last inspection to improve efficiency and the performance against national standards. However, performance against national targets still required improvement.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.
- From August 2017 to July 2018 the trust was consistently worse than the standard and performed worse than the England average. However, performance had improved over the four months prior to inspection.
- From August 2017 to July 2018 performance against this metric showed a peak of approximately 40% of patients waited more than four hours in January 2018, with an improved figure at the end of the of the reporting period of approximately 24% patients waiting more than four hours.
- Additional data supplied to us by the trust showed that on average between September 2017 and August 2018, 43% of patients waited more than four hours after decision to admit at Royal Sussex County hospital. This was compared to 6.5% at Princess Royal hospital.
- From July 2017 to June 2018 the monthly percentage of patients that left the trust's services before being seen for treatment was similar to the England average.
- The service had effective strategies in place to address capacity, performance and flow challenges. However, they were dependant on building work completion to create more capacity within the department and the creation of additional bed capacity within the hospital. Funding had been made available to secure the building of a new acute floor, which was expected to provide additional capacity to cope with the increased volume of patients who attend the department. Building work was due to commence within the next couple of months.

However:

- The services were planned and provided in a way that met the needs of the local people. The service had effective relationships with a variety of organisations and charities within the local area which provided support in the community for patients.
- In the main, patients received treatment within one hour of arrival in line with the best practice guidance.
- Patients with pre-existing physical or mental health illnesses were easily identifiable on the electronic patient system.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- The department had regular meetings to discuss any patients who were classed as 'frequent attenders.' This enabled staff to put a care management plan in place to ensure they were treated appropriately.
- The leadership team had established the 2018/19 Patient Winter Planning Group which included staff participation from all cross-party groups to enable staff to give great patient care.
- Comfort rounds were used, which meant that staff ensured patients were safe, had a call bell in reach and to ensure their care needs were met.
- The department saw a significant number of patients who were homeless and had drug and alcohol support needs. To ensure they received appropriate care, a drug and alcohol worker from a local substance misuse service attended the department daily to identify any patients who might need support.

Urgent and emergency services

Is the service well-led?

Good

Our rating of well-led improved.

This reflects the significant improvements made in the service, governance, risk management and the culture driven by the leadership team in a short space of time.

We rated it as good because:

- The leadership of the service had changed since our last inspection. We observed the changes had a positive impact on the staff and department efficiently and effectiveness.
- Staff were engaged, supported and felt valued by senior staff.
- The culture was significantly different to previous inspections. Staff displayed a 'can do' attitude to any challenges they faced. All disciplines of staff had a shared focus and purpose to ensuring patients received the best possible care and experience. Staff morale was good, and staff were positive about the overall leadership of the trust.
- The urgent and emergency service leadership team had the right skills and abilities to run a service providing high quality sustainable care. The leaders were visible and understood the challenges facing the service.
- Accountability of patient care and ownership of emergency care performance standards was shared throughout the trust. This had changed from our previous inspection.
- The trust wide Patient First Improvement System had enabled staff and leaders to make positive changes in a structured and planned way. The system included 'key drivers' which the service identified for example giving patients pain relief within 30 minutes of arrival. The daily huddles were open to all and enabled every member of staff the opportunity to suggest positive changes or voice their ideas.
- The leadership team shared the same sense of purpose and worked together to drive improvements and ensure patients received safe high-quality care. They had a good knowledge of how services were provided and were quick to address any shortcomings that were identified.
- The nursing team was established with experienced staff that provided clinical and professional leadership by supporting and appraising junior staff.
- Consultant leadership in the department was committed and consultants demonstrated clinical ownership of the patients in the department
- The service engaged with patients, staff, the public and local organisations to plan and manage appropriate services.
- There was a supportive culture of learning and education and staff told us that this was a real focus and they felt invested in. The practice educators were driving the education, training and development of staff and staff had been very positive about their role.

However:

- There was a lack of structured departmental meetings as given the demands of the service it was difficult to dedicate time to these to ensure enough staff could attend them to be effective. However, we saw that learning, complaints, experiences and ideas were shared in a variety of other ways. For example, by the daily huddles which were open to all.

- The department took part in national audits to compare treatment results with other hospitals. However, their data was amalgamated with that of the Princess Royal Hospital and so it was not possible to be specific about the effectiveness of treatment at the Royal Sussex County Hospital. The service had taken action to address this and we saw recent ongoing and planned audits were separated by hospital site.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

- A drug and alcohol worker from a local substance misuse service attended the department daily and reviewed the electronic patient system to identify patients with drug and alcohol support needs. Staff demonstrated to us how this would be identified on the electronic patient system.
- The service offered a clinical fellow programme. This allowed the opportunity for doctors to work in a part clinical (75%) and part research (25%) role for one year. This had created a flexible workforce to cover the needs of the service and provided the opportunity for the service to gain research and innovation projects. The clinical fellow programme had been replicated by other hospitals nationwide.
- As part of the trust wide Patient First Improvement plan staff identified there was a high haemolysis rate of blood samples. This resulted in a delay as the blood sample had to be taken from the patient again. Haemolysis of blood samples occurs when the red blood cells get damaged and therefore the results of the blood tests are inaccurate and need to be repeated. The service researched the best way to prevent haemolysis. For example, by mixing the blood tubes with anticoagulant additives gently first. Prior to making the changes in the process there was a haemolysis rate of 12% which has now reduced to 2% (the national average is 8%).
- There had been significant positive changes made in a relatively short space of time. One of the most significant was the culture which had changed, all staff had a ‘can do attitude’ and were committed to working together to drive further improvements in patient safety and experience.
- The service had received and been nominated for a variety of national awards;
- In October 2017, the service was the winner of RCEM Quality Improvement Project, Award in celebrating 50 years of Emergency Medicine.
- In November 2017, the service was highly commended in the Health Services Journal within the workforce category for work on innovative staffing solutions for medical staffing (clinical fellows) May 2018.
- In May 2018, the service achieved BMJ Award highly commended for Innovation team of the year for staffing solutions to emergency departments.
- In May 2018, the service was the winner for Health Services Journal Award, acute service redesign, single clerking project.
- In July 2018, the service was Highly Commended in the Patient Safety Awards, Prompt Cards in the Emergency Department.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Actions the trust SHOULD take to improve:

- The trust should ensure that patients identified at an increased risk of developing a pressure ulcer are given preventative equipment promptly.

Urgent and emergency services

- The trust should ensure mandatory training including Safeguarding adult training is improved amongst medical staff.
- The trust should ensure patients are aware of their right to have a chaperone.
- The trust should ensure intravenous fluids are prescribed in line with trust policy.
- The trust should ensure that there is an effective process to check the expiry date of medicines.
- The trust should consider reviewing the length of nursing documentation.
- The trust should improve extended advanced life and trauma training for nurses.
- The trust should consider the risk to patients who self-present to the hospital and the length of time until they receive an assessment.
- The trust should continue to improve efficiency and flow in order to improve performance and meet standards.
- The trust should consider how they align with the trusts strategy.
- The trust should monitor privacy and dignity of patients waiting in “the cohort area.”

Medical care (including older people's care)

Good ↑

Key facts and figures

Medical care services are offered from the Royal Sussex County Hospital (RSCH) and Princess Royal Hospital (PRH). These services include the management of respiratory diseases, diabetes and endocrinology, HIV and sexual health, stroke, and elderly medicine. The trust also provides a specialised service for older patients including managing frailty, cognitive problems and older people with multiple medical problems.

Acute stroke services are based at RSCH and specialist inpatient rehabilitation takes place at the rehabilitation centre at PRH.

The Sussex Cardiac Centre provides care for patients with heart conditions and for patients who require heart surgery.

The Sussex Kidney Unit provides treatment and support for patients with kidney disease. The unit provides clinics in general nephrology, low clearance and renal vasculitis, as well as transplant and dialysis clinics. A secondary care hypertension clinic is also provided.

There are 371 medical inpatient beds located across 24 wards. A site breakdown can be found below:

- Royal Sussex County Hospital: 245 beds are located within 16 wards and units.
- Princess Royal Hospital: 108 beds are located within seven wards and units.
- Hurstwood Park Hospital: 18 beds located on Plumpton Ward.

The trust had 47,921 medical admissions from May 2017 to April 2018. Emergency admissions accounted for 20,270 (42.3%), 2,180 (4.5%) were elective, and the remaining 25,471 (53.2%) were day case. The chart below shows how the number of medical admissions at the trust relates to other NHS trusts in England.

Admissions for the top three medical specialties were:

- Gastroenterology - 8,864 admissions
- Geriatric medicine - 7,847 admissions
- General medicine - 6,952 admissions

We visited 16 medical wards and units. We reviewed 27 patient records, 10 medicine charts and nine "Do Not Attempt Resuscitation" orders. We checked over 30 items of medical equipment. We spoke with 21 patients and one visitor, and 141 staff who worked in medical care. Staff included volunteers, housekeeping staff, estates and facilities staff, therapy staff, technicians, consultants, doctors, pharmacist leads, nurses, student nurses and care support workers.

Medical care (including older people's care) service at the Princess Royal Hospital is outlined in a separate report specific to that location.

Summary of this service

Our rating of this service improved. We rated it as good because:

At our previous inspection in April 2017, we found several concerns such as;

Medical care (including older people's care)

- risk management strategies were not carried out in practice for the wards in the older buildings which were no longer fit for purpose
- no trust wide learning from incidents
- medical services operated in isolation
- culture of silo working and acceptance of poor behaviour amongst staff

At this inspection, we saw ample evidence of improvements made through the trust new strategy such as the "Patient First" programme. Despite significant lack of registered nurses and financial challenges, the service had embedded the programme and made great strides in a measured way not only to improve but ensured concerns found in the previous inspection were addressed. This resulted in us improving the ratings for all the key questions in medical care.

The service had also benefited from changes in the divisional structure and a new model of shared leadership between medical, nursing and operational managers called 'triumvirates'. These changes had been implemented in August 2017 by the new trust leadership and staff we spoke with agreed that more improvements and innovations had been achieved in the last year. Staff reported the medical services no longer operated in isolation and now learnt and shared information across the services.

Although the medical wards were still located in the older Barry building, we saw risk management strategies put in place such as fire safety risk assessments and beds removed from overcrowded or unsuitable spaces. Meanwhile, the new purpose-built building works were well underway and on schedule for completion by end 2020.

We found a culture of openness and transparency about safety. Staff could raise concerns and report incidents, which were regularly reviewed to aid learning. Lessons learned were effectively shared and we saw changes implemented within the wards as the result of investigations.

There were sufficient numbers of staff with the right qualifications, training and experience to meet the needs of patients. Staffing was reviewed regularly to ensure the correct skill mix and numbers of staff on the wards and throughout the department.

Staff followed trust policies and best practice with regards to the department's environment and equipment. Premises and facilities were visibly clean and suitable. Infection control and equipment management were regularly monitored.

The service undertook audits to ensure they regularly reviewed the effectiveness of care and treatment of patients. These showed that the care delivered was meeting national standards.

There was a good culture amongst staff. Staff described how they worked together across the medical services and were supported to challenge poor behaviour amongst themselves.

Patients received co-ordinated care from a range of different staff, teams and services. Staff worked collaboratively to meet patients' individual needs, including their mental health and emotional wellbeing. Patients and relatives we spoke with gave positive feedback about the care they received.

Is the service safe?

Good

Our rating of safe improved. We rated it as good because:

Medical care (including older people's care)

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, people received a sincere and timely apology, staff told patients about any actions taken to improve processes and gave suitable support.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to monitor and prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well. Staff carried out risk management strategies in unsuitable premises and kept patients safe. The service had systems to provide assurance that information relating to Control of Substances Hazardous to Health (COSHH) was available, complete and accurate, and staff understood it.
- We found staff responded well to the deteriorating patient and there was effective sepsis management. We saw clear processes of on-going assessment and escalation were clearly documented in patient records. Patients received timely consultant review on admission and staff completed comprehensive risk assessments for the prevention of falls and pressure ulcers.
- The service gave, recorded and stored medicines safely. Patients received the right medication at the right dose at the right time. Unlike the previous inspection in April 2017, we found staff recorded and monitored the ambient room temperature in medicine storage areas and took relevant actions when out of range temperatures were identified at this inspection.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- Staff understood how to protect patients from abuse and the service worked well with other organisations to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Staff described how well they were supported by practice educators.
- The service had adequate staff to keep people safe from avoidable harm and abuse and to provide the right care and treatment. Staffing levels and skill mix were planned, implemented and reviewed to keep people safe. While the lack of registered nurses remains a significant challenge, any staff shortages were responded to quickly and adequately. There were effective handovers and shift changes, to ensure staff managed risks to people who use services.
- Although there were sufficient staff to meet patients' needs, there was a higher vacancy rate amongst Band 5 nurses. Where there was a risk that patients' needs might not be met, matrons and ward managers worked clinically to fill the gaps. However, this took away from their management time. There was a continual band five rotational programme and an active recruitment plan for nursing staff.
- The service planned for emergencies and staff understood their roles in the event one should happen. Emergency plans were regularly tested and reviewed.

However:

- However, we noted the medication record forms contained more than one space for the prescriber to record the date of each prescription, which was a potential source of confusion. In some cases, it was not clear that the medication

order had been correctly signed by the prescriber. When we raised this with senior managers, the trust responded immediately. The forms and last audit results were reviewed by the drugs and therapy committee, who recommended a change in the layout of the chart to help eliminate any confusion that may exist. The new layout forms were being rolled out before the end of the year.

- The printed copies of early warning score forms showed different trigger scores for escalation. The early warning score form for vital observations showed a trigger score of five or more and the sepsis form showed a trigger score of three or more. Managers we spoke with reported the trust was in the process of replacing the forms. Although documentation for the early warning score were being replaced and where the old forms were being used, there was a risk of escalation not occurring in a timely way due to differences in the scoring systems. Records we reviewed and staff we spoke with provided assurance that patients were not meanwhile put at risk as staff had escalated at the lower trigger score for escalation.
- We found the clinical director for specialty medicine in this division had been vacant for seven months. We raised this with the trust who acknowledged they are trying to attract a consultant into this key role. We were told new consultants had been appointed and the trust hoped this would assist in recruitment. Ward managers we spoke with told us of a consultant commencing in October 2018.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers monitored to make sure staff followed guidance and ensured consistency of practice.
- Staff carried out comprehensive assessments to meet people's needs and improve their health. This included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. They used special feeding and hydration techniques when required. They adjusted to patients' religious, cultural and other preferences.
- The 2017 patient-led assessment of the care environment survey showed the trust scored 95.3% for food and hydration, which was significantly better than the England average of 89%.
- The service monitored the effectiveness of care and treatment and used the findings to improve them. They participated in relevant local and national audits, and other monitoring activities such as service reviews, benchmarking, peer review and service accreditation. Staff shared up-to-date information about effectiveness internally and externally. Staff understood the information and used it to improve care and treatment and people's outcomes.
- Outcomes for patients were good. The service performed well in audits such as the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade A in the latest audit, August 2017 to November 2017. This had improved since the 2017 inspection where the trust achieved a grade B in the audit from August 2016 to November 2016.
- Although the service did not meet the aspirational standards of the National Audit of Inpatient Falls 2017, the service had implemented initiatives such as individualised patterned blankets which had led to a reduction in falls. Data showed a falls rate of 0.79 falls per 1000 bed days as at September 2018. This is eight times lower than the national average. Another example, Emerald ward (dementia unit) showed a reduction in falls from 60 to 26 in the last financial year due to raised awareness, use of falls mats and placing of patients within the ward.

Medical care (including older people's care)

- The service managed pain relief well. They had improved pain management from 15% to 50% in assessing and offering analgesia within 30 minutes of the patient's arrival on the ward. Staff used appropriate pain score tools and regularly checked patient's pain levels. Feedback from patients described they received pain relief medication promptly.
- The service made sure staff were competent for their roles. Staff had the right qualifications and skills to carry out their roles effectively and in line with best practice. Staff received timely supervision and appraisals of their work performance and they had access to learning and development, including mandatory training. The service had a clear and appropriate approach for supporting and managing staff when their performance is poor or variable. We saw marked improvement of appraisal completion rate at 93.1% from 78.3% in the previous inspection.
- There was effective multi-disciplinary team working across the service. Staff of different disciplines worked together as a team to assess, plan and provide people coordinated care. Doctors, nurses and other healthcare professionals worked collaboratively to understand and meet the range and complexity of people's needs when planning people's discharge or transition. People were discharged at an appropriate time and when all necessary care arrangements were in place.
- Seven-day services/cover was available to pharmacy, physiotherapy and occupational therapy. Access to dieticians or speech and language therapists was provided Monday to Friday, 9am to 5pm with an out of hours telephone advice line to support staff. Nurses were trained to carry out assessments for patients on the stroke ward where dietary advice and support with eating affected recovery were required out of hours.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to information they need to assess, plan and deliver care to people in a timely way. When there are different systems to hold or manage care records, these were coordinated.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Staff understood and monitored the use of restraint and used less restrictive options where possible.
- Staff understood and recognised that the deprivation of a person's liberty only occurred when it was in that person's best interest, was a proportionate response to the risk and seriousness of harm to the person, and there was no less restrictive option that could be used to ensure the person got the necessary care and treatment. Staff used the Deprivation of Liberty Safeguards, and orders by the Court of Protection authorising deprivation of a person's liberty appropriately.

However:

- The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 64.6%, which did not meet the aspirational audit standard of 90%. The 2016 figure was 60.0%. We saw the trust had an action plan to address this and worked with an NHS provider to roll out of a streamlined rapid access pathway for new referrals compliant with National Optimal Lung Pathway in late 2018/early 2019.
- We saw name boards on three wards were not completed or were only partially completed. Some were completely blank and some had the nurses' names only. While this was not in line with trust standards, we found patients and relatives we spoke with at this inspection described they knew who to speak and raise questions with when required. We were told the trust had plans to implement an electronic version across the trust.

Medical care (including older people's care)

Is the service caring?

Outstanding ☆ ↑

Our rating of caring improved. We rated it as outstanding because:

- The service had a strong, visible person-centred culture. Despite staff and financial challenges, staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who use the service, those close to them and staff were strong, caring and supportive. These relationships were highly valued by staff and promoted by leaders.
- Staff had support to initiate improvements in quality of care. We saw a ward manager's innovation such as the 'blanket project' promoted people's dignity and individual needs for the care of the elderly. Individual blankets were used to allow patients to recognise their own bed space and protect them from falls.
- We saw staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Feedback from people who use the service, those who are close to them and stakeholders was continually positive about the way staff treat people. People described that staff "go the extra mile" and the care they received exceeds their expectations.
- Staff involved patients and those close to them in decisions about their care and treatment. We found people who use services were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person. Staff always empowered people who use the service to have a voice and to realise their potential. They showed determination and creativity to overcome obstacles to delivering care. People's individual preferences and needs were always reflected in how care was delivered.
- Staff provided emotional support to patients to minimise their distress. We also observed staff provided each other emotional support to ensure they received good health and wellbeing. Staff highly valued people's emotional and social needs and we saw these were not only embedded in their care and treatment, but they went over and beyond to innovate the "Small Acts of Friendship" programme to help elderly patients retain dignity, social activity, mobility and well-being whilst in hospital. Feedback from patients and staff were positive.
- There was a strong sense of togetherness amongst staff from all different grades despite facing challenges outside their control.
- Overall, we observed staff truly respected people and valued them as individuals, and empowered people as partners in their care. Staff recognised and respected the totality of people's needs. They always considered of people's personal, cultural, social and religious needs.
- The Friends and Family Test showed the recommendation rate for medicine at the Royal County Sussex Hospital site to be above 90% from June 2017 to May 2018. Staff provided continual high-quality care. This was supported by all patients and relatives we spoke with who were consistently positive about the care which they described have exceeded their expectations.

Is the service responsive?

Good ● ↑

Our rating of responsive improved. We rated it as good because:

Medical care (including older people's care)

- The service planned and provided services in a way that met the needs of local people. We saw flexibility, choice and continuity of care were reflected in the services.
- People could access the service when they needed it. Services ran on time. People were kept informed of any disruption to their care or treatment. The service monitored waiting times for referral to treatment within 52-weeks. This had improved from the previous inspection, with no patients waiting longer than 52-weeks or more. GPs could directly refer patients to the new medical assessment complex at the hospital. This was used to reduce referral to treatment times.
- There was an improvement on the referral to treatment times, compared to the previous inspection, where six of the eight specialties (geriatric medicine, neurology, rheumatology, thoracic medicine, dermatology and general medicine) were better than the England average. Two specialties (cardiology and gastroenterology) were below the England average.
- The service had done everything within their remit to improve access and flow. Initiatives such as discharging patients before midday, regular and effective monitoring and managing of medical outliers and the service had recruited a new manager to help with the flow. The service also monitored delayed transfers of care and worked with system partners to improve the position. Capacity to deal with the demand could be fully realised once the trust's 3Ts project is completed.
- Staff provided coordinated care and treatment with other services and other providers.
- Facilities and premises were appropriate for the services being delivered.
- The service took account of patients' individual needs. Staff accounted the needs of different people when planning and delivering services. For example, on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation.
- Staff made reasonable adjustments and removed barriers when people find it hard to use or access services.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. It was easy for people to complain or raise a concern and they were treated compassionately when they did so. There was openness and transparency in how complaints were dealt with. Complaints and concerns were always taken seriously, listened to and responded to in a timely way. The service made improvements to the quality of care as a result of complaints and concerns.

Is the service well-led?

Good

Our rating of well-led improved. We rated it as good because:

- The trust had a clear statement of vision and values for what it wanted to achieve and workable plans to turn it into action, driven by safety and quality. Staff in all areas knew and understood the vision, values and strategic goals. The vision, values and strategy had been developed through a structured planning process with regular involvement from internal and external stakeholders, including people who use the service, staff, commissioners and others.
- The board and other levels of governance within the organisation functioned effectively and interacted with each other appropriately. Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, were clearly set out, understood and effective.

Medical care (including older people's care)

- We saw good local ward and department leadership. Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff we spoke with described they were valued and how they felt there was a culture of collective responsibility between teams and services.
- The service had the processes and information to manage current and future performance. The information used in reporting, performance management and delivering quality care is accurate, valid, reliable, timely and relevant. We saw information from people's experience was reported and reviewed alongside other performance date to aid effective decision-making. A full and diverse range of people's views and concerns are encouraged, heard and acted on. Information on people's experience is reported and reviewed alongside other performance data.
- Staff described good visibility of the senior leadership team and gave positive reviews of their ward managers. There was also an overwhelming positive praise for the chief nurse.
- The service had an effective process to identify, understand, monitor and address current and future risks. They escalated performance issues to the relevant committees and the board through clear structures and processes. We saw clinical and internal audit processes functioned well and had a positive impact on quality governance, with clear evidence of action to resolve concerns.
- The trust and service managed financial pressures so that they do not compromise the quality of care.
- Staff understood candour, openness, honesty and transparency and challenged poor practice. The service had mechanisms to support staff and promote their positive wellbeing. Behaviour and performance inconsistent with the values were identified and dealt with swiftly and effectively, regardless of seniority.
- The service had a strong focus on continuous learning and improvement at all levels. We saw the leadership team supported safe innovation and staff had objectives focused on improvement and learning. The service encouraged staff to use information and review performance to make improvements.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

- The service had shown falls reduction in four care of the elderly wards at the Royal Sussex County Hospital site as a result of the "picture blanket project" initiated by a ward manager. We saw staff used these as bedspreads which protected patients from falls as they could recognise their own beds. The ward manager had been nominated for a Health Service Journal award. Other providers had approached the service to explore the same initiation for their services.
- The service had introduced the "Small Acts of Friendship" scheme to support elderly patients retain their dignity, social activity, mobility and well-being whilst in hospital. Volunteers provide free-of-charge hair dressing, hand massage therapies, poetry reading, art classes and a mobile library service to the elderly care wards.
- The "Patient First" initiative had provided focus and a platform for staff to raise ideas. We saw these were well run as short and focused sessions by each ward, involving staff at all levels ranging from doctors, nurses, administrative staff to housekeepers who had contributed to those ideas. It gave staff the confidence and motivation to make continual improvements for patients.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Actions the trust SHOULD take to improve:

Medical care (including older people's care)

- The trust should ensure the layout of all medication paperwork be clear for prescribers where they are required to record the date of each prescription to eliminate any potential confusion.
- The trust should ensure printed copies of early warning score forms and sepsis assessment sections showed consistent trigger scores for escalation to avoid any confusion for staff.
- The trust should continue their efforts to address the nursing and medical workforce challenges.
- The trust should ensure the vacancy for the clinical lead for specialty medicine in this division is filled.
- The trust should continue to carry out the actions they identified from the national audits such as the Lung Cancer Audit 2017.
- The trust should ensure staff followed trust standards to ensure name boards were completed.
- The trust should ensure seven-day services were made available for the dietetic and speech and language therapy services.
- The trust should continue to work on improving its referral to treatment performance in all specialties.

Surgery

Good ↑

Key facts and figures

BSUH provides surgical services to the local populations in and around the city of Brighton and Hove and some tertiary services to wider South East of England region.

It provides surgical services across two sites, the Royal Sussex County Hospital (RSCH) at Brighton and the Princess Royal Hospital (PRH) at Haywards Heath.

The Surgical division is made up of four directorates which encompass; head & neck, abdominal surgery and medicine, musculoskeletal (MSK), and perioperative.

Each Directorate is led by a Clinical Director, Lead Nurse and Directorate Manager. The Division is led by a tripartite team of Chief of Surgery, Chief Nurse and Director of Operations.

The Royal Sussex County Hospital has eight general theatres, a recovery unit and a theatre admission unit with 10 patient bays.

There are 151 surgical beds across four wards. On Level 9a there are 58 beds for upper/lower gastrointestinal and emergency surgery and digestive diseases. Level 8a East has 24 beds for trauma and orthopaedics. Level 8a West has 32 beds for neurovascular, spinal and ear, nose and throat surgery. Level 8 Tower has 37 beds for vascular assessment and surgery.

The trust had 34,848 surgical admissions from May 2017 to April 2018. Emergency admissions accounted for 7,465 (21%), 21,874 (63%) were day case, and the remaining 5,509 (16%) were elective.

(Source: Hospital Episode Statistics)

During our inspection, we visited all areas of the surgical services, including wards, theatres including the theatre admission unit. We also visited the neurovascular theatre. We visited Sussex Eye hospital which undertakes all ophthalmic surgery and had its own theatres and pre- assessment area and is located separately but across the road from the main trust hospital.

We spoke with 41 staff of all grades, including, nurses, doctors, healthcare assistants, therapists, and housekeeping, other healthcare professionals as well as the management team for the division.

We reviewed 13 sets of patient records. We spoke with 14 patients and two relatives about their experience, and observed care and treatment being delivered. We observed nursing, doctor and multi-disciplinary team handovers, nursing safety huddles and ward rounds. We reviewed performance data before, during and after the inspection. We also considered views and feedback provided at staff focus groups and drop-in sessions, which we facilitated before the inspection.

Summary of this service

Our rating of this service improved. We rated it as good because:

- Statutory and mandatory training compliance had improved since the last inspection. Staff understood how to protect patients from abuse and worked well with other agencies.

Surgery

- The service controlled infection risk well. The surgical wards and departments displayed their environmental risk assessments and had up to date records of their cleaning schedules. Theatres had put in place a schedule for deep cleaning. This was an improvement since that last inspection when this information was not easily available.
- The service had improved how it carried out the safe surgery checklist and undertook audit and research to ensure this remained a robust process.
- Anaesthetic machine safety checks were in place. This was an improvement on our last inspection when we found there were gaps in the checking of this equipment.
- The service prescribed, gave recorded and stored medicines well. Recording of supply, administration and wastage of controlled drugs in theatres had improved, with no block signing, all entries checked were legible and correct. Medicines in surgical wards and departments were managed safely.
- Since the last inspection initiatives had been taken to review all patients on the waiting list for specific bowel surgery which meant no patient was waiting 52 weeks or more. The service had improved its referral to treatment time (RTT) since the last inspection.
- There was an improvement on the RTT, compared to the previous inspection, when all specialities were below the England average. Two specialities (Trauma and orthopaedics and ophthalmology) were better than the England average and three were similar (ear, nose and throat, urology, and oral). Three specialities (neurosurgery, general surgery and cardiothoracic) were greater than 5% below the England average.
- Staff knew what incidents to report and how to report them. Managers investigated incidents and shared lessons learned. They identified any themes and monitored near misses.
- Staff provided care and treatment based on national guidance and service policies reflected this. Managers checked to make sure staff followed guidance.
- Managers made sure staff had the right skills to perform their role. They met with staff regularly to appraise performance and encouraged continued professional development. Practice educators on all wards and departments supported staff training within a positive learning environment.
- Doctors, nurses and other health professionals worked together to benefit patients and supported each other to provide good care.
- Staff treated patients with compassion, dignity and respect and supported patients with mental health needs. Patients and those close to them were involved in their plan of care. Patient feedback was positive.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with the staff.
- The service had managers at all levels with the right skills and abilities to run the service, and provide quality care. Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

However:

- In wards and theatres there were some pieces of equipment that had not been serviced in line with schedule and fire risk assessment in wards level 8a East and 8a West had identified actions and on both wards these actions were only partially complete.
- Patients were staying longer than their required recovery time in theatre due to a lack of bed availability in critical care and ward areas.

Surgery

- There was some inconsistency in recording why medications were not administered. Out of eight charts checked, four showed no documentation of reasons for not administering drugs by using the suggested code, which meant a lack of information when reviewing treatment.
- There was little evidence of patient forums or a way of patients feeding back about specific areas of the service.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- The service provided mandatory training in key skills to all staff. Nursing staff achieved the trust target of 90% in six out of eight subjects listed. Medical and dental staff achieved above 90% in one subject, were close to target in four subjects and below target in three. For both staff groups this was an improvement from the previous inspection.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Wards and departments displayed information about the safeguarding leads and information on how to escalate concerns.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean and tidy. Theatres had reviewed its use of safer sharps and demonstrated good practice.
- All departments and wards displayed their environmental risk and assessments and up to date cleaning schedules. Theatres had put in place a schedule for deep cleaning. This was an improvement since the last inspection when risk assessments and cleaning schedules were not displayed.
- Theatre staff followed the 'Safe Management of Anaesthetic Related equipment (2009) by consistently checking anaesthetic machines. This was an improvement on our last inspection when we found there were gaps in the checking of this equipment.
- Equipment used in the event of an emergency was checked daily to make sure it was present and in working order. The cleaning cupboards inspected on the wards and theatres were locked at the time of inspection.
- Theatre staff carried out the World Health organisation (WHO) 'Five Steps to Safer Surgery' and all steps of the process were fully completed. This was an improvement on our previous inspection when we observed the debriefing process was not always fully completed. We observed audit and research into the debrief process was underway to ensure the process remained robust.
- The service prescribed, gave, recorded and stored medicines well. Recording of supply, administration and wastage of controlled drugs in theatres had improved, with no block signing. All entries checked were legible and correct. Medicines in surgical wards and departments were being managed safely.
- The service used safety monitoring results well. All patients had a full risk assessment that staff reviewed regularly from admission to discharge. The current guidance for sepsis was reflected within the sepsis screening and care bundle seen to be accessible on all wards areas. Staff used this alongside the national early warning tool, which was in place across the service, to monitor the patient and to identify patients at risk of unexpected deterioration, in line with National Institute for Health and Care Excellence (NICE) Guidance.
- The service managed patient safety incidents well. Staff knew what incidents to report and could demonstrate how to use the electronic system. Managers gave feedback to all staff after investigating incidents to prevent them happening again. Staff understood the principles of Duty of Candour. Regular mortality and morbidity meetings were held to discuss patient deaths and other adverse events in an open manner, review care standards and make changes if needed.

Surgery

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. The leadership team told us the trust recruitment of staff remained a challenge. Rotas were planned, this allowed for adjustment to make sure of the correct skill mix. Staffing shortfalls were escalated and covered by bank or agency staff. Patients on the wards told us they felt safe.
- Staff kept appropriate records of patient care and treatment. We found up to date and completed risk assessments and saw they were reviewed regularly. Records were clear, up to date and available to all staff providing care.
- Safety thermometer information was displayed on each ward area for patients and visitors to the ward to see. The information was up to date and presented in such a way that it could be easily understood. The information was compared across the trust to drive improvement and change of practice.
- Staff planned for emergencies and staff understood their role if one should happen.

However:

- Fire risk assessment completed for wards level 8a East and 8a West had identified actions and on both wards these actions were only partially complete.
- In wards and theatres there were some pieces of equipment that had not been serviced in line with the servicing schedule. On one ward two pieces of equipment had no record of service and in main theatres of nine pieces of equipment checked four appeared to be out of date with service schedule.
- There was some inconsistency in recording why medications were not administered. Out of eight charts checked four of the charts showed no documentation of reasons for medicines not being given which meant a lack of information when reviewing treatment.

Is the service effective?

Good

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

- The service provided care and treatment based on national guidance and service policies reflected this. Managers checked to make sure staff followed guidance.
- Staff assessed patients' nutritional states and gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary and there was good access to specialist nutritional support. The service made adjustment for patients' religious, and cultural preferences. There were protected mealtimes to support patient nutrition.
- The service monitored the effectiveness of care and treatment and consistently used the findings to improve them. The local clinical audit processes enabled services to compare outcomes across the trust and there was evidence of improvement programmes.
- Information about the outcomes of people's care and treatment were routinely collected and monitored. The service participated in national audits to enable its practice to be compared and action was taken to improve areas identified from audit that were not at the required level. Overall, performance in national audits was broadly in line with national averages.
- The service had a pain management team and staff were proactive in monitoring and preventing post-operative pain. Patients told us that staff checked regularly and acted quickly if they did report pain.

Surgery

- The service made sure staff were competent for their roles. Managers appraised staff performance and gave positive support for personal development plans with supported access to local and external training. Practice educators actively supported the ward and theatre departments to develop a learning culture.
- Staff at all levels and from all disciplines worked together as a team for the benefit of their patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The service was working toward seven-day services in line with National Health Service Improvements (NHSI), Seven-day services in the NHS. We saw in the trust operational plan 2018-2019, that they plan to deliver the Seven Day Service standards for all admitting specialities by 2020. There was a consultant ward round seven days a week.
- Staff understood the process of consent and knew the process for making an application for deprivation of liberty safeguards. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those that lacked the capacity to make decisions about their care.

Is the service caring?

Good ➔➔

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

- Staff cared for patients with compassion, treating them with dignity and respect. Staff were passionate about delivering high standards of care and took account of patient feedback. Feedback confirmed that staff treated them well with kindness.
- All wards displayed their friends and family feedback showing a response rate between 23 and 34 per cent. Staff gave patients a card on discharge asking them to feedback about their experience. All wards had an annual positive performance above 90%.
- Patients described patient centred care with good support from the multi-disciplinary team. Staff were described as kind and caring. Call bells were seen to be within in reach and staff were responsive to patient needs.
- Patients told us they had sufficient information to make decisions about their care. Staff communicated well with patients and checked their understanding. Discharge planning considered patient need, level of support required and made referral to required services.
- The service provided emotional support to patients, information was easily available about support groups, and it supported spiritual needs through a multi faith chaplaincy.
- Staff were observed to be non-judgemental and caring in the way they managed patients with mental health needs. Staff had access to the mental health team when necessary and described the support from security staff with distressed patients as prompt, supportive and safe. All staff undertook conflict management training.

Is the service responsive?

Good ➔

Our rating of responsive improved. We rated it as good because:

Surgery

- Managers planned and provided services in a way that met the needs of the local people. They were flexible and had made changes to improve services and support patients more effectively. The hospital had a significant redevelopment programme underway, directions to the surgical wards and departments were clear and easy to follow. Information about the building work and services was clearly available to visitors at the main entrances of the hospital.
- People could access the service when they needed to. Initiatives had been taken to review all patients on the waiting list for specific bowel surgery which meant no patient was waiting 52 weeks or more. This was an improvement since the last inspection when there was a backlog of patients waiting for surgery. Theatre utilisation rates were monitored to make sure the theatre was used efficiently.
- There was an improvement on the RTT, compared to the previous inspection, when all specialities were below the England average. Two specialities (Trauma and orthopaedics and ophthalmology) were better than the England average and three were similar (ear, nose and throat, urology, and oral). Three specialities (neurosurgery, general surgery and cardiothoracic) were greater than 5% below the England average.
- Staff took account of patient's individual needs and had access to specialist nurses and other staff to support patient specific needs. Support was available for patients with dementia, learning disabilities and mental health problems with lead practitioners and link persons at department level.
- The service had improved their response time for complaints and whilst it was outside the policy guidelines, there was a clear plan for continued improvement. The process for complaints was understood by staff and learnings were shared across the service.
- The theatre recovery area continued to ensure that patients were not admitted inappropriately from other departments to ease patient flow.

However:

- Patients were staying longer than their required recovery time in theatre due to a lack of bed availability in critical care and some ward areas. Staff monitored delayed discharge times but felt this would not improve until the completed expansion of critical care giving greater capacity.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good because:

- The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. The leadership structure was clear and staff knew their reporting lines and responsibilities.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action with involvement from staff and patients. Staff could clearly explain what the vision was and were actively engaged in training for the strategic patient first approach to working. Staff could clearly explain why they thought this was a positive initiative to improve patient care.
- Managers across the trust promoted a positive culture that supported and valued staff. There were opportunities for professional development. Staff felt supported and respected by their colleagues at all levels and staff told us this had improved since the last inspection.

Surgery

- The trust used a systemic approach to continually improve the quality of its services and safeguarding its standards of care by creating an environment in which clinical care would flourish. The governance structure had been redesigned to bring the clinical specialties reporting together under the surgery division. There was clear understanding of responsibilities and reporting lines.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them. Staff and managers could identify what risks were on their own local risk registers. There was a comprehensive risk register across the surgery division and staff were aware of actions taken to mitigate risk. There was regular a review and update of risks.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. Staff had access to up to date information on patient care and treatment, and were aware of how to use and store confidential information.
- We saw the staff encouraged patients to complete the family and friends test on their care and treatment. They used social media mechanism for engaging with staff, they also answered patient complaints and responded to concerns and compliments on the NHS choices website.
- A trust wide staff engagement survey demonstrated that staff working in surgery across all sites scored an improvement in overall staff engagement. The most significant improvement was in how likely staff would be to recommend the trust to friends and family as a place to work with a positive response of 46.71% in 2017 rising to 75% in August 2018. Staff were recognised for outstanding practice.
- The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. Managers encouraged staff innovation and shared good practice across the service.

However:

- There was little evidence of patient forums or a way of patients feeding back about specific or specialised areas of the surgery service.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Actions the trust SHOULD take to improve:

- The trust should complete all actions found in the fire risk assessments on wards Level 8a East and Level 8a West.
- The trust should ensure all equipment in use is serviced in line with service schedule.
- The trust should ensure staff record why medications are not administered.
- The trust should ensure that patients were not staying longer than their required recovery time in theatres.
- The trust should engage with patients in such a way as to develop their services.

Critical care

Good ↑↑

Key facts and figures

The Intensive Care Unit was identified by the trust as the location "where we care for patients who are extremely sick and need constant close monitoring and support from staff, machines and medicine to keep normal body functions going". The critical care team supported the care of inpatients across all the hospitals specialities.

We inspected the critical care units on level five and level seven of the main hospital block and the cardiac critical care unit on level six. The inspection was announced to ensure everyone we needed to speak to was available.

As part of the inspection we reviewed information provided by the trust as well as information that was available from open sources. During the inspection site visit we spoke with 23 members of staff, including nursing and medical staff, allied health professional and other support staff. We spoke with five patients and three visitors.

We attended improvement huddles, patient handovers, site meetings and various ward rounds as well as observing direct patient care. We checked various pieces of equipment across all critical care units and reviewed seven sets of patient notes.

Summary of this service

Our rating of this service improved. We rated it as good because:

- The service had addressed the significant backlog of incidents that had not been investigated. The number of outstanding investigations had stabilised and the number outstanding generally matched the number being reported.
- Incidents were thoroughly investigated and root causes were found. Where incidents were unavoidable, the service sought to try to take any learning that may have been available.
- The environment and equipment was clean and we observed all staff were bare below the elbow. There was a clear sense that infection prevention and control was now treated as a priority.
- Medicines management had improved significantly. Consequently, there were fewer medication errors. A system called the 'five rights of medicine administration' had been implemented. This required the staff to check the right patient, right drug, right dose, right route, right time. The five rights would then be checked three times.
- Multi-disciplinary team working was well co-ordinated and utilised the skills of all the staff. Medical, nursing, therapy and dietitian staff had an equal role to play in patient care.
- Staff appraisal rates had risen to 94.4% across all staff groups in the critical care units. Staff told us how their appraisals had real value.
- A programme to give general critical care nursing staff neuro competencies had been established. This had dramatically improved the skill mix across the units. There were now 56% of staff that had neuro competencies and could work with all patients admitted to critical care.
- We saw a significant number of plaudits from patients, relatives and loved ones describing how exceptional the care provided by the critical care team had been both for the physical wellbeing of the patient and the emotional wellbeing of the loved ones.

Critical care

- Patients and visitors that we spoke with were unanimous in their praise of the care they or their loved ones received. One patient described how they had had frequent visits to the unit, that at no time had they ever been judged and were always treated with kindness.
- We observed many interactions between staff and patients, and staff and relatives. These demonstrated that all were given personalised care and privacy and dignity was always maintained.
- The service had improved the provision of information for patients and visitors that did not speak English as a first language.
- The critical care department carried out research with their interpreting provider to establish the three most common languages used. As a result, a full suite of information had been translated into the three most commonly used languages.
- A large picture that showed all the stages of the critical care pathway had been placed in the relatives' room on level seven. The pictures displayed could be understood by adults and children alike as well as those who did not speak English as a first language. Included in the picture were links to a wide variety of support groups and information sources. These could be directly accessed by using a smartphone to link to the QR code
- The critical care directorate had a clear vision and strategy for the service.
- The vision and strategy were aligned to the trust's true north objective where the patient is at the heart of everything that is done.
- There had been a significant culture shift where staff described critical care as a more cohesive unit. The differences between the neuro critical care staff and the general critical care staff had been overcome.

However:

- Some pieces of equipment had not been serviced in accordance with their service due dates.
- Critical care staff did not carry out dementia assessments on patients directly, instead asking the dementia lead for the hospital to do so.
- Coverage from the critical care outreach team was not provided 24 hours a day, seven day a week. This was against the Guidelines for the Provision of Intensive Care Services, 2015.
- There was not a critical care pharmacist. This was against the Guidelines for the Provision of Intensive Care Services, 2015.
- There had been occasions when patients' diaries had gone missing when being discharged from critical care. This meant that some patients could have missed a key component to their continued recovery.
- Patient flow remained a significant problem for the service.
- The service had not met its target of admitting all patients to the critical care unit within four hours of the decision to admit. There were significant delays discharging patients to the general ward environment
- Out-of-hours discharges were well above the 6.3% target in all five months from April 2018.
- The critical care team did not have a wide range of service level agreements with organisations that could assist with patients leaving the critical care environment.
- The critical care team did not have a designated lead for mental health.

Critical care

Is the service safe?

Good ↑↑

Our rating of safe improved. We rated it as good because:

- The service had addressed the significant backlog of incidents that had not been investigated. The number of outstanding investigations had stabilised and the number outstanding generally matched the number being reported.
- We saw and heard of how themes and trends were being identified from incidents. This had led to further staff training, changes in process and improvements in patient safety.
- Incidents were thoroughly investigated and root causes were found. Where incidents were unavoidable, the service sought to try to take any learning that may have been available.
- There was a strong reporting culture which had been developed by the senior leadership team and the clinical risk nurse. This in turn had filtered down to all staff. All staff we spoke with felt confident in reporting incidents.
- The environment and equipment was clean and we observed all staff were bare below the elbow. There was a clear sense that infection prevention and control were now treated as a priority.
- All staff, without exception cleaned their hands-on entry and exit to and from the units and before and after every patient contact.
- Medicines management had improved significantly. Consequently, there were fewer medication errors. A system called 'five rights' of medicine administration. This required the staff to check the right patient, right drug, right dose, right route, right time. The five rights would then be checked three times.
- Mandatory training completion rates had improved and the trust target of 90% was met across the critical care units.
- Nurse staffing had improved and there was less of a reliance on agency staff to fill the rota.
- The critical care team had appointed their own dietitian to work exclusively in critical care.
- However:
- Some pieces of equipment had not been serviced in accordance with their service due dates.
- Some patients were ventilated in the theatre recovery area following surgery due to the lack of a critical care bed. These instances were not reported as incidents as a member of the critical care team would be with the patient. At the time of the inspection there had been no patient safety incidents because of this. The completion of building works in 2020 would give critical care around 20 extra beds which would alleviate the need to ventilate patients in recovery in the future.
- Although plans were in place to fully staff the outreach team, there were insufficient staff at the time of the inspection to provide a full outreach service. There were however clear processes to follow at night and these were known across other directorates.

Is the service effective?

Good ↑

Critical care

Our rating of effective improved. We rated it as good because:

- Multi-disciplinary team working was well co-ordinated and utilised the skills of all the staff. Medical, nursing, therapy and dietitian staff had an equal role to play in patient care.
- We observed the multi-disciplinary team attending rehabilitation and tissue viability ward rounds. These were well managed and each member of the team had their opportunity to contribute.
- We were told about an occasion where a baby had to be delivered on the critical care unit. The critical care staff worked closely with their colleagues from the maternity unit to ensure that the patient and their baby were cared for safely.
- The appointment of a dietitian to the service had improved the understanding of a patient's nutrition and hydration needs. A comprehensive guidance document had been produced to assist all staff in this regard. We saw evidence in the patients records of the dietitian referrals and the input from the dietitian.
- The hospital continued to perform better than other similar critical care departments in terms of their risk adjusted acute hospital mortality. Mortality rates were within expected limits. The risk adjusted hospital mortality ratio was 0.9 in 2016/17. This was within the expected range. Additionally, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.6 in 2016/17. This was also within the expected limits. This assured us that the intended outcomes for people using this service were being achieved.
- Staff appraisal rates had risen to 94.4% across all staff groups in the critical care units. Staff told us how their appraisals had real value.
- A programme to give general critical care nursing staff neuro competencies had been established. This had dramatically improved the skill mix across the units. There were now 56% of staff that had neuro competencies and could work with all patients admitted to critical care.

However:

- Critical care staff did not carry out dementia assessments on patients directly, instead asking the dementia lead for the hospital to do so.
- Coverage from the critical care outreach team was not provided 24 hours a day, seven day a week. This was against the Guidelines for the Provision of Intensive Care Services 2015.
- There was not a critical care pharmacist. This was against the Guidelines for the Provision of Intensive Care Services 2015.
- The service was not meeting its target of completing rehabilitation assessments for 95% of their patients.

Is the service caring?

Outstanding ☆ ↑

Our rating of caring improved. We rated it as outstanding because:

- Feedback from people who use the service, those who are close to them and stakeholders is continually positive about the way staff treat people. People think that staff go the extra mile and their care and support exceeds their expectations. Relationships between people who use the service, those close to them and staff are strong, caring, respectful and supportive.

Critical care

- We saw a significant number of plaudits from patients, relatives and loved ones describing how exceptional the care provided by the critical care team had been both for the physical wellbeing of the patient and the emotional wellbeing of their loved ones.
- People's emotional and social needs were seen as being as important as their physical needs.
- We saw how the extended family of a patient that had been injured in an accident had travelled from overseas to the unit to offer their gratitude in person. This was because they had heard first-hand accounts of the support the team had provided not just to the patient, but their whole family.
- Relatives of a patient that had died thanked the team for all they had done and how sensitive they had been when dealing with the organ donation process. Staff were visibly moved when it was said that they had been key to their loved one providing life to someone else.
- The family of a patient that had given birth on the critical care unit had conveyed their gratitude for the care provided during a traumatic experience.
- Patients and visitors that we spoke with were unanimous in their praise of the care they or their loved ones received. One patient described how they had had frequent visits to the unit, that at no time had they ever been judged and were always treated with kindness.
- We observed many interactions between staff and patients, and staff and relatives. These demonstrated that all were given personalised care and privacy and dignity was always maintained.
- We saw an example where two nursing staff went out of their way to fully establish a patient's wishes and to make sure that they fully understood the conversation they were having. This demonstrated a real focus on the wellbeing of the individual.

Is the service responsive?

Good

Our rating of responsive improved. We rated it as good because:

- The service had improved the provision of information for patients and visitors that did not speak English as a first language.
- The critical care department carried out research with their interpreting provider to establish the three most common languages used. As a result, a full suite on information had been translated into the three most commonly used languages.
- There were notices placed across the critical care units in the next six most commonly used languages. This told anyone visiting how they could obtain further information in their language.
- A large picture that showed all the stages of the critical care pathway had been placed in the relatives' room on level seven. The pictures displayed could be understood by adults and children alike as well as those who did not speak English as a first language. Included in the picture were links to a wide variety of support groups and information sources. These could be directly accessed by using a smartphone to link to the QR code.
- The service had introduced a standard operating procedure that was followed if a patient under the age of 18 years was on the critical care units.

- The service had developed what they called ‘stress busting’ boxes. These boxes could be used to store items important to the patient. If they were able, they could leave a message for loved ones to read if they were unable to communicate when they visited.
- Complaints remained exceptionally low with just one complaint received. Although there had only been one complaint, we saw that learning had been taken from it.
- In the four months prior to the inspection, there had been zero re-admissions to the critical care units within 48 hours.

However:

- Patient flow remained a significant problem for the service due to the flow issues across the hospital.
- The service had not met its target of admitting all patients to the critical care unit within four hours of the decision to admit. There were significant delays discharging patients to the general ward environment
- Out of hours discharges were well above the 6% target in all five months from April 2018.

Is the service well-led?

Good ↑↑

Our rating of well-led improved. We rated it as good because:

- The critical care directorate had a clear vision and strategy for the service.
- The vision and strategy were aligned to the trust’s true north objective where the patient is at the heart of everything that is done.
- There had been a significant culture shift where staff described critical care as a more cohesive unit. The differences between the neuro critical care staff and the general critical care staff had been overcome.
- The directorate managers also described how a culture had developed where they, and senior nursing and medical staff were able to constructively challenge each other and that the mindset was about making improvements to the service.
- We were told by a variety of staff how the arrival of the new executive team and the move to a new structure, in which critical care was its own directorate in the specialist services division, had combined to show real benefits to critical care.
- Staff told us how the introduction of the improvement huddle had led to changes being made that had improved safety and mitigated risk.
- Risk was well managed and we saw the directorate risk register was regularly reviewed.
- A system had been introduced where managers job roles were reviewed to determine the key elements of their role and how often each task was performed. This meant in the event of anyone being absent for a sustained period could have their work covered. This mitigated the risk of single points of failure.

However:

- The critical care team did not have a wide range of service level agreements with organisations that could assist with patients leaving the critical care environment.
- The critical care team did not have a designated lead for mental health.

- No specific training was provided for staff around the mental health of patients.

Outstanding practice

We found examples of outstanding practice in this service:

- The emotional support provided to patients and their relatives throughout their stay in critical care.
- The pictorial explanation of the critical care pathway was innovative and cold be understood by a wide cross section of visitors. The immediacy of the link to useful information would be incredibly useful for visitors.
- The introduction of stress busting boxes for patients to keep small things that mean a lot to them, particularly how they could be adapted to be used for each individual patient.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Actions the trust SHOULD take to improve:

- The trust should develop a system that ensures that patient diaries stay with the patient when they leave critical care.
- The trust should review the provision of psychological support provided to patients during their stay in critical care.
- The trust should look to provide training for all staff to better equip them when dealing with patients with mental ill health.
- The trust should continue the work that had already started to integrate the cardiac critical care unit with the general and neuro critical care units.
- The trust should review how it screens patients for dementia in the critical care environment.
- The trust should continue the upward trend of completing pain assessments for all patients.
- The trust should continue to work with the rest of the hospital to further reduce the length of time from a patient being wardable to being discharged.
- The trust should continue to work to further reduce the number of out of hours discharges.

Maternity

Good ➔➔

Key facts and figures

The trust has 73 maternity beds across two sites (Royal Sussex County Hospital and Princess Royal Hospital). Of these beds 40 are located within two wards at Royal Sussex County Hospital. The other 33 beds are located within two wards at Princess Royal Hospital.

Brighton and Sussex University Hospital (BHUT) provides maternity services on the Royal Sussex County Hospital and Princess Royal Hospital sites. This report focuses on the Royal Sussex County Hospital (RSCH). From April 2017 to March 2018 there were 5,056 deliveries at the trust of these approximately 3,500 babies were delivered at RSCH per annum. There is a community maternity service which achieves a high rate of 9.1% for home deliveries. The trust also provides antenatal services at Hove Polyclinic.

The number of deliveries at the trust has fallen slightly over the last two years (January 2016 to March 2018). In the most recent quarter of available data (January 2018 to March 2018) there were 1,218 deliveries at the trust, down from 1,349 deliveries in the same period of the previous year (January 2017 to March 2017).

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. We carried out our inspection on 25 and 26 September 2018 and reviewed all areas where maternity patients received care and treatment. These included the antenatal ward (including the planned assessment unit and day assessment unit/triage area), post-natal ward, labour ward, early pregnancy unit, antenatal clinic, midwife led unit, obstetric theatres and recovery. We spoke with 28 staff from across the department including the head of midwifery, matrons, consultants, a registrar, midwives including specialist midwives, housekeepers, maternity support workers, the governance/risk lead, safeguarding and mental health midwife and community midwives. We also spoke with 13 patients and relatives and reviewed 13 sets of maternity records. Before, during and after our inspection we reviewed the hospitals performance and quality information. This information included meetings minutes, policies and performance data.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The trust had managers at all levels with the right skills and abilities to run the service. Previous concerns about fire safety, theatre ventilation and the operations of the lifts had been addressed and taken seriously.
- The service controlled infection risk well and had suitable premises and equipment which was well maintained.
- Staffing levels were much improved and one to one care labour was achieved 99-100% of the time. Staff had completed mandatory training in line with trust targets. Staff were competent with high appraisal rates and opportunities for further training were identified and supported.
- Risk was well managed within maternity and when incidents did occur they were investigated and lessons learnt were shared among the team and wider directorate. Risk was reviewed through a series of local and trust wide meetings.
- Outcomes for people who use services are positive, consistent and regularly exceeded expectations. Audit had been used effectively to show improvement and high performance was recognised by credible external bodies.

Maternity

- The department had an awareness that maternity specific tools were needed throughout the department as women's maternity needs were different to that of other patients within the hospital.
- Women were supported in a caring and compassionate way, with their dignity and privacy maintained. Staff supported women in making their own choices and accommodating these where ever possible.
- Where people's needs and choices were not being met we saw this was identified and used to inform how services were improved.
- A range of specialist midwives were available to support women. This included mental health, teenage pregnancy, homeless and substance abuse specialist midwives.
- Community teams worked cohesively with the department and a separate homebirth team worked across the trust ensuring a better that national homebirth rate.
- Discharge of patients was well managed and planned. Women undergoing caesarean section were given an estimated discharge date on arrival and recovered under an enhanced recovery protocol.
- The trust had managers at all levels with the right skills and abilities to run the service.
- All staff we spoke to felt supported by their line manager. Midwifery staff spoke positively about the leadership of the department and the support they were offered.
- The trust had systems for identifying risks and planning to eliminate or reduce them. There was a demonstrated commitment to best practice performance and risk management.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action these were often developed with involvement from staff and patients.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. We saw evidence that domestic staff followed guidance regarding the required cleaning standards, practices and frequency of cleaning.
- The service had suitable premises and equipment and looked after them well. Staff reported they had enough equipment and that if needed replacements were quick. There was currently a back log which had meant that some CTG machines were past the service date. However, it was clear these were known about and had been scheduled to be serviced.
- Fire safety was previously a concern across the department. During this inspection we saw all areas had up-to-date and actioned risk assessments and staff attended ward based fire evacuation simulation. All items identified by the CQC during the earlier inspection were prioritised and actioned. We saw a clear fire evacuation plan was displayed on each level and the division was 94% compliant with fire training as of August 2018. The maternity department had also trained several midwives to act as fire wardens and ensured one was available on each shift. The role included ensuring correct procedures were followed in case of a fire.

Maternity

- During our previous inspection we had concerns over staff awareness of an over-ride key that allowed an emergency lift to be accessed if a woman needed to be transferred down to the second theatre on level five. The department had addressed this with further training and the override key had been highlighted to staff during huddles to emphasise its use.
- The obstetric theatre ventilation system had been repaired. During our last inspection this had been in breach of national recommendations and posed an infection control risk. The ventilation system was now performing within the recommended number of air changes. At the most recent verification in August 2018 the airflow was complaint with 23.5 changes per hour.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. Vacancy rates for midwifery staff were currently 2% and we were told the department had a waiting list of midwives that were wanting to work at the hospital.
- One to one care in labour was being achieved 99-100% of the time which was much better than the previous time we inspected. Staff reported increased staffing levels had dramatically helped.
- The trust reported an average vacancy rate of 4.3% from September 2017. However, the Royal Sussex County hospital site now has filled most consultant vacancies with only one consultant post unfilled. The staff reported using a locum consultant who was familiar to the trust and department.
- Documented individualised antenatal risk assessments were regularly reviewed throughout pregnancy and we saw individualised management plans for any women where additional risks were identified during the initial clinical risk assessment.
- The department had recently undertaken a review of all cases of hypoxic-ischaemic, encephalopathy (HIE) cases within one year. The aim was to determine any common themes and to identify any learning points from them. The department did not discover any common themes but does now send all placentas from HIE cases to histology for sampling. They have also increased the training around CTG interpretation, so all obstetric clinicians attended annual training alongside midwives.
- Staff kept appropriate records of patients' care and treatment. The overall quality was good, notes were legible; entries were signed, dated and timed in line with best practice guidance. Examples included adequate use of the venous thromboembolism (VTE) score checklist, World Health Organisation (WHO) checklist used in theatres, charts for growth and early warning scores.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time. We saw swipe card access to all medication/ clinical rooms, ensuring medicines were stored securely.
- Patient safety incidents were well managed, from June 2017 to May 2018, the trust reported no incidents which were classified as never events for maternity. All incidents were reviewed by the departments risk co-ordinator who led any investigations. This work was cross site and was fed back to the weekly incident meetings and the Patient Safety Team.
- The trust reported one serious incident (SI) in maternity which met the reporting criteria set by NHS England from June 2017 to May 2018. The incident was a screening issue at the antenatal clinic in RSCH. It centred mostly around a lack of ability to accurately track the booking cohort for the antenatal screening programmes. We spoke with the antenatal screening co-ordinator who explained although the system remained the same the department was limited

by the current IT systems within the department. They had introduced several extra 'fail safe' measures to ensure no women missed their screening. This included community midwives checking if women had attended ten days after their appointment, this was audited and communicated to the screening team. The department had recently submitted the first quarter data and these were complete with no women missing their screening.

However:

- The department had undertaken a nationally recommended maternity specific staffing review in January 2018. Following this the recommended staffing levels were one midwife to every 26 patients. The current template was still one midwife to every 30 women. The department had put a business case to increase the template but it had still not made any significant progress. The impact of this was that staff felt busy particularly on shift where they were a midwife short.
- The department had a uniform policy that allowed all staff to wear their own clothes into work, this was intended to fit with the departments ethos of promoting normality in pregnancy and birth. We reviewed the policy and saw some members of staff were not following it correctly. For example, we saw midwives wearing watches and incorrect footwear. We also saw staff with no name badges, faded name badges and some that were not clearly visible. This was raised during our previous inspection and was still not fully embedded.
- We reviewed 13 sets of notes and found them generally well ordered although we did see some loose pages within notes that could have become separated from patient records. We also found records with missing information examples included fluid balance chart not fully completed and incomplete birth summaries and babies' details.
- Some clinical rooms had ambient temperatures that were higher than the recommended maximum temperature of 25 degrees Celsius. This had been risk assessed and fans had been placed in rooms to help. The pharmacy had also minimised the amount of stock that the department could keep in the room to ensure a high turnover and minimise the risk.
- We observed a safety huddle meeting which was interrupted several times and was not protected time. This may lead to messages being missed due to the chaotic nature of the surroundings. We attempted to attend another huddle the following day which was due to start at 11:45, we waited until 12:15 but the huddle had still not occurred. Staff reported it was not always a set time as the ward activity was very changeable.

Is the service effective?

Outstanding ☆ ↑

Our rating of effective improved. We rated it as outstanding because:

- Outcomes for people who use services are positive, consistent and regularly exceed expectations. The department had been recently identified as an outlier for third and fourth degree tears. These tears are referred to as Obstetric Anal Sphincter Injuries (OASI). The department had undertaken a piece of work called the 'ORB', which stands for OASI Reduction at BSUH. The project encompassed research and evidence from other trusts and focused on position, guidance, protection and pace of delivery. Since the introduction of the project the rates of OASI had reduced significantly with rates of 2.3%. This is much better than the previous high of 7.7% and was also better than the trust target of 5%.
- The trust took part in the 2017 Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE) audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 5.72. The trust's performance for this audit was much better than the national comparator group. It showed the trust was more than 10% lower than the average for the comparator group rate of 6.71.

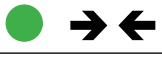
Maternity

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- High performance was recognised by credible external bodies. In July 2018 the trust was recognised as one of the top performing hospitals in the UK for helping diabetes patients control their glucose levels. The trust offered a diabetic clinic for women identified as at risk of gestational diabetes. It was located in the ante-natal clinic. Mothers had dedicated diabetes notes and a new diabetes protocol which aimed to reduce inductions of labour for women with gestational diabetes. In the two years since this was first developed there have been no diabetes birth defects experienced by mothers.
- The department had an awareness that maternity specific tools were needed throughout the department as women's maternity needs were different to that of other patients within the hospital. For example, the maternity department had a separate sepsis screening tool that was completed and placed in all women's notes. This had maternity specific questions such as if a woman may be suffering with mastitis (infection of the milk ducts).
- The homebirth rate at RSCH was much better than the national average, with 6.5% reported against a national average of 2.3%
- Brighton Hospital University Trust were taking part in the Maternal and Neo-Natal Health Safety Collaborative. This was a national initiative to reduce the rates of maternal deaths and stillbirths and brain injury. The introduction to this scheme was attended by the matron, obstetric lead and labour ward leads. The obstetric consultant at BHUT was the lead for the county on this initiative. This showed a commitment to achieve better rates of Intrauterine foetal death and stillbirth.
- The continuing development of the staff's skills, competence and knowledge was recognised as being integral to ensuring high-quality care. Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice. Recent examples included staff had attended the Royal College of Midwives labour ward leader course. This was a multi-professional course to develop midwives to undertake improvement projects. Staff had also been involved in developing regional teaching for nursery nurses and extended training in advanced neo-natal life support.
- A practice development midwife and a clinical skills facilitator worked across maternity to ensure staff had access to training and worked within the department to offer midwives support when needed. Staff took part in skills drills and had regular workshops the latest included bereavement, cardiac care, In vitro fertilisation and suturing.
- Staff were consistent and proactive in supporting people to live healthier lives. There was a focus on early identification and prevention and on supporting people to improve their health and wellbeing. The community team offered a range of antenatal classes and had recently identified the need to include a healthy eating class for women with raised body mass index (BMI) as well as a class for women suffering from pelvic pain.
- We saw information on what to eat during pregnancy and advice on smoking cessation available to women. A smoking cessation service provided flexible and accessible support to help women stop smoking. A specialist midwife was available to women throughout their pregnancy.
- Staff, teams and services worked collaboratively and found innovative and efficient ways to deliver more joined-up care to people who use services.
- Increased numbers of midwives undertook New-born Infant Physical Examination (NIPE) training and supported midwives to deliver NIPE checks at home. The department had also purchased Bilirubinometers (a device that directing light into the skin of the neonate and measuring the intensity of specific wavelength that is returned to detect jaundice). This allowed women to return home without delay and allowed mothers who had birthed at home to remain there without the need to visit hospital.

Maternity

- The department carried out a paper audit of the World Health Organisation (WHO) documents monthly within the obstetric theatres. We saw evidence that observational audits were also conducted quarterly. We saw recent audit results which showed good compliance with the debriefing, sign-in, time out, and sign-out. There had been some issues with staff not signing the sign out section, which had been addressed by an increased focus and weekly auditing.
- Women had access to a range of pain relief methods. This included Entonox (gas and air) and Pethidine (a morphine-based injection) for medical pain relief during labour. Epidurals were available 24 hours, seven days a week. Women generally received epidurals within 30 minutes of request.
- Alternative pain management was encouraged including the use of transcutaneous electrical nerve stimulation (TENS) machines, (these are machines which are used as an alternative to medication, and they can ease pain in some people with certain types of pain). Aromatherapy oils were kept in fridges for all women to use throughout birth and postnatally.
- Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other preferences.
- All patients we spoke to said they had received support to breastfeed soon after birth, and that this had continued on the post-natal ward. Breastfeeding initiation was consistently above the trust target of 85% with figures averaging 87%. Patient information of breastfeeding support was seen throughout the department.
- Previously the maternity dashboard showing the department had not met expected targets in some patient outcome indicators. We saw an improvement in many of these indicators, and where the department was not meeting targets there were action plans in place to ensure patient outcomes remained high. An example of this was the number of women who experienced shoulder dystocia 2.7% against a target of 0.5%. The department had understood the challenges of this and was undertaking a deep dive and audit to ensure no learning opportunities were missed.
- During our inspection we saw that maternity had achieved an appraisal rate of 95.2% which was the highest across the trust.
- Midwife support, consultants and anaesthetists were available on site 24 hours seven days a week. This ensured women had access to support and advice at all times. Maternity services offered a 24-hour telephone triage service. This service could be accessed at any stage of pregnancy.
- Obstetric theatres were staffed by a separate theatre team across a 24hour period. This team were solely dedicated to support obstetrics and were not included in the staffing of the main theatres across the hospital.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Staff followed the trusts Policy for Consent to Examination or Treatment dated 18th February 2016. We reviewed this document which was detailed and highlighted the duty to appoint an Independent Medical Capacity Advocate (IMCA) for patients who lacked capacity. The document also outlined the use of 'Gillick competencies' in relation to children. Gillick competence reflects a child's increasing development to maturity.

Is the service caring?

Good 

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

Maternity

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. We spoke with 12 patients and their relatives who all had positive reports of the care they had received.
- People's emotional and social needs were important to staff. We saw staff taking time to interact with patients and saw examples where staff demonstrated the importance of gaining the trust of women they were treating. Positive comments included, "We felt in safe hands throughout, even though there were one or two complications." And "We will always remember your kindness, support and amazing care on the most special day of our lives."
- From June 2017 to June 2018 the trust's maternity Friends and Family Test (birth) performance (% recommended) was in line with or greater than the England average for all months other June 2018, where the trust's score fell to 94% (compared to the England average of 97%).
- Women we spoke with confirmed that staff explained processes in detail, spent time with them and provided reassurance. Women using maternity service could access support for specific health related issues including diabetes or mental health needs. Midwives assessed women for anxiety and depression during their initial antenatal appointment and then they were given continuous support as required once admitted.
- Staff showed determination and creativity to overcome obstacles to delivering care. People's individual preferences and needs were always reflected in how care was delivered. This included allowing high risk women to be supported to birth at home or with limited consultant presence in hospital. If their needs could not be met the women were made aware of the reasons and offered the best possible solutions.
- The trust performed in line with other trusts for 14 out of 16 questions in the CQC maternity survey. The trust was amongst the best performing trusts for two of the four survey question metrics relating to labour and birthing areas and better than other trusts in the other two questions.
- There was a dedicated bereavement lead at RSCH and Princess Royal Hospital. They worked hard to improve the service over the last two years. Bereavement services now included home visits and telephone access to the bereavement team. The service also helped with funeral arrangements, referrals for specialist counselling and arranging follow up consultant care (dedicated pregnancy loss consultants were based at both sites).
- A recently completed bereavement suite enabled women to give birth in a separate delivery room and then and spend time with their baby in a fully furnished bedroom with kitchenette and bathroom facilities. The suite had been designed and furnished with input from families that had suffered loss within the department. Families could spend as long as they needed within the suite and it was away from the labour ward to protect mothers from labouring women. We were told of a homeless couple who had recently used the suite following a bereavement, the staff were able to connect them with other support services and they stayed for a week. The couple fed back that "it was the kindest anyone had ever been to them".
- Stillbirth and Neonatal death charity (SANDS) training, had been undertaken by a total of 80 Maternity, Gynaecology & Neonatal staff. Bereavement training was also now included in all mandatory training within the department.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good because:

- The trust planned and provided services in a way that met the needs of local people. The importance of flexibility, informed choice and continuity of care was reflected in the services offered to women.

- Where people's needs and choices were not being met we saw this was identified and used to inform how services were improved. An example of this was the development of a transgender and non-binary protocol. This included building the teams presence at relevant local events and working alongside local transgender support groups to encourage and support those who wished to have a family.
- The service took account of patients' individual needs. Reasonable adjustments were made and action taken to remove barriers when people found it hard to use or access services. Women with specific needs or care needs due to physical disabilities or wheelchair access were referred by community midwifery to the labour ward leads who met with the woman to develop plans to offer the best support. This included discussing the use of appropriate rooms, whether self-transfer was possible and bathroom facilities. Information was also passed to the postnatal team to ensure care plans continued when patients were transferred to the ward. All facilities were wheelchair-accessible.
- Women had access to translation services if English was not their first language. The department tried to ensure this was face-to-face, but if this was not available then they could access language line for immediate translation. We were given examples where women were offered double appointments to ensure detailed discussion could take place. A health visitor also ran a support group for women whose first language was not English to encourage social engagement and integration.
- A range of specialist midwives were available to support women. These included a specialist Birth Stories midwife who helped women who had experienced trauma during labor and birth. It provided a one to one session counselling session with the patients' obstetric notes available.
- A teenage pregnancy midwife was available to offer support for young women and their partners who are under 20. The service helped with antenatal care, arranged scans and any other appointments needed.
- A specialist perinatal mental health midwife provided support to women with mental health issues and more recently tokophobia (an intense anxiety or fear of pregnancy and childbirth). Women had access to a perinatal mental health clinic which provided advice, assessment and treatment for women with a past or current history of severe mental illness
- Women had access to a range of antenatal care. Antenatal care, parent craft and postnatal clinics were provided in a variety of locations including GP surgeries and children's centers throughout the area. This encouraged attendance by taking services closer to where women lived. Community midwives provided antenatal classes on a variety of topics, including water birth, vaginal birth after cesarean (VBAC), breastfeeding and homebirth.
- There was an average of 20 transfers between units within the trust each month. None of these were women who were in-utero. There have been no unit closures in the same time frame. We reviewed the trusts transfer policy 'Brighton and Sussex University Hospitals Transfer Policy' dated March 2016. This included numbers for the local ambulance service in cases of emergency transfers. Transfers often occurred as the trust had a high number of babies requiring special care, because the special care baby unit (Trevor Mann Unit) provided level three support. Women were told at initial booking that the maternity service was a one hospital trust which provided maternity care over two sites. Women were made aware that they may be asked to attend a different hospital site if one maternity unit was full. We saw no complaints relating to women having to attend a different site to the one they requested.
- The department recently undertook training with the local NHS ambulance team to agree terminology to be used when calling for an ambulance for transfer. All staff now have a laminated card for reference. The aim was to ensure a consistent approach considering human factors to minimise risk.
- Community teams worked shifts and were not on call, there was a separate homebirth team working across the hospital. Staff in the community would work in the acute setting if there were no calls within the community. However, they were not placed in charge of labouring women or given duties that would restrict them leaving if they were called away.

- Discharge of patients was well managed and planned. Women undergoing caesarean section were given an estimated discharge date on arrival and recovered under an enhanced recovery protocol.

However:

- There was patient car parking on the hospital site for maternity patients. However, the parking was limited and during busy times we saw long queues formed. During our inspection we witnessed a father who missed the birth of their child as his partner laboured quickly and he was stuck in the queue for the car park.
- We also spoke with women who had concerns at the length of time it takes to get the lift to arrive and get up to the 13th floor. This was often delayed by patients stopping to get in and out of the lifts on the way up and could be distressing for women who were experiencing labour.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good because:

- The trust had managers at all levels with the right skills and abilities to run the service.
- All staff we spoke to felt supported by their line manager. Midwifery staff spoke positively about the leadership of the department and the support they were offered. Staff across the department including the community teams felt they could access the leadership team and were able to describe how this would happen.
- The department had direct access to the trust board every month through the divisional governance board meeting. Several meetings fed into this meeting including the patient safety team, audit meeting and safety and quality meeting. This allowed information to be fed up to the board but also back to the frontline staff.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action these were often developed with involvement from staff and patients.
- The division worked with the trust to contribute to a revised trust clinical strategy. They had outlined their key objectives which included upgrading the obstetric theatre on level13, securing access to a second obstetric theatre, and developing an alongside Midwifery Led Unit at Princess Royal Hospital. The objectives also included a review the physical environment and facilities following the completion of the trusts building programme and to realise potential to develop as a regional centre of excellence for clinical services, teaching and research.
- The maternity department recently demonstrated full compliance with the NHS resolution and Clinical Negligence Scheme for Trusts (CNST) premium incentive scheme. This meant maternity had met the ten strict national safety criteria including clear and effective plans for staffing levels, training, and ensuring that patients had effective ways to give feedback.
- The trust had systems for identifying risks and planning to eliminate or reduce them. There was a demonstrated commitment to best practice performance and risk management. Risk was reviewed through a series of local and trust wide meetings. We saw there were comprehensive assurance systems, and performance issues were escalated through clear structures and processes. The directorate lead for operations and the risk manager held monthly meetings within the maternity department. They discussed developing risk and progress on the current risk register.

- The department attended Mortality and Morbidity meetings monthly. All deaths that were mandated in the guidance had been identified and had either undergone a case note review or were in the process of undergoing a review. The deputy medical director, for safety and quality, presented to the 'Grand Round' on the subject of learning from deaths including case presentations in neonatology mortality. For neonatal mortality the trust was the 16th out of all 57 level three units in the country.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively. Staff were consulted of any changes across the department and felt they had a voice. For example, the majority of staff were against the recent 'helping hands' on call rota system, so this did not go ahead. We also heard staff were consulted about the changes to the location of services and given a choice where they worked and input into the changes.
- Regular 'Pulse' check surveys are held to see how staff were feeling this has improved from 3.63 to 4.11 from 2017 to August 2018. It was reported this was the biggest improvement in the trust and better than the national average.
- The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. Maternity managers and matrons were enrolled on the 'Patient First Fundamentals' programme and had started to focus on the next steps.
- A women centred World Health Organisation (WHO) checklist had been developed in obstetric theatres. The aim was to make the woman the centre of the checklist by making sure all staff introduced themselves by name and designation to the woman and her partner. They were also part of the nationwide initiative called the theatre cap challenge, where staff names and roles are printed on their theatre caps. The aim was to flatten hierarchies, open communication channels and reduce the number of incidents in theatres. Alongside this the maternity staff were in the process of filming in a simulation setting from the woman's perspective. They planned to use this both internally for training but also to promote best practice externally too.

However:

- Staff had reported dismissive behaviours from a consultant working within the department. Staff had reported this to managers and incident reporting forms completed. We were told by the matron that this was being investigated but no conclusion had been reached.
- During our previous inspection we had concerns over staff awareness of an over-ride key that allowed an emergency lift to be accessed if a woman needed to be transferred down to the second theatre on level five. We saw evidence that the department had addressed this with further training and, in response to our feedback, had now provided override keys for the antenatal and postnatal ward and for the on call obstetric anaesthetist. However, there had been no formal risk assessment or business continuity plan if the lifts were to fail across the department. This showed that the department had not fully explored the risks associated with access to theatres or the department as a whole.
- The IT systems used in maternity were not effective at collecting data efficiently. We were given several examples where this was a barrier to staff being able to do their job effectively. The community team had now received laptops that had improved access to test results but they were still having to complete paper records as they were not compatible with the current system. Screening was reliant on many fail safes to ensure women were not missed as the current IT systems were unable to update teams if women were not screened on time. We also saw that one to one care in labour was calculated using a paper based system that relied on midwifes completing a paper based form every four hours. The department were aware of the issues and were currently seeking a new system. We also saw this highlighted on the risk register which showed that department were aware of the risks.

- Although we saw evidence of the clinical and internal audit processes working well, we were aware that key members of staff, including the risk lead and ward managers, were not always aware of how audits were used to improve the service. An example of this was a lack awareness of action plans or a gap analysis following national audits such as the recent Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE) audit report.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

- Outcomes for people who use services are positive, consistent and regularly exceed expectations. The recent OASI Reduction at BSUH (ORB) project had made an immediate impact on reduced third and fourth degree tears.
- The trust's performance for the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE) audit was much better than the national comparator group. It showed the trust was more than 10% lower than the average for the comparator group rate of 6.71.
- In July 2018 the trust was recognised as one of the top performing hospitals in the UK for helping diabetes patients control their glucose levels. The trust offered a diabetic clinic for women identified as at risk of gestational diabetes. Mothers had dedicated diabetes notes and a new diabetes protocol which aimed to reduce inductions of labour for women with gestational diabetes. In the two years since this was first developed there have been no diabetes birth defects experienced by mothers.
- Staff were consistent and proactive in supporting people to live healthier lives. There was a focus on early identification and prevention and on supporting people to improve their health and wellbeing.
- A women centred World Health Organisation (WHO) checklist had been developed in obstetric theatres. The aim was to make the woman the centre of the checklist by making sure all staff introduced themselves by name and designation to the woman and her partner. Alongside this the maternity staff were in the process of filming in a simulation setting from the woman's perspective. They planned to use this both internally for training but also to promote best practice externally too.

Outpatients

Requires improvement

Key facts and figures

The outpatient department at the Royal Sussex County Hospital is part of the Brighton and Sussex University Hospitals Trust.

Between May 2017 and April 2018 there were 354,339 appointments at the Royal Sussex County Hospital, which equated to 38% of the overall appointments across the trust during the same period.

Outpatient services at the Royal Sussex County Hospital are located throughout the site, with the main outpatient, diabetes, maxillofacial, sexual health and HIV clinics located in a building opposite the main hospital site. Other specialist clinics were situated within different areas of the main hospital.

As part of our announced inspection we visited the main outpatient department; the ear, nose and throat department; the maxillofacial clinic; the cancer centre; sexual health and HIV clinics and ophthalmology outpatients.

The hospital provides outpatient services covering a range of specialities including but not limited to: medicine, cardiology, neurology, rheumatology, diabetes, respiratory, ophthalmology, ear, nose and throat (ENT) and dental.

The service provides both consultant and nurse led outpatient clinics across a range of specialities. Outpatient clinics were held between 08:00am and 6:00pm with some additional ad-hoc clinics on a Saturday dependent on speciality.

During our inspection we spoke with 13 patients and two relatives. We spoke with 35 members of staff including nurses; consultants; registrars; medical students; junior doctors; health care assistants; therapists; receptionists and administrative staff; dieticians; divisional, directorate and service managers. We reviewed four patient records. We reviewed performance information about the department and the trust.

The service was previously inspected in 2017. That inspection also included diagnostic imaging services. Diagnostic imaging services are now inspected separately and have a separate report and therefore we cannot directly compare ratings. During this inspection, we only looked at services provided within the outpatient department.

The last inspection rated the service as requires improvement overall. On this inspection we maintained this rating, however the rating for safe improved from requires improvement to good.

Summary of this service

Our rating of this service stayed the same, although we saw that improvement had been made. We rated it as requires improvement because:

- Some items of clinical equipment in the ophthalmology clinic were seen to be overdue for maintenance.
- The service did not monitor or audit the quality of patient records.
- Although there was a trust wide programme for providing training to staff regarding the Mental Health Act 1983, no staff in outpatients had received Mental Health Act training.
- Patients could not always access the service when they needed it. Overall waiting times from referral to treatment were worse than the national average.
- Patients referred on a cancer pathway were not always treated within 62 days of referral from their GP. The trust was performing worse than the England average in this area.

Outpatients

- The patient led assessment of the care environment audits for dementia and disability scored significantly worse than the national average across four outpatients areas that were assessed. The trust wide dementia strategy did not have any outpatient related actions.
- Department waiting times for individual clinics were not recorded or collected by the services.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results. However, trust wide, not all complaints were responded to within the timeframe set in the trust guidelines.
- The leadership and governance structures did not provide consistent and visible support to staff working in outpatients, although arrangements were in place to appoint to key management vacancies and address this moving forward.
- There were some discussions of governance at the team meetings within the outpatient department, however the interface between local and divisional governance was in its infancy. This meant that governance issues may not be consistently communicated between operational and divisional teams.
- The service had a vision for what it wanted to achieve. A new clinical strategy had been created since our last inspection and we were told that this had involved in depth discussions with divisions and services and had been aligned to the trust strategic objectives. However, we were unable to see the strategy due to it not being approved or ratified, and staff we spoke with had not been involved or engaged with this process.
- There were improvement projects being run within the department, however key staff from the departments were not always included as part of this, such as outpatient improvement meetings where performance information was reviewed.
- Action plans were not in place following poor performance in three areas of the Patient Led Assessment of the Care Environment audits.
- The trust did not always collect, analyse and use information well to support it activities.

However:

- Staff recognised incidents and reported them appropriately. Lessons were learned and improvements made when things went wrong. Staff understood their responsibilities to raise concerns, to report safety incidents, concerns and near misses, and to report them internally and externally.
- Outpatient services were provided from premises where risks were assessed and mitigated, particularly where these had been identified because of the age and design of the buildings.
- The service had enough staff with the right skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean.
- The service provided mandatory training and key skills to all staff and made sure everyone completed it.
- Emergency equipment in all outpatient clinics was accessible and checked in line with trust policy.
- Medicines and medicines-related stationary were managed in a way that kept people safe; prescriptions were tracked and medicines were stored securely.
- The service had systems which promoted patient safety and we saw staff following these. For example, staff were completing the World Health Organisation safety checklist prior to dental extractions which ensured all patient safety checks had been completed.

Outpatients

- Patient's physical, mental health and social needs were holistically assessed and staff delivered patient care in line with evidence based care and best practice guidelines.
- Staff had the skills, knowledge and experience to deliver effective care, support and treatment. Staff had access to appraisals, ongoing training and assessments of competency.
- All necessary staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Staff gave patients enough food and drink, where appropriate, to meet their needs whilst in the outpatient department
- People were treated with compassion, kindness, dignity and respect, when receiving care. Feedback from people who used the service and those who are close to them was positive about the way staff treated people.
- Patients were given timely support and information to cope emotionally with their care, treatment or condition.
- Staff communicated with people so that they understood their care, treatment and condition. At the end of their appointment patients were informed of the next steps, such as when they would receive test results or when their next appointment would be and with whom.
- The service had taken action to address some issues around privacy and dignity since our last inspection. This included the creation of a patient assessment room so that patients no longer had to be weighed in corridors.
- Patients referred on a two week wait pathway for suspected cancer could expect to see a specialist within two weeks of referral from their GP and the trust was performing better than the England average in this area.
- Once a decision to treat had been made for a patient with a cancer diagnosis, they could expect to be treated within the operational standard of 31 days, and the trust was performing better than the England average in this area.
- The service took account of patients' individual needs. The main outpatient departments were signposted, and the service had addressed issues identified in previous inspections relating to patient needs including the provision of a disabled access toilet in main outpatients.
- Since our last inspection, the central administrative service and outpatients had been merged as a standalone directorate. This meant that the majority of outpatient services were under one directorate, which would enable better governance of key performance figures such as mandatory training.
- Staff felt well supported at a local level by the department manager and individual line managers.
- The culture of the staff in the department was positive and open. Staff put patients at the centre of their work.
- The service demonstrated a commitment to improvement and innovation. There had been a significant improvement in the friends and family response rates and the successful roll out of the e-referral system.
- The Royal Sussex County Hospital outpatient department was piloting the Patient First Improvement Project for outpatient services across the trust. Staff we spoke with were enthusiastic and engaged with this process.

Is the service safe?

Good

Outpatients

Our rating of safe improved. We rated it as good because:

- Staff recognised incidents and reported them appropriately. Lessons were learned and improvements made when things went wrong. Staff understood their responsibilities to raise concerns, to report safety incidents, concerns and near misses, and to report them internally and externally.
- Outpatients services were provided from premises where risks were assessed and mitigated, particularly where these had been identified because of the age and design of the buildings.
- The service had enough staff with the right skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Staff working in outpatients had a high level of compliance with mandatory training. Reflective practice sessions were a regular feature and included team reflections on safety issues and incidents.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. Cleanliness of the environment audits consistently met or were better than the trust compliance target and patients we spoke with told us the hospital felt clean. This had improved from the previous inspection.
- Emergency equipment in all outpatient clinics was accessible and checked in line with trust policy. Staff had received training in basic life support and resuscitation trolley were accessible and regularly checked to ensure that equipment was fit for use.
- Medicines and medicines-related stationary were managed in a way that kept people safe; prescriptions were tracked and medicines were stored securely. The service had made improvements in monitoring the temperature of the medicines cold chain within outpatients.
- Medical records were stored securely within outpatients. Following our previous inspection, the service had created new digitally locked notes stores that were only accessible to nursing and healthcare assistant staff.
- The service had systems which promoted patient safety and we saw staff following these. For example, staff were completing the World Health Organisation safety checklist prior to dental extractions which ensured all patient safety checks had been completed.

However:

- Some items of clinical equipment in the ophthalmology clinic were seen to be overdue for maintenance, although this was something staff were aware of and were addressing.
- The service did not monitor or audit the quality of patient records. During our previous inspection, records audits indicated that the quality of patient records had decreased. Since then, no further audits had been completed which meant that the service could not be assured of the quality of the records.

Is the service effective?

We do not rate outpatients service for effective. Our findings are as follows:

- Patient's physical, mental health and social needs were holistically assessed and staff delivered patient care in line with evidence based care and best practice guidelines.
- Staff had the skills, knowledge and experience to deliver effective care, support and treatment. Staff had access to appraisals, ongoing training and assessments of competency. The service was exceeding the trust target for staff appraisals.

Outpatients

- All necessary staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. We saw that written consent was obtained for patients undergoing minor surgical procedures on an outpatient basis.
- Staff gave patients enough food and drink, where appropriate, to meet their needs whilst in the outpatient department.

However:

- Although there was a trust wide programme for providing training to staff regarding the Mental Health Act 1983, no staff in outpatients had received Mental Health Act training. Staff were aware of how to escalate mental health concerns, including urgent referrals.

Is the service caring?

Good

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

- People were treated with compassion, kindness, dignity and respect, when receiving care. Feedback from people who used the service and those who are close to them was positive about the way staff treated people.
- Patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition.
- Staff communicated with people so that they understood their care, treatment and condition. At the end of their appointment patients were informed of the next steps, such as when they would receive test results or when their next appointment would be and with whom.
- The service had taken action to address some issues around privacy and dignity since our last inspection. This included the creation of a patient assessment room so that patients no longer had to be weighed in corridors.

However:

- The patient led assessment of the care environment result for dignity, scored significantly worse than the national average in the outpatient areas assessed. Staff were seen to protect patients' dignity as much as they could within the environment they were operating out of.

Is the service responsive?

Requires improvement

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Patients could not always access the service when they needed it. Overall waiting times from referral to treatment were worse than the national average.
- Patients referred on a cancer pathway were not always treated within 62 days of referral from their GP. The trust was performing worse than the England average in this area.

Outpatients

- A one-stop breast clinic was removed in May 2017. The trust told us this was due to the volume of patients being referred outstripping the capacity of the service and resulting in patients receiving on the day imaging dependant on when they were referred in to the service rather than being based on clinical need. An assessment process based on clinical need had been implemented in place of the one-stop clinic.
- The patient led assessment of the care environment audits for dementia and disability scored significantly worse than the national average across four outpatients areas that were assessed. The trust wide dementia strategy did not have any outpatient related actions.
- Department waiting times for individual clinics were not recorded or collected by the services. This meant that the service did not have oversight of patient waiting times within the department and as a result were unable to put appropriate measures in place to address this.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results. However, trust wide, not all complaints were responded to within the timeframe set in the trust guidelines.

However:

- Patients referred on a two week wait pathway for suspected cancer could expect to see a specialist within two weeks of referral from their GP and the trust was performing better than the England average in this area.
- Once a decision to treat had been made for a patient with a cancer diagnosis, they could expect to be treated within the operational standard of 31 days, and the trust was performing better than the England average in this area.
- The service took account of patients' individual needs. The main outpatient departments were signposted, and the service had addressed issues identified in previous inspections relating to patient needs including the provision of a disabled access toilet in main outpatients.
- Senior staff told us the monitoring of clinic start and finish times was a draft indicator for the outpatient department Patient First Improvement System driver improvement project which started in September 2018 and was running for five months into 2019.

Is the service well-led?

Requires improvement

Our rating of well-led stayed the same. Although there had been efforts to improve the leadership, strategy and governance of the service, it was not yet embedded.

We rated it as requires improvement because:

- Whilst the service had managers with the right skills and abilities to run a service providing high-quality and sustainable care, there were key vacancies in the division, and the management structure had not yet been embedded. While staff acknowledged that the divisional leadership team had raised their visibility within the general outpatient department, this had been for a period of only a few weeks. Prior to this there had been limited contact for most staff with senior leaders for several months.
- There was a new governance structure in place across the trust which indicated that governance fed from the departments up through the divisions and to board level. There were some discussions of governance at the team meetings within the outpatient department, the interface between local and divisional governance was in its infancy. This meant that governance issues may be missed at a divisional and senior level.

Outpatients

- The service had a vision for what it wanted to achieve. A new clinical strategy had been created since our last inspection and we were told that this had involved in depth discussions with divisions and services and had been aligned to the trust strategic objectives. However, we were unable to see the strategy due to it not being approved or ratified, and staff we spoke with had not been involved or engaged with this process.
- There were improvement projects being run within the department, however key staff from the departments were not always included as part of this, such as outpatient improvement meetings where performance information was reviewed.
- Action plans were not in place following poor performance in three areas of the Patient Led Assessment of the Care Environment audits and no evidence to suggest the service was going to make any changes in response to the audits.

However:

- Since our last inspection, the central administrative service and outpatients had been merged as a standalone directorate. This meant that the majority of outpatient services were under one directorate, which would enable better governance of key performance figures such as mandatory training.
- Staff felt well supported at a local level by the department manager and individual line managers.
- The culture of the staff in the department was positive and open. Staff put patients at the centre of their work.
- The service demonstrated a commitment to improvement and innovation. There had been a significant improvement in the friends and family response rates and the successful roll out of the e-referral system.
- The Royal Sussex County Hospital outpatient department was piloting the Patient First Improvement Project for outpatient services across the trust. Staff we spoke with were enthusiastic and engaged with this process.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

- The trust should ensure that patient records are audited for quality.
- The trust should ensure that staff in outpatients receive training in the Mental Health Act.
- The trust should ensure that outpatient services are included as part of the dementia strategy.
- The trust should ensure that action plans are implemented and monitored following poor performance in three areas of the Patient Led Assessments of the Care Environment scores.
- The trust should continue to develop the leadership and governance functions of outpatients. Staff should be appropriately involved in all areas of performance. Performance monitoring activities undertaken by staff should be meaningful and focused on improving performance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Our inspection team

This inspection was led by Catherine Campbell, Head of Hospital Inspection. An executive reviewer, David Melbourne, supported our inspection of well-led for the trust overall.

The team included one inspection manager, 20 inspectors, one executive reviewer, and 25 specialist advisers.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.