Brighton and Sussex University Hospitals NHS Trust

Princess Royal Hospital

Quality Report

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Date of inspection visit: 4th-8th April 2016
Date of publication: 17/08/2016

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Inadequate
Medical care (including older people's care)	Requires improvement
Surgery	Requires improvement
Critical care	Requires improvement
Maternity and gynaecology	Requires improvement
End of life care	Good
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

The Princess Royal Hospital in Haywards Heath (centre for elective surgery) forms part of Brighton and Sussex University Hospitals (BSUH) which is an acute teaching hospital.

The hospital provides services to the local populations in and around the City of Brighton and Hove, Mid Sussex and the western part of East Sussex.

We inspected this hospital on 4-8 April 2016 and returned for an announced inspection on 13 April 2016.

Our key findings were as follows:

Safe

- Staff compliance in mandatory training, statutory training and appraisals fell well below the trust target of 95% for statutory training and 100% for mandatory training, for both nurses and doctors across every department in the hospital.
- Staff were reporting incidents. However staff feedback on learning from incidents and staff understanding of what incidents they should be reporting varied across departments.
- The trust had a Duty of Candour (DOC) policy, DOC template letters and patient information leaflets regarding DOC, and we saw evidence of these. The trust kept appropriate records of incidents that had triggered a DOC response, which included a DOC compliance monitoring database and we saw evidence of these. Most staff we spoke with understood their responsibilities around DoC, although this varied with poor staff awareness in critical care.
- Staff we spoke with were generally aware of the principles of the prevention and control of infection (IPC). The hospital was generally clean at the time of our inspection however there was room for improvement with curtain changing regimes. The cleanliness of the hospital was being audited by the facilities department. There had been some significant concerns over the cleanliness of the hospital and the validity of the auditing of cleanliness by a previous contactor. Hospital cleaning and auditing was now being performed 'In House' and staff had recognised that this had improved as a result.
- However, Staff did not comply with national and European regulations on the safe storage and disposal of hazardous waste or on the safe storage of chemicals in critical care.
- Medicines were not consistently being managed safely across all hospital departments. We found issues with secure and safe storage temperatures of medications along with stock management.
- The IT systems used in the hospital caused problems for staff in all areas. Information was difficult to locate and stored in a variety of formats which made it difficult for staff to access information when required. Locums and agency staff reported that they were unable to use the system.
- The trust had a safeguarding vulnerable adults and children policy, and guidelines were readily available to staff on the intranet and staff were able to access this quickly. However, safeguarding training for all staff groups was vastly lower than the Trusts target.
- Nurse staffing across the service was variable with some wards and areas being understaffed. Nursing staff numbers, skill mix review and workforce indicators such as sickness and staff turnover were assessed using the electronic rostering tool, the Safer Nursing Care Tool. The planned and actual staffing numbers were displayed on the wards visited. Agency and bank staff were used where needed to supplement nursing numbers.
- In ED the emergency medicine consultant cover breached the CEM standard and as such may adversely affect the quality of patient care and safety during the times when EMC cover is absent.

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Effective

- Staff generally followed established patient pathways and national guidance for care and treatment. Although we saw some examples of where some aspects of patient pathway delivery could be improved.
- National clinical audits were completed. Mortality and morbidity trends were monitored monthly through SHIMI (Summary Hospital-level Mortality Indicator) scores.Reviews of mortality and morbidity took place at local, speciality and directorate level although a consistent framework of these meetings across all specialities was not in place. The trust's ratio for HSMR was better than the national average of 80%.
- Although local audits were evident, there was a lack of robust, embedded learning and practice change based on audits. This included the lack of a sepsis audit programme.
- Mandatory training attendance was low across the whole hospital and we saw that some specific training needs were not met. For example, there were low levels of nursing and medical staff with specialist resuscitation and trauma course attendance.
- There were inconsistencies in the documentation in the recording of Mental Capacity Act (MCA) assessments and recording ceilings of care for DNACPR.
- Appraisal arrangements were in place, but compliance was low across the hospital. Trust wide only 68% of staff had received an annual appraisal. Accountability for these lapses was unclear.
- The nutritional needs of patients were assessed at the beginning of their care in pre-assessment through to their discharge from the trust. Patients were supported to eat and drink according to their needs. There was access to dieticians and medical or cultural diets were catered for.
- The trust did not meet the requirements of the key performance indicators of the National Care of the Dying Audit 2014. They did not have access to specialist palliative support, for care in last days and hours of life, as they did not have a service seven days a week. They did not have a non-executive director for end of life care services. Also they did not have a formal feedback process regarding capturing bereaved relative's views of delivery of care.

Caring

- Staff were caring and compassionate to patients' needs, and treated patients with dignity and respect.
- Patients and relatives told us they received a good care and they felt well looked after by staff.
- The staff mostly respected confidentiality, privacy and dignity.
- The majority of patients we spoke with felt involved in their care and participated in decisions regarding their treatment. They said staff were aware of the need for emotional support to help them cope with their treatment.
- We saw no comfort rounds taking place whilst we were in the ED department. This meant patients who were waiting to be treated may not have been offered a drink nor have their pressure areas checked.

Responsive

- The ED encountered issues around the department's inability to meet surges in demand; escalation protocols, leadership and record keeping all caused delays to assessment and treatment. Many of these issues were longstanding and had been brought to the trust's attention previously.
- Some people were unable to access services for treatment when they need to. The hospital did not take the needs of some patients into account when planning services. The admitted referral to treatment time (RTT) was consistently below the national standard of 90% for most specialties. The trust had failed to meet cancer waiting and treatment times.

Summary of findings

- The length of stay for non-elective surgery was worse than the national average offor trauma and orthopaedics, colo-rectal surgery and urology
- The percentage of patients whose operations were cancelled and not treated within 28 days was consistently higher than the England average.
- The percentage (31%) of admitted patients who moved wards during the night, (between 10 pm and 6 am).
- Performance for out of hour's discharges was variable and was connected to generally poor patient flow across the hospital.
- There was room for improvement in the consistency of discharge protocols and documentation for patients who needed rehabilitation.

Well-Led

- Staff in general reported a culture of bullying and harassment and a lack of equal opportunity. Staff survey results for the last two years supported this. Staff from BME and protected characteristics groups reported that bullying, harassment and discrimination was rife in the organisation with inequality of opportunity. Data from the workforce race equality standard supported this. Staff reported that inconsistent application of human resource policies and advice contributed to inequality and division within the workforce which led to a lack of performance and behaviour management.
- The trust had a complex vision and strategy which staff did not feel engaged with. There was a lack of cohesive strategy for the medical services either within their separate directorates or within the trust as a whole. Whilst there were governance systems in place they were complex and operating in silos. There was little cross directorate working, few standard practices and ineffective leadership in bringing the many directorates together.
- Staff told us there was a disconnection between staff and the executive board.
- Department's maintained risk registers; however it was unclear how this fed into the directorate risk and trust register. This was because we did not see evidence of information sharing among the multiple directorates.

  The results of the most recent staff survey continued to raise concerns about staff welfare, moral and organisational culture at the trust.

  In the 2014 staff survey over 50% of staff said their last experience of harassment or bullying was not reported by themselves.

  Numerous members of staff told us they felt poor behaviour and poor performance of other staff members was tolerated and went unchallenged. Some nurses said they felt unsupported in their role as managers spent the majority of their time at RSCH. Staff told us that there was managerial support up to the level of matron, but there was a lack of support beyond that level.

  There was evidence of a breakdown in communication between the executive team and the directorate teams, which resulted in the inability of local senior staff to obtain approval for urgent issues, such as nurse recruitment.

  Staff were not able to obtain human resources support in a timely manner.

Outstanding Practice:

- Brighton and Sussex University Hospitals NHS Trust was amongst Britain's most dementia friendly trusts. The trust was one of five in the National Dementia Care Awards. The trust's dementia team provided direct support to patients living with dementia in both the specialist dementia wards and in the trust in general.

Importantly, the trust must:

Summary of findings

- The provider must ensure that there are sufficient numbers of staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of patients using the service at all times. This includes ensuring that newly appointed overseas staff have the support and training to ensure their basic competencies before they care for and treat patients.
- The provider must ensure that medicines are always supplied, stored and disposed of securely and appropriately. This includes ensuring that medicine cabinets and trollies are kept locked and only used for the purpose of storing medicines.
- The provider must ensure its governance systems are embedded in practice to provide a robust and systematic approach to improving the quality of services. This includes improving learning from incidents, safeguarding and complaints across the directorates.
- Facilitate and establish a line of communication between the clinical leadership team and the trust executive board.
- Urgently review staff skill mix in the mixed/neuro ICU unit. This must include an analysis of competencies against patient acuity.
- Implement an action plan to reduce further nurse sickness absence and attrition through a transparent, sustainable programme of engagement that must include a significant and urgent improvement in staff training.
- Review funding for multidisciplinary specialties and ensure business cases submitted by specialists are considered appropriately. This specifically refers to pharmacy, occupational therapy and dietetics.
- Adhere to RCN guidelines that the nurse coordinator remains supernumerary at all times.
- Review and improve medical and nursing cover to meet relevant CEM and RCPCH standards and reflect/review activity rates relating to paediatric for the unit.
- Review clinical training records for medical and nursing staff and rectify gaps in role specific resuscitation training such as ALS and PILS.
- Complete mandatory training and performance appraisals for all staff.
- Review the actual risk of the Alert computer system.
- Ensure that resuscitation/emergency equipment is always checked according to the trust policy.
- Ensure staff are working under appropriately approved Patient Group Directions (PGDs). Ensure PGDs are reviewed regularly and up to date.
- Continue to ensure lessons learnt and actions taken from never events, incidents are shared across all staff groups.
- Ensure the 18 week Referral to Treatment (RTT) is addressed so patients are treated in a timely manner and improve outcomes for patients.
- Ensure safe and secure storage of medical records.
- Monitor the turnaround time for biopsies for suspected cancer of all tumour sites.
- Ensure that all staff complete mandatory training in line with trust targets, including conflict resolution training.
- Ensure that all relevant staff have the necessary level of safeguarding training.

In addition the trust should:

Summary of findings

- The provider should ensure there is a cohesive vision and strategic plan for the directorates which engages staff and provides an effective guide in the development of services.
- The provider should continue to prioritise patient flow through the hospital as this impacted on length of stay, timely discharge and capacity.
- The provider should ensure there is documentary evidence available to support recording that staff mandatory training is in line with trust targets.
- The provider should ensure that there are sufficient staff available to offer a full seven-day service across all directorates and support services.
- The provider should review the HR policies and ensure they are fit for purpose.
- The provider should ensure that effective HR resources are available that support staff. In particular the provider should continue to address the culture of bullying and intimidation found in some areas of the service.
- Ensure all staff are included in communications relating to the outcomes of incident investigations.
- Implement a sepsis audit programme.
- Review the workload of the nurse practice educators and assess the impact on their availability for bedside learning and teaching.
- Make adjustments to the rehabilitation pathway to ensure it is fully compliant with NICE CG83.
- Harmonize computerised patient information and management software between trust sites.
- Review and improve major incident storage facilities and replenish stock.
- Review analgesia authorisation for Band 5 nursing staff (PGD).
- Ensure equipment and medicines required in an emergency are stored in tamper evident containers.
- Review the provision of pharmacy services across the seven day week and improve pharmacy. support.
- Review the nurse staffing levels to ensure all areas are adequately staffed.
- Ensure all staff have had an annual appraisal.
- Review the consent policy and process to ensure confirmation of consent is sought and clearly documented.
- Review the provision of the pain service in order to provide a seven day service including the provision of the management of chronic pain services.
- Continue in embedding its governance systems to ensure a more consistent approach to governance processes.
- Have a defined regular audit programme for the end of life care service.
- Provide a seven day service from the palliative care team as per national guidelines.
- Record evidence of discussion of an end of life care patient's spiritual needs.
- Ensure all DNACPR, ceilings of care and Mental Capacity assessments are completed and documented appropriately as per guidelines.
- Ensure that all staff receive annual appraisals.
- Have a non-executive director for end of life care services.
- Implement a formal feedback process to capture bereaved relatives views of delivery of care.

Summary of findings

On the basis of this inspection, I have recommended that the trust be placed into special measures.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Inadequate 	In our view, the ED did not adequately protect patients from avoidable harm. There was inadequate emergency medicine consultant presence in the department which could affect the quality and safety of care patients receive. Levels of mandatory training and appraisals fell well below the trust target, there was poor compliance with safeguarding training to protect patients from harm; and the recording of mandatory training was inadequate. There was inadequate nurse staffing in the resuscitation department. Medicines were not stored in accordance with The Medicine Act 1968, drugs were not kept securely; and there was no fridge in the department, which meant there could be a significant delay in patients receiving emergency medication. Staff were also unaware were the major incident equipment was stored. The electronic patient record system is not fit for purpose and could pose a safety risk. There was poor completion of local and national audits because of the inability of the electronic patient system to support these. There was a lack of evidence to support evidence based care and compliance with national guidance. Nursing leadership was poorly organised with no single individual providing strategic nursing direction. There was poor completion of patient assessments such as pressure area assessments. There were not robust processes in place to ensure emergency equipment was fit for use. There was only one part time children's nurse, which did not comply with the Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012).

Summary of findings

Medical care (including older people's care)

Requires improvement

There was understaffing throughout most of the medical services. Although there had been some improvement with the recruitment of a large number of overseas nursing staff this had placed additional burden on existing staff who provided the new recruits with mentoring and support.
The trust had a complex vision and strategy which staff did not feel engaged with. There was a lack of cohesive strategy for the medical services either within their separate directorates or within the trust as a whole. Whilst there were governance systems in place they were complex and operating in silos. There was little cross directorate working, few standard practices and ineffective leadership in bringing the many directorates together.
There was also a problem in managing staff from different ethnic backgrounds, which was compounded by ineffective HR policies and lack of leadership support. Many of the trust's policies and procedures had not been recently reviewed.
The management of incident reporting was variable across the directorates with limited feedback or learning identified. We found there was under reporting across the medical services. Although staff were good at recording any clinical incident, non-clinical events such as understaffing were not always being recorded.
We saw that patients' care needs were assessed, planned and delivered in a way that protected their rights. Medical care was evidence- based and adhered to national and best practice guidance.
The care delivered was routinely measured to ensure quality and adherence to national guidance and to improve quality and patient outcomes. Patient outcomes were monitored and reviewed through formal national and local audits.
Patients told us that staff were kind and considerate and usually involved them in decisions about their care, and were kept up-to-date with their progress. The majority of feedback received was positive and the kind and caring attitude of the staff praised. We saw that patients were treated with dignity and respect.
The majority of the records and medical notes we reviewed were well completed. Each month a number of records were reviewed from each ward and feedback given to the ward managers on how

well they had been completed. The hospital had systems in place to review a number of records each month to ensure identify when patients who were becoming increasingly unwell, and provide increased support. Recognised tools were used for assessing and responding to patient's' risk

Surgery **Requires improvement** 

The service had experienced seven never events over a seven month period in 2015, two of these took place at the PRH and involved implanting the wrong prosthesis. These had been rigorously analysed and changes had been made in order to ensure they were not repeated.
The service was not meeting its referral to treatment targets (RTT) of being seen by the service within 18 weeks, the only specialty to meet this target was cardiology surgery.
Patient referrals on the waiting list for specific colon surgery could not be found in the outpatient system. The service did not fully understand why these referrals had been lost and had started work to identify them and review treatment.
Not all staff had received annual appraisals and less than 50% of staff had the opportunity to complete statutory and mandatory training provided by the trust.
The service had experienced a reconfiguration of its services and had started to get its governance systems in place but this was in its early stages and needed further embedding. Additional reconfiguration was being planned to further focus elective and non-elective activity into specific sites.
However:
The service's wards and departments were clean and staff adhered to infection control policies and protocols. Record keeping was comprehensive and audited regularly. Decision making about the care and treatment of a patient was clearly documented.
There was a high number of nursing vacancies; agency and bank staff were used and sometimes staff worked additional hours to cover shifts.
Patients' needs were met at the time of the inspection.
Medicines including controlled drugs and medicines related stationary (prescription pads) were held securely and appropriate records kept. There were

Summary of findings

regular safe, secure storage of medicine's audits which included areas such as fridges, medicines trolleys, drug cupboards, controlled drug cabinet and storage of intravenous drugs.
Treatment and care were provided in accordance with the National Institute of Health and Care Excellence (NICE) evidence-based national guidelines. There was good practice, for example, assessments of patient needs, monitoring of nutrition and falls risk assessments.
Multidisciplinary working was effective.
Access to further development and clinical training was accessible and there was evidence of staff being supported and developed in order to improve outcomes for patients.
Performance against national audits such as patients with a fractured neck of femur (broken hip) audit showed evidence of good outcomes for patients.
The service worked well with its seven clinical commissioning groups (CCGs).
Leadership at a local level was good and staff told us about being supported and enjoyed being part of a team. There was evidence of innovative multi-disciplinary working with staff working together to problem solve and develop patient centred evidence based services which improved outcomes for patients.

Critical care

Requires improvement

Overall we rated critical care as requires improvement. This reflects inconsistent nurse staffing levels that did not always meet the safe standards established by the Faculty of Intensive Care Medicine and the Royal College of Nursing. A dedicated nurse practice educator was available in the unit on a part time basis only, which meant staff did not always have timely or regular access to a suitable range of clinical education.
Staff did not always understand or use incident reporting processes and investigations did not always result in demonstrable learning. There was a lack of governance in relation to the management and resolution of risks identified on the risk register. However, local leadership at the unit level demonstrated passion for safe care and treatment and for developing the unit to meet increasing demand. This included the successful

Summary of findings

implementation of four additional high dependency beds in the unit to increase capacity. The beds were funded but the executive team had not yet approved the recruitment of new nurses required to staff the beds. This meant they were unused.
There was inconsistent and sometimes limited input from a multidisciplinary team of specialists with significant shortfalls in pharmacy, dietician and occupational therapist cover. The unit did not fulfil the requirements of national guidance in relation to the rehabilitation of patients through a follow up clinic. A dedicated audit nurse worked between critical care sites and there was a local audit plan in place. Although this demonstrated a focus on improving evidence-based care, there was inconsistent evidence outcomes and learning were used to improve practice.
A critical care outreach team was available 24-hours, seven days a week and provided hospital-wide support for patients with deteriorating conditions. This team also education sessions for staff and followed-up with patients after they were discharged from the critical care unit to a ward.
Staff were encouraged and supported to lead research projects, which they were able to present at national conferences as a knowledge-sharing strategy and were used to plan changes in practice.
Dedicated housekeeping staff and an infection control lead nurse maintained a high level of cleanliness, hygiene and infection control.
There was a demonstrable lack of communication and understanding between the executive team and local leadership. Staff did not feel engaged with the trust and could not identify any positive changes made in the unit as a result of executive-level support.

Maternity and gynaecology — **Requires improvement**

The interpersonal issues between some consultants undermined the performance of this service. While some staff identified improvements in working relationships, in the areas of governance and risk, the service experienced setbacks in 2014 from which it had only begun to recover and progress in

Summary of findings

2016. All consultants were yet to engage and participate fully in areas; including investigating serious incidents, reviewing and updating protocols and attending safety and quality meetings.
Midwives reported on staff shortages and some staff expressed their concern about the potential risks to women and their babies. They told us staff routinely covered vacant shifts, could not always take breaks during 12-hour shifts and provided the scrub practitioner role in theatre. The service also identified risks from the shortage of medical staff, the high use of locum cover and the failure to achieve waiting time targets in gynaecology.
The hospital failed to meet all five standard measures in the National Neonatal Audit programme.
The service had some of the best rates across England, for home birth and for breast feeding. In addition, the trust had appointed three new consultants and they were making a positive contribution to the service. Patient records were up-to-date and accurate and the areas we visited were clean. The service had responded to the local demand for variety of menus and alternative treatments in the form of aroma therapy. The service had introduced an advanced recovery programme in gynaecology. They ran one-stop clinics for women and their babies who were vulnerable as a result of their circumstances.
The service had a committed team of midwives and nurses and an active Maternity Services Liaison Committee with participation from local parents and their families.

End of life care

Good

Overall we rated the end of life care service at the Princess Royal Hospital as good. This was because:
The hospital provided end of life care training for staff on induction and an ongoing education programme which was attended by staff. A current end of life care policy was evident and a steering group met regularly to ensure that a multidisciplinary approach was maintained.
The specialist palliative care team were a dedicated team who worked with ward staff and other departments in the hospital to provide holistic care for patients with palliative and end of life care needs in line with national guidance.

Summary of findings

The Princess Royal Hospital and its staff recognised that provision of high quality, compassionate end of life care to its patients was the responsibility of all clinical staff that looked after patients at the end of life. They were supported by the palliative care team, end of life care guidelines and an education programme.

The specialist palliative care team was highly thought of throughout the hospital and provided support to clinical staff. The team worked closely with the end of life care facilitator to provide education to nurses and health care assistants. Medical education was led by the medical consultants and all team members contributed to the education of the allied healthcare professionals. The majority of end of life care was provided by clinical staff on the wards. The palliative care service worked as an advisory service seeing patients with specialist palliative care needs, including those at the end of life.

Staff at the hospital provided focused care for dying and deceased patients and their relatives. Most of the clinical areas in the hospital had an end of life care link person. Facilities were provided for relatives and the patient's cultural, religious and spiritual needs were respected.

Staff in the mortuary, bereavement office, PALS and chaplaincy supported the palliative care teams and ward staff to provide dignified and compassionate care to end of life care patients and their relatives. Medical records and care plans were completed and contained individualised end of life care plans. Most contained discussions with families and recorded cultural assessments. The DNACPR forms were all completed as per national guidance.

There was evidence that systems were in place for the referral of patients to the palliative care team for assessment and review to ensure patients received appropriate care and support. These referrals were seen and acted upon promptly.

The trust had an advance care plan which supported a patient to develop their wishes and preferences. The plan could be located in the patient's health record on admission and was accessible to the out of hour's community service.

The trust had a Rapid Discharge Pathway (RDP) and the documentation for this process was available

Summary of findings

on the end of life care intranet site which staff could access. The discharge team worked closely with the specialist palliative care team and coordinated the discharge of end of life care patients trust wide. The response time for discharge depended on the patients preferred place of care and what area the patient lived in.
The trust had a multi professional end of life steering group that oversaw the improvement plans that were in place to support the work towards meeting the five priorities of care for end of life, and also meeting the National Institute of Health and Care Excellence's (NICE) end of life guidance.
The end of life care service had board representation and was well led locally. This had resulted in a well led trust wide service that had a clear vision and strategy to provide a streamlined service for end of life care patients.
However we identified that the service was required to improve for the following:
The trust was not meeting the requirements of three key performance indicators of the National Care of the Dying Audit 2014. In their response to the audit in the End of Life Audit- Dying in Hospital 2016 the trust was worse than the national average for two areas.
There were inconsistencies in the documentation in the recording of spiritual assessments, Mental Capacity Act assessments and recording of ceilings of care (best practice to guide staff, who do not know the patient, to know the patients previously expressed wishes and/or limitations to their treatment) for patients with a DNACPR.
Patients did not have access to a specialist palliative support, for care in the last days of life, as they did not have a service seven days a week.

Outpatients and diagnostic imaging — **Requires improvement**

Incidents were not consistently being discussed at meetings or learning from incidents demonstrated. Assurance could not be given patients who had been their referral changed from routine to urgent on the referral management system were being seen in a timely manner. Some pathology samples for cancer diagnoses were not being fast tracked as there was no way of identifying them. There was no monitoring of turnaround time for these samples.

Summary of findings

The outpatients and diagnostic imaging departments had undertaken local audits to monitor the quality, safety and effectiveness of care. We saw that staff on the whole had a good awareness of National Institute for Health and Care Excellence (NICE), although some staff in outpatients were unaware of what a NICE guideline was. We saw competency documents, which indicated staff were competent to perform their roles.

Patients were not always treated with dignity and respect. We saw staff did not always consider the privacy of patients. Staff did not always introduce themselves to their patients. We witnessed breaches of confidentiality in patient waiting areas.

The trust had failed to meet the England standard for referral to treatment (RTT) times since September 2014. The trust had failed to meet cancer waiting and treatment times.

The pathology department was not providing diagnostic results for suspected cancer in a timely way. It had met the target time for suspected breast cancer results, but not others.

Call centre data indicated almost half of all calls had been abandoned and unanswered over the last year.

Sixty percent of clinics were cancelled with less than six weeks' notice. There was no monitoring of overrunning clinics by managers. Staff recorded clinic delays on occasion, but not routinely.

There was no formal strategy or vision in place in the outpatient department. Not all staff felt they could approach their managers for support. Senior managers and the executive team were not always visible to staff in the department.

We found staff cared for patients in a kind and compassionate manner. Volunteers provided extra assistance to patients moving from one area to another.

Princess Royal Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; End of life care; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Princess Royal Hospital

Brighton and Sussex University Hospitals (BSUH) is an acute teaching hospital with two sites the Royal Sussex County Hospital in Brighton (centre for emergency and tertiary care) and the Princess Royal Hospital in Haywards Heath (centre for elective surgery). The Brighton campus includes the Royal Alexandra Children's Hospital and the Sussex Eye Hospital.

Providing services to the local populations in and around the City of 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.

Out of 326 authorities, Brighton & Hove is ranked 102nd most deprived authority in England in 2015. This means they are among the third (31%) most deprived authorities in England

The health of people in Brighton and Hove is varied compared with the England average. Deprivation is higher than average and about 17.7% (7,700) children live in poverty. 13.3% (294) of children are classified as obese, better than the average for England. The rate of alcohol specific hospital stays among those under 18 was 63.1%, worse than the average for England. The rate of smoking related deaths in adults was worse than the average for England.

The health of people in Mid Sussex is generally better than the England average. Deprivation is lower than average, however about 7.7% (2,000) children live in poverty. Life expectancy for both men and women is higher than the England average. 11.6% (147) of children are classified as obese, better than the average for England.

The Trust has 1,165 Beds; 962 General and acute, 74 Maternity, and 43 Critical care. It employs 7,195.92 (WTE) Staff; 1,050.59 of these are Medical(WTE), 2,302.52 Nursing (WTE), 3,842.81 Other.

It has revenue of £520,761m; with a full cost of £521,218m and a Surplus (deficit) of £457k.

Between 2015-2016 the Trust had 118,233 inpatient admissions; 640,474 Outpatient attendances, and 156,414 A&E attendances.

Our inspection team

Our inspection team was led by:

Chair: Martin Cooper Consultant

Head of Hospital Inspections: Alan Thorne, Care Quality Commission

Detailed findings

The team included CQC inspectors and a variety of specialists: including consultants in Surgery, Medicine, Paediatrics, end of life care, senior nurses, a non-executive director, a director of nursing, allied health professionals and experts in facilities management, governance, pharmacy, and equality and diversity.

How we carried out this inspection

To understand patients' experiences of care, we always ask the following five questions of every service and provider:• Is it safe?• Is it effective?• Is it caring?• Is it responsive to people's needs?• Is it well-led?

The inspection team inspected the following seven core services at the Princess Royal Hospital:• Accident and emergency• Medical care (including older people's care)• Surgery• Critical care• Maternity and gynaecology• End of life care• Outpatients and diagnostic imaging

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included clinical commissioning groups (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch team.

We spoke with staff, patients and carers via email or telephone, who wished to share their experiences with us. We carried out the announced inspection visit on 4-8 April 2016 and returned for an announced inspection on 13 April. We held focus groups and drop-in sessions with a range of staff in the hospital including; nurses, junior doctors, consultants, midwives, student nurses, staff side representatives, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested. We talked with patients and staff from the majority of ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

Facts and data about Princess Royal Hospital

Trust wide Safe:

- The trust have reported seven never events between Jan' 15 to Jan' 16, all seven were attributed to surgery and four of which were related to wrong site surgery incidents. All never events took place between June to December 2015. All reported within Surgery. Wrong site surgery accounts for the majority (4).
- 98% of NRLS incidents were rated as low or no harm.
- The trust reports lower incident numbers compared to the national average.
- There have been 54 serious incidents reportedbetween Jan' 15 and Jan' 16.
- Safety thermometer Public Health observatory data for Dec' 14 to Dec' 15 reports low numbers of MRSA (2) compared to MSSA (21) and C.Diff (58).
- Between December 2014 to December 2015 there have been two MRSA cases.
- C. diff cases have peaked above the England average 7 out of 12 months.
- Safety thermometerdata for Jan' 15 to Jan' 16 shows a decline in the number of Pressure ulcers and Falls and consistent C.UTIs reported across the time period. From Apr' 14 to Jul' 15 ambulance median time to initial assessment was significantly higher than the England average however fell to below the England average from Aug' 15 to Oct' 15
- Medical skill mix is similar to the England average for all staffing groups.

Trust wide Effective:

Detailed findings

- Unplanned re-attendances to A&E within seven days percentages were consistently higher than the England average throughout the period Sep' 13 to Oct' 15
- Unplanned re-attendances to A&E within seven days percentages were consistently higher than the England average throughout the period Sep' 13 to Oct' 15
- Trust scores in the CQC A&E survey 2014 were rated as "about the same as other trusts" for questions relating to the effective domain.
- Trust scores were within the upper England quartile for three of the measures in the 2013 RCEM Consultant Sign-off Audit
- Scores for Royal Sussex County Hospital (RSCH) in the severe sepsis and septic shock 2013/14 audit were within the upper England quartile for two, in the lower quartile for four and between the upper and lower quartile for the remainderof the 12 measures audited
- RSCH scores in the assessing for Cognitive impairment in older people audit 2014/15 were within the upper and between the upper and lower England quartile for the five measures audited.
- Asthma in children's audit 2013/14 placed the Royal Alexandra Children's hospital in the upper England quartile for five, and in the lower quartile for two of the seven measures.
- Mental health in the ED 14/15 audit for RSCH scores were in the lower England quartile forfour of the eight measures and between the upper and lower quartile for the remainder.
- No mortality indicators highlighted as a risk for this trust.
- There are no mortality outliers for this trust.
- Cancer patient experience survey, has eight measures in the bottom 20% comparable to other trusts, four measures were within the top 20% and the remaining were in the middle 60% comparable to other trusts.
- Paracetamol overdose audit 2013/14 scores at Royal Sussex County Hospital were in the upper England quartile for three of the four measures audited and between upper and lower quartile for the remaining one measure.

Trust wide Caring:

- The percentage who would recommend the trust (FFT) is lower than the England average for the whole time period until the most recent data for Dec '15, where is it currently above the England average.
- CQC inpatient survey 2014, the trust scored about the same compared to other trusts for all measures.
- Patient-led assessments of the Care Environment (PLACE) were found to be better in each audit from 2013 to 2015, however Privacy, dignity and wellbeing and Facilities have declined over the time period from previous scores.

Trust wide Responsive:

- The standardised relative risk of re-admission for elective procedures at Princess Royal Hospital for elective procedures were 33% higher than the England average noticeably for General Medicine (across all sites) and Clinical Haematology.
- Scores in the National Diabetes Inpatient Audit 2013 (NaDIA) at Royal Sussex County Hospital were worse than the England average for 17 of the 20 measures audited but better for the remaining three measures.
- MINAP 2013/14 scores at Royal Sussex County and at Princess royal Hospitals were lower for two of the three measures compared to 2012/13 scores and lower than the England average for two of the three measures.
- The standardised relative risk of re-admission at Royal Sussex County Hospital for both elective and non-elective procedures were mostly the same as the England average.
- Trust scores in the Sentinel Stroke national Audit programme(SSNAP) for combined total key indicators (patient centred and team centred) at Princess Royal Hospital declined from C to D in the Jul' to Sep' 15 quarterly audit. Whereas the combined total key indicators improved from D to C at the Royal Sussex County Hospital in the same period.

Detailed findings

- In the 2012/13 Heart failure audit Royal Sussex County Hospitals scored below the England average for in hospital care measures and mostly the same for discharge care measures whereas Princess Royal Hospital score below for in hospital measures and better than the England average for two of the seven discharge care measures.
- NaDIA 2013 scores for Princess Royal Hospital were better than the England average for seven of the 19 measures but worse for the remaining 12 measures.
- The percentage of patients seen within four hours were consistently lower than the England average and lower than the 95% target throughout the period Sep' 13 to Dec' 15.
- The total time spend in A&E was consistently longer than the England average throughout the period Sep' 13 to Oct' 15.
- The percentage of patients waiting four to twelve hours from decision to admit to being admitted through the A&E were consistently worse than the England average for the period Jan' 15 to Dec' 15.
- The percentage of patients leaving before being seen were worse than the England average for the majority of monthsbetween Sept' 13 – Nov' 15
- The trust were rated as "about the same as other trusts" for all the questions in the A&E survey 2014 pertaining to the responsive domain.
- Delayed transfer of carebetween Apr' 13 and Aug' 15 has the top three reasons as waiting for further non acute NHS care (46.6%) patient or family choice (20.7%) and awaiting care package in own home (12.3%).
- Bed occupancy is below the national average between Q1 14/15 to Q1 15/16 the most recent data up to Q3 15/16 has it above the England average.
- The number of complaints have varied between 1,338 to 1,126 over the five year financial period.
- Since 2012/13 there has been a slight decline in the number of complaints with the lowest number reported in 2013/14 (1,126).

Trust wide Well-Led:

- General Medical Council 2015 national training survey highlights the trust score about the same as other trusts for all but two measures where it scored worse for Induction and Feedback.
- In the NHS Staff survey 2015 the trust has improved it score across most measures, it scored better than other trusts in 16 measures compared to the 2014 survey, where the trust scored worse than other trusts for 20 measures and was found to be similar to other trusts for all others questions.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Urgent and emergency services

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

Information about the service

The Princess Royal Hospital (PRH) provides a full range of elective and general acute services, an emergency department (ED) and a maternity unit, working in clinical partnership and interdependently with the Royal Sussex County Hospital (RSCH) at Brighton. PRH accepts medical emergency patients. All surgical emergency patients, with the exception of urology cases, are transferred to RSCH.

There is a paediatric walk-in centre, which treats minor injuries and illnesses. More complex paediatric patients are stabilised and transferred to the Royal Alexandra Children's Hospital (RACH) in Brighton.

The Sussex Orthopaedic Centre (SOC) is also located on the PRH site and is responsible for a variety of elective orthopaedic surgery. In addition, any patients in the area sustaining a fracture of the hip are treated at PRH.

The department had a total number of 60,741 ED attendances between April 2014 and December 2015. Like the other EDs in the trust, this figure represents a significantly higher attendance rate compared to the previous two years. For example, attendances in 2013/14 amounted to just over 31,000.

Between April 2015 – August 2015 24.6% of attendances resulted in admission, which is worse than the England average of 22.2%.

Patients arriving at the ED by ambulance are taken into the department via the ambulance entrance where they are assessed by a nurse and then allocated to the appropriate area of the ED. The adult emergency department has a three-bay resuscitation area, six cubicle spaces in majors, two side rooms, an eye examination room, emergency nurse practitioner (ENP) cubicle and two treatment rooms.

In addition, there a 'clinical decision unit' (CDU) adjacent to the ED, which comprises a four bedded bay area with two side rooms. Patients who meet the criteria can be admitted here for up to 24 hours if an immediate decision about their care and treatment cannot be reached.

Patients who self-present to the ED are booked in by a receptionist and directed to the waiting area, and then they are assessed by a nurse in an assessment cubicle and allocated to an appropriate area in the department. Emergency nurse practitioners (ENP's) assess and treat patients with minor injuries and illnesses. Children who attend can wait in a separate 'child friendly' waiting area.

We reviewed data and a variety of information supplied to us prior to and during the inspection. We received information from members of the public who contacted us to tell us about their experiences both prior to and during the inspection. We also reviewed the trust's performance data. The CQC held 29 focus groups where staff could talk to inspectors and share their experiences of working at the hospital.

During our inspection, we reviewed information from a wide range of sources to get a balanced and proportionate view of the service and spoke to 20 members of staff along with 12 patients and relatives of patients. We visited all areas of ED and observed care being delivered in a variety of settings.

Urgent and emergency services

Summary of findings

Overall, we rated the ED at Princess Royal Hospital 'Inadequate'. This was because:

In our view, the ED did not adequately protect patients from avoidable harm.

There was inadequate emergency medicine consultant presence in the department which could affect the quality and safety of care patients receive.

Levels of mandatory training and appraisals fell well below the trust target, there was poor compliance with safeguarding training to protect patients from harm; and the recording of mandatory training was inadequate.

There was inadequate nurse staffing in the resuscitation department.

Medicines were not stored in accordance with The Medicine Act 1968, drugs were not kept securely; and there was no fridge in the department, which meant there could be a significant delay in patients receiving emergency medication. Staff were also unaware were the major incident equipment was stored.

The electronic patient record system is not fit for purpose and could pose a safety risk. There was poor completion of local and national audits because of the inability of the electronic patient system to support these.

There was a lack of evidence to support evidence based care and compliance with national guidance.

Nursing leadership was poorly organised with no single individual providing strategic nursing direction. There was poor completion of patient assessments such as pressure area assessments. There were not robust processes in place to ensure emergency equipment was fit for use.

There was only one part time children's nurse, which did not comply with the Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012).

Are urgent and emergency services safe?

Inadequate

We rated ED at the Princess Royal Hospital Inadequate for 'Safe' because:

- The emergency department (ED) at Princess Royal Hospital (PRH) did not adequately protect patients from avoidable harm.
- The College of Emergency Medicine (CEM) standards state there should be an emergency medicine consultant (EMC) presence from 8.00am until midnight seven days a week. In the PRH ED, there was only an EMC present in the department from 9am until 5pm Monday to Sunday and no cover during evenings or weekends. We were unable to determine the status on Bank Holidays. This breached the CEM standard and as such may adversely affect the quality of patient care and safety during the times when EMC cover is absent. However there was EMC cover via telephone 24 hours a day.
- Staff told us the trust's senior management lacked understanding of their challenges and those members of the senior team did not offer support when they were busy.
- Medicines were not stored in accordance with The Medicine Act 1968, drugs were not kept securely.
- Staff told us nurse staffing requirements had not been reviewed since changes in activity had occurred. For example, the attendance of all the patients in the local area with hip fractures.
- Staff compliance in mandatory training, statutory training and appraisals fell well below the trust target of 95% for statutory training and 100% for mandatory training, for both nurses and doctors.
- The levels of documented safeguarding training among ED staff required improvement to protect patients from abuse.
- There were dedicated facilities for children but there was a lack of trained children's nurses. There was only

one part time children's nurse, which did not comply with the Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012).

- There was a current policy and equipment to support the department in the event of a major incident; however, staff did not know where the equipment was located. It was located in an unused part of the hospital, which would be difficult to access in an emergency. There was no process in place for checking this equipment to ensure it was all within date. In addition there was a vast amount of out of date equipment stored in the same location.
- The department uses a paper free computer software system, which documents, reviews and integrates all the clinical information.
- Staff told us this system was dangerous as there was scope for mistakes. Additionally it was time consuming and took time away from caring for patients.
- There was no fridge within the department and some emergency medications need to be stored in the fridge. The nearest emergency medications were on another unit, which took six minutes for staff to obtain. This could mean a significant delay in a patient receiving emergency medication.
- We saw the department was unable to respond to deteriorating patients due to lack of nursing staff especially in the resuscitation area.
- The receptionist who booked patients in on arrival in the department had no medical training but was responsible for alerting nursing staff if she felt the patient needed urgent attention. This was a risk as potentially unwell patients could wait sometime when the department is busy before being triaged.
- **Incidents.**

- Staff reported incidents through an electronic system. Some of the data supplied to us was trust wide and not split into sites. We were shown a summary of 2 serious incidents (dating from 2011 – 2016) and 68 safety incidents (between October 2015 – January 2016) where we were able to identify as PRH. Of these, 90% resulted in no harm to the patient and the rest rated as low harm.
- Senior staff analysed incident reports to identify trends. For example, all falls and pressure ulcers for patients in ED were recorded and analysed to increase staff awareness. Incidents relating to staffing, facilities and environment were the most commonly reported category of incident, accounting for 25% of incidents.
- If an incident was assessed as a serious incident, it was reported using StEIS (Strategic Executive Information System). Serious incidents can include but are not limited to patient safety incidents for example loss of confidential information. Any serious incident, which meets the definition of a patient safety incident, should be reported to both StEIS and national reporting and learning system (NRLS.)
- There were no serious incidents reported between January 2015 – January 2016. Staff discussed serious incidents at the ED safety and quality meeting and we saw evidence of this in meeting minutes.
- The trust implemented some innovative ways of sharing information from serious incidents including a 2-4 minute podcast made after every investigation. This was for staff to listen to or play at team meetings as the basis for discussion.
- There had been no reported never events in the previous 12 months. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented, so any Never Event reported could indicate unsafe care.
- We found there was a clear culture of incident reporting and staff told us they were encouraged to report incidents.
- The trust produced a "Patients 1st" safety bulletin, which contained anonymised accounts of incidents, lessons learned and remedial actions taken. This had been produced monthly since 2011. The bulletins were emailed to all trust staff on the 1st day of every month with a request to print off and share with any staff that did not regularly access emails.
- The Chief Executive published a weekly message, which included a 'Spotlight on Safety' section where current safety issues were highlighted.
- In the 2014 staff survey 11% of staff felt they were not treated fairly when involved in an error compared to 5% in 2013. This suggested not all staff thought there was a fair transparent process when involved in incidents.

- Staff reported they completed incident reports however did not feel there was a robust system for sharing the learning as most of the information was published on the trust's internet and they did not have the time to access it.
- We reviewed minutes from monthly emergency department operational meetings and acute floor directorate safety and quality meeting. Attendance at these meetings was not recorded. Staff told us that information from these meetings was not disseminated to them.
- Staff, patients and relatives were supported and informed of mistakes in accordance with the trust's duty of candour (DOC) policy. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- The trust had a DOC policy, DOC template letters and patient information leaflets regarding DOC, and we saw evidence of these.
- The trust kept appropriate records of incidents that had triggered a DOC response, which included a DOC compliance monitoring database and we saw evidence of these.
- The trust's patient safety incident form included prompts to ensure DOC conversations were undertaken when incidents were graded as moderate or above and we saw evidence of this.
- DOC compliance data as of April 2016 indicated 77% of patients had a DOC conversation within 10 days, 71% of patients received a DOC letter within 10 days and 51% of DOC reports were completed within 60 days.
- The majority of staff we spoke with were confident in describing the DOC process to us.

- **Cleanliness, infection control and hygiene**

- There were infection prevention and control policies and procedures in place that were readily available to all staff on the trust's intranet.
- There were no methicillin resistant Staphylococcus aureus or C.difficile (forms of bacteria) acquisitions associated with the ED between April 2015 and October 2015.
- There were dedicated infection control nurses who monitored infection control and prevention in the department.
- Side rooms were available for patients presenting with a possible cross-infection risk.
- Hand washing sinks were readily available with sanitising hand gel throughout all the locations we inspected.
- The cleaning of the department was undertaken by domestic staff employed by the trust.
- One member of staff told us that cleanliness audit was undertaken by the domestic supervisor weekly and there was not 24 hour domestic cover for the ED. After 8 pm, staff could contact the on-call domestic team if needed.
- Staff completed a cleaning domestic schedule but told us they did not follow the schedule because it was impossible to complete the whole list in a week. Instead, staff had developed their own schedule which they felt was adequate. Staff used a colour coding system for cloths and mops to reduce the risk of cross-contamination. Disposable curtains were changed every six months.
- Staff we spoke with were generally aware of the principles of the prevention and control of infection (IPC).
- There was a sepsis champion nurse in post whose role included initiating treatment for patients who presented with sepsis and improving awareness of the signs and symptoms of sepsis. This achieved better patient outcomes. For example using the sepsis7 pathway however we did not see any completed pathways at the time of our inspection. 'Think sepsis' posters were displayed in the department in order to raise awareness of the condition with staff.
- We observed staff regularly use hand gel on entering clinical areas and between patients but staff did not always clean equipment in between patients such as monitoring devices, which posed an infection risk.
- Commodes were not marked as clean, which meant there was no way of telling which commodes were clean and which ones where dirty. This represented an infection risk. The trust undertook an audit of commodes in December 2015, which showed only 36% of commodes, had a label indicating that they had been cleaned.

- **Environment and equipment**

Urgent and emergency services

- Staff told us there was inadequate space to assess and treat minor injuries and illnesses. This was because here was no minor's area and only one ENP assessment cubicle, this meant there was often a delay to patients waiting times.
- The resuscitation department was not fit for purpose. This was because when there were three patients being treated staff did not have sufficient room to be able to work safely. We saw a staff member struggle to carry out an assessment of a patient with the addition of the equipment that was required and there was little space for staff to prepare medications and infusions.
- There was a warming cabinet used to store intravenous fluids. The cabinet had an integral temperature thermometer that displayed a temperature of "36.1 degrees". However the display panel had a sticker over it, which had "37.3 degrees" written on it. There was an additional temperature monitor with the monitoring probe inside the cabinet, which displayed" 37.9 degrees". We asked staff what the intravenous fluids were used for and they said that they were rarely used and given to patients who were hypothermic (low body temperature). Staff said the temperature of the cabinet was not monitored. The lack of monitoring and contradictory temperature recordings presented a risk to patients as the temperature of the fluid was not known and as such could cause significant harm to a patient.
- We raised this issue with the trust on the day of the inspection. We returned to the department for an unannounced inspection seven days later and found the cabinet in exactly the same condition.
- There was no piped oxygen, suction or call bells in the cubicles. There were portable oxygen cylinders and portable suction was available. However, there was a lack of checking processes to ensure these were operational. Patients were not able to summon help if required as there were no call bells.
- Medical gas cylinders should be kept in a purpose built cylinder store that should allow the cylinders to be kept dry and in a clean condition. However, the oxygen cylinders were on the floor in corridors, which posed a trip risk and the risk of theft. We saw the cylinders were secured to the walls when we returned, which reduced the risk of harm.
- There was a drink refreshment trolley available in the department for patients and visitors and a water filter machine in the waiting area.
- Storage areas were generally well organised, clean and tidy. However, one store area that was previously an operating theatre contained a significant amount of decommissioned equipment.
- The x-ray department and computed tomography (CT) scanning facilities were in close proximity to the ED department and were easily accessible.
- There were not robust systems in place to monitor, check and maintain equipment. Emergency equipment must be checked on a daily basis to ensure all the equipment is available and in date for use in an emergency. Paper records of equipment checks demonstrated gaps in the checking process. There were numerous occasions when the equipment had not been checked and staff told us that they were aware that the checking process was inconsistent. Staff told us the system in place was for it to be checked daily and then documented on the notice board that the check had been completed. The lack of a robust checking system represents a risk to patients because equipment required in an emergency may not be available.
- We returned for an unannounced inspection and reviewed the record of the equipment checklist again. During this seven day period there were two days when the check had not been completed.
- Staff did not consistently check the children's emergency equipment trolley and the paper record of the equipment checklist demonstrated gaps in the checking process. This meant staff did not know if the equipment needed in an emergency would be safe to use.
- Equipment had been labelled to verify it had been electrically tested within the past year.
- Signage in the department could be improved, for example to indicate where emergency equipment was located.
- The inspection team had concerns regarding the security of the receptionist, the staff offices and staff rest room. There was no door to the staff offices and staff rest room, which meant unauthorised people, could gain access. Additionally, the access door to the office where the receptionist sat was not locked, which was a staff security risk.
- The medical equipment and devices management group had a meeting every three months and we saw evidence of minutes from these meetings.
- There was a mental health nurse available between the hours of 9am and 5pm to provide assessment and

emotional support to patients who attended with a mental health illness. We saw there was a dedicated room for the assessment of patients with a mental health illness. However, this room had not been assessed for safety. For example, it had ligature points and other items of equipment that patients could potentially harm themselves with. Staff assured us that patients were never unsupervised in this room.

- **Medicines**

- Staff worked to an established medicines management policy, which was augmented by an optimisation policy issued in January 2016.
- The door of the clinical room was left open four times during our inspection and we found cupboards in this room that were not locked and contained medications that were not kept securely.
- We looked at controlled drugs (CD's) in the department. We checked order records, and CD registers and found these to be in order. Staff checked and documented stock balances of CDs daily.
- There was a drug cupboard mounted to the wall in the assessment cubicle and cupboard had the key in the lock for the duration of the inspection. Drugs in this cupboard could be subject to misuse and were not being kept securely. The cubicle was not always occupied and therefore the drugs could be stolen. We highlighted this issue to the trust on the day of the inspection and found the key was still in the medicine cupboard when we returned for an unannounced inspection.
- Some emergency drugs needed to be stored in a fridge. The department's fridge was out of use and staff told us the nearest fridge containing emergency medication was on Balcombe ward, which was the closest ward to the ED. Access to this ward was restricted and the nurse in charge held the keys to the room where the fridge was kept. The process of walking to the ward, obtaining the medicine and returning to the ED took six minutes during a trial we conducted. This presented an unacceptable risk to patients who may experience a significant delay in receiving emergency medication. In addition, the fridge on Balcombe ward had a faulty lock which meant the fridge was open and not secure. The trust told us that this issue had been escalated and was awaiting repair.
- We raised this issue with the trust on the day of our inspection and were told the fridge had been broken for seven days and an order had been placed for a replacement fridge.
- The trust sent the inspection team an email during the inspection, which stated that a new fridge had a delivery date and in the meantime, a replacement fridge would be sourced. During our unannounced return seven days later, the new fridge was still in its box. Staff told us it had arrived faulty and was going to be returned to the company. We were told there was a temporary fridge installed in the resuscitation area, which we were unable to verify as the area was in use.
- Pharmacy services were available from 9 am to 5 pm Monday to Friday and 9am until 12 noon on Saturdays. Some staff said they received minimal support from the pharmacy department. Medications were replenished three times a week by pharmacy staff and if additional stock was required staff sent an order via email to the pharmacy department.
- Staff prescribed medications electronically, which also enabled them to record and check allergies. Staff highlighted serious safety concerns regarding the electronic system and the administration of medications. Their main concern was the system allows more than one staff member to view the prescription chart at one time. Therefore it was possible to administer medication twice. This was especially a risk if the patient was not able to communicate with the staff. We did not see evidence of a policy to mitigate this risk.
- Staff reported medication incidents and errors using the electronic incident reporting system. Between October 2015 - January 2016, there was 63 medication errors in RSCH and PRH ED. In 37%, the wrong quantity of drug was administered.
- Staff undertook audits of medicine security, including CDs. Between November 2015 – January 2016, 11 CDs were unaccounted for. Pharmacy staff offered support in all medication incident investigations, which were reviewed by trust medicines safety group.
- The medication safety group monitored the governance and safety of medicines. This was a sub group of the drugs and therapeutics committee. The drugs and therapeutics committee in turn reported to the safety and quality board. Prescribing guidelines were developed in line with national best practice from the National Institute of Health and Care Excellence (NICE) and NHS Protect.

- Patient group directions (PGD's) are written directions that allow the supply and / or administration of a specific medicine by a named authorised health professional to a well-defined group of patients for a specific condition.
- Staff were supplied and administered medicines through PGD's. However, the PGDs were all past their review dates and not all the copies used by staff had been authorised by the organisation.
- Emergency medicines were available for use but there was no evidence that these were regularly checked.
- Patients who had an allergy were given a red identification wrist band so they could be easily identified.

- **Records**

- Patients' records were managed in accordance with the Data Protection Act 1998.
- The ED used an electronic patient record system and was the only department in the hospital to use the system. The computer software system is designed to document, review and integrate all the clinical information.
- Staff raised significant concerns about the system therefore we asked staff to print off four patient records for us to review, we found it extremely difficult to find even basic information for example a patient's allergies. It was not easy to locate any previous medical history or the presenting complaint. It was extremely small print and in a sporadic layout. This would be a significant risk for example if a patient was being transferred to RSCH and they were not able to communicate this information.
- In addition staff raised the following safety concerns and frustrations regarding the system.
- In summary these concerns included:
- It has not integrated with any other system and the rest of the hospital does not use it.
- It is unable to be used for audit purposes as it does not have an audit function.
- It does not link with GP computer systems
- It does not calculate NEWS (national early warning system) scores
- It is time consuming and takes time away from caring for patients. We asked a member of staff to demonstrate how to input information after they had assessed a patient. There were a significant amount of steps to undertake and it took a considerable amount of time, longer than hand-written charts would take.
- Locums and agency staff are unable to use the system as an electronic access card is required, and although temporary cards are available staff reported difficulty in obtaining these especially out of hours, in addition locums and agency staff were not familiar with the system.
- We asked a member of staff to demonstrate the system to us whilst inputting information. We saw it was an unintuitive system which would take significant training and practice to navigate efficiently. We also saw that there was a variety of locations that information could be inputted and this was user dependent. There was poor completion of assessments such as pressure area assessments and staff told us this was because of the time taken to complete. This is a safety risk as important assessments are not undertaken which could mean important information such as a pressure area was missed.
- Staff said the system allowed for duplication of giving medication. For example if a member of staff has administered a medicine and was delayed documenting this on the system, another member of staff could look at the system and think the medication has not been administered and administer the medication again. This was reflected when we were given a demonstration of the system.
- Staff said they had worked out 'work arounds', which made using the system slightly easier. However, this added to the risk as if staff worked in different ways, the room for error was greater. Staff told us that they had repeatedly raised their concerns with the managers regarding issues with the system but no action had been taken.
- The system is included as an item on the risk register and there were three clinical incidents reported between October 2015 – January 2016. However, these all related to operational breakdowns rather than specific safety incidents.
- In three of four records we reviewed, there was no pressure area assessment or falls risk assessment. Two patients were aged over 75 and did not have a mental capacity assessment, this is against trust policy.

- The system however did have set pathways for example if a patient presented with a stroke there were pre-set diagnostics and tests for completion.
- Staff told us the system did not have any sepsis triggers, which would alert staff to the possible diagnosis of sepsis. Instead staff used their own clinical judgement, however there was no evidence this had resulted in any issues.
- Staff completed individualised risk assessments based on patient needs and using established care pathways, such as for a fractured hip.
- At the end of each shift, the shift leader completed a shift handover sheet, which they emailed to band six and seven nurses, lead consultants, the matron and the directorate lead nurse. This included issues around staffing, the bed status, the amount of four and 12 hour breaches and any other issues. However, staff told us issues reported on this were rarely acted upon. We asked the trust to provide two weeks of completed handover sheets, which they were not able to provide.
- Information governance was part of the trust's statutory training. However, only 43% of ENPs, 10% of nurses and 16% of doctors had completed the training. None of the reception staff had completed the training. This staff group had access to sensitive and confidential information and they need to have an understanding of confidentiality, information security management and NHS records management to ensure breaches do not occur.
- There was an overall trust completion rate of 31%, which was worse than the trust target of 95%.

- **Safeguarding**

- The trust had a safeguarding vulnerable adults and children policy, and guidelines were readily available to staff on the intranet and staff were able to access this quickly.
- Staff had access to the child protection register should they have any concerns and needed to access it.
- Staff talked confidently about what signs to look for if they had concerns about a patient and what action they would take.
- There were safeguarding leads in the hospital that acted as a resource for staff and linked with the trust's safeguarding team. Their names and contact details were displayed in the department.
- Safeguarding children training was included in the trust's statutory training programme and 57% of ENPs, and 54% of nursing staff had undertaken safeguarding children three training. This was worse than the trust target of 100%.
- Only 19% of medical staff had completed safeguarding children training and only 18% had completed safeguarding adults training. This was worse than the trust target of 100%
- Safeguarding adults training was included in statutory training but only 50% of ENPs and 81% of nurses had undertaken this training. This was worse than the trust target of 100%.
- There were posters displayed in the department advising staff and the public of the steps to take if they felt a person in vulnerable circumstances was being abused, or at risk of abuse.
- Staff had access to an investigation and action process if a child presented with unexplained bruising.

- **Mandatory training**

- The ED department separated training into mandatory and statutory training, which were delivered using a combination of e-learning and practical teaching sessions.
- Overall only 14% of medical staff had completed statutory training; this was worse than the trust target of 100%.
- Overall 46% of nursing staff and 37% of ENPs had completed statutory training. This was worse than the trust target of 100%.
- Of the remaining staff groups, 47% had completed mandatory training.
- Overall only 13% of medical staff, 52% of nurses and 37% of ENPs had completed mandatory training. This was worse than the trust target of 95%
- Of the remaining staff groups 34% of staff had completed mandatory training.
- Staff told us it was difficult to undertaken mandatory and statutory training as often they would book their training but it would be cancelled at short notice as they were needed to work clinically.
- Poor compliance with mandatory and statutory training means patients may be at risk of receiving care and treatment that is out of date and not best practice.
- Only 13.33% of staff had received infusion pump training, which concerned the inspectors given the relatively high usage of such devices within acute care.

- We saw a clinical training log with 37 named nursing staff, we were not sure this was an accurate reflection of the staff group. Of the 37 staff, 15 had up to date intermediate life support (ILS) training, 14 had up to date paediatric life support (PILS) training and three had up to date advanced life support (ALS) training.

- **Assessing and responding to patient risk**

- Patients who arrived by ambulance as a priority were transferred immediately to the resuscitation area, or to an allocated cubicle space. For the majority of seriously ill patients, the ambulance crew telephoned the ED prior to ensure there was an appropriate area to place the patient and warn staff of their arrival.
- Other patients who arrived by ambulance arrived in the 'majors' area, where a nurse took a handover from the ambulance crew. Based on the information received, a decision was made regarding which part of the department the patient should be treated.
- The receptionist who booked the patients in on arrival to the department had no medical training but was responsible for alerting nursing staff if they felt the patient needed urgent attention. This presented a risk as potentially unwell patients could wait a significant time in the waiting area when the department was busy before being triaged by a nurse.
- Triage was undertaken in accordance with the Manchester Triage System. This is a tool used widely in ED departments to detect those patients who require critical care or are ill on arriving at the ED. Triage nurses followed a pathway or algorithm and assigned a colour coding to the patient following initial assessment. Red being the label assigned to those patients who needed to be seen immediately through to orange (very urgent), yellow (urgent), green (standard) and blue (non-urgent).
- The trust used a national early warning system (NEWS) tool. This scoring system enabled staff to identify patients who were becoming increasingly unwell, and provide them with increased support. The electronic patient records system did not calculate the NEWS score when the patient's observations were entered and staff had to calculate the NEWS score manually. We reviewed three NEWS scores and they had been completed correctly and the correct action was taken.
- Staff used the Malnutrition Universal Screening Tool (MUST) and the venous thromboembolism (VTE) assessment tool to identify those at risk from developing blood clots. Patient records we reviewed showed poor completion of these assessments. Staff told us that there was poor completion because it took too long to complete these on the electronic system.
- During our inspection the resuscitation area was full with three patients. Two of the patients were acutely unwell and another acutely patient arrived via an ambulance. The patient who was more stable was transferred to a cubicle to accommodate the recently arrived patient. We saw there was only one registered nurse working within the resuscitation department with a health care assistant (HCA).The nurse was busy trying to look after the other two patients when the third patient arrived and the paramedic gave the handover of the patient to the HCA. It is not considered good practice to handover an acutely unwell patient to an HCA as they do not have the level of knowledge and skills required to fully understand the information.
- We saw the HCA was struggling to find a pulse and oxygen saturation levels on the patient because the patient was so unwell.
- The inspection team were concerned regarding the safety of the patients in the resuscitation department and highlighted their concerns to the nurse in charge of the ED. The nurse in charge contacted the critical care outreach team, who provide urgent support to acutely unwell patients across the hospital. It was not clear staff on duty understood the risks of the situation and they did not respond appropriately in the first instance.
- A consultant or the most senior doctor if out of hours undertook a board round three times a day which they used to discuss all patients in the department.
- A board round is a process which improved communication among the multi-disciplinary team (MDT), enhanced team working and provided a more coordinated approach to the treatment of the patient and help in decision making. Board rounds also meant patients were assessed by a consultant and therefore if there had been any change in their condition this would be highlighted.
- Situation, Background, Assessment, Recommendation (SBAR) is an easy to remember structured way of communicating information that requires a response from the receiver and can be used very effectively to escalate a clinical problem that requires immediate attention. Staff can also use it to facilitate efficient

handover of patients between clinicians or clinical teams. The ED was not using SBAR and there was no system in place that could be used instead of SBAR, which meant there was no consistent approach.
- The department did not use an acuity or dependency tool for staffing requirements, such as a baseline emergency staffing tool (BEST.)This meant staff did not assess the clinical needs of patients using an established tool and could not accurately assess the optimal level of support each patient needed.
- When patients had been waiting for two hours the shift co-ordinator informed the lead doctor, this was to try to ensure the patient did not breach the four-hour target and had a better patient experience.
- The trust had a full capacity protocol, which was written in June 2015 but staff were not aware of this policy or what is contained. Staff we spoke with were not aware of any escalation procedures for when demand exceeded capacity.
- Staff used prompt cards, which were a checklist of actions undertaken in medical emergencies or procedures, such as for patients who presented with sepsis or a prolonged seizure. Prompt cards could be used by all members of the emergency team and could improve patient safety and reduce human factor errors.

- **Nursing staffing**

- The ED at PRH was 101% over establishment which was better than the trust average of a 94% establishment.
- The average bank and agency use was 37%, which was above the trust average of 21%.This would suggest that there was insufficient nurses employed as staffing was 1% over establishment.
- This meant that there was not a robust system in place to assess and ensure the nurse staffing levels were in line with the needs of the department.
- ED's at both hospitals had a higher turnover rate of 15%, which was worse than the trust of 12%. There was vacancy rate of 5%, which was lower than the trust average of 9% and a sickness rate of 7%, which was worse than the trust average of 5%.
- ENP cover was provided between 8am and 9pm, seven days a week.
- Staff told us that nurse staffing requirements had not been reviewed since the services provided at the hospital changed and were no longer in line with the department's needs.
- During March 2016, the monthly actual staff hours was below the established number of nurses needed 39% of the time.
- Five members of staff told us at focus groups that the department often felt unsafe due to the lack of staff.
- Staff reported understaffing via the trust's electronic incident reporting system and said they felt the matter had not been addressed by managers.
- Between November 2014 – October 2015 there were 11 patient safety incident reports, which related to lack of nursing staff; however, staff told us that not all staff reported such incidents.
- Staff told us that when the electronic patient record system was introduced an additional nurse was put on each shift to allow for additional time spent using the system. However this extra nurse had been withdrawn and staff felt this was additional burden to their work load.
- The service provided for paediatrics was meant to be a walk in centre for minor injuries and illnesses. However, sick children were sometimes seen there when they were brought in by a concerned parent.
- There was only one part time paediatric nurse employed , which did not comply with the Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012). Nurses had been rotating to RACH for three months to gain experience in paediatrics, however staff told us that this has stopped recently due to staff shortages.
- We saw evidence of an adequate induction process for agency staff.
- We witnessed three members of staff speaking in their native language to each other, which is against the trust's behavioural values.
- There was no practice educator employed and staff told us this was an issue as they lacked training, support and clinical supervision. In addition there was no facilitator for students which added to their workload and did not create a good learning environment for students.
- The trust was taking positive action to recruit and retain staff. The recruitment strategy included investment in advertising, social media and recruitment agencies. The trust had recently undertaken an international recruitment process.
- In the 2014 staff survey 57% of staff felt there was enough staff in the organisation to do their job properly.

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- In the 2014 staff survey, over 50% of staff said they put themselves under pressure to work, despite not feeling well enough.

Medical staffing

- Care was led by 15 consultants, who were supported by 18 middle grade doctors, 15 trainee doctors, 11 junior doctors and six trainee GP's. In addition there were seven trust grade doctors (senior doctors employed by the trust) and four education fellow doctors.
- Proportions of consultants and junior doctors were both similar to the England averages.
- The trust did not meet The College of Emergency Medicine (CEM) recommendations that there should be an emergency medicine consultant (EMC) presence from 8am until midnight seven days a week. In the PRH ED, there was an EMC present in the department from 9am until 5pm Monday to Friday and no cover during evenings or weekends. We were unable to determine the availability of EMCs on Bank Holidays. This breached the CEM standard and as such may adversely affect the quality of patient care and safety during the times when EMC cover is absent.
- A senior grade doctor covered the department after 5pm. This may be a senior doctor in training or a senior trust grade doctor. If they needed help or support they telephoned the consultant at RSCH who could give advice but could not come to the department.
- Junior medical staff told us they had received an adequate induction programme prior to starting their work in the department, but we did not see evidence of this.
- Junior and middle grade doctors provided cover 24 hours, seven days a week.
- There was a GP rota, which provided two GP's between 9am and 7pm and who treated patients with minor illness and injuries.

Major incident awareness and training

- The trust had an up to date emergency preparedness, resilience and response policy which included business continuity management.
- The policy provided assurance that frameworks existed within the trust that supported a high level of preparedness to any business-disrupting event or major incident, regardless of source.
- Staff were made aware of the trust's major incident plan through electronic and paper means. The current policy was available on the trust's intranet.
- Staff told us they did regularly take part in major incident exercises but were unable to provide evidence of this.
- We asked three members of staff where the major incident equipment was stored and none of them knew where it was located.
- We saw decontamination equipment was stored in a disused part of the hospital and access to it was difficult. There was equipment available to deal with casualties contaminated with chemical, biological or radiological material, or hazardous materials and items. There was a large amount of out of date equipment stored in the same location as the equipment that was in date, which could cause confusion.
- Staff told us the equipment was checked on a monthly basis however we did not see evidence of this.
- Chemical, biological, radiological and nuclear defence training was mandatory and 48.89 % of staff had received this.
- We saw posters fixed to the wall with sticky tape, this could be an infection control risk.
- Staff consistently adhered to the 'bare below the elbows' policy. Personal protective equipment (PPE) such as disposable gloves and aprons were readily available in all areas, however we saw staff wearing gloves when using the computer, which presented a cross infection risk.
- Generally, staff marked equipment with a sticker when it had been cleaned and was ready for use. One trolley that contained equipment for taking blood had rusty sides and the drawer runners were dusty. In addition, the top of the soap dispensers in the resuscitation department were dusty.
- The trust had a waste management policy, which was monitored through regular environmental audits. Clinical and domestic waste bins were available and clearly marked for appropriate disposal. Disposable sharps were managed and disposed of safely.
- Posters and information cards explained waste segregation procedures and waste segregation instructions.
- The sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- Infection prevention and control was included in the trusts mandatory training programme. Only 35% of clinical staff and 50% of non-clinical staff had completed training.

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- For the month of January 2016 the hand hygiene score was 98%, which demonstrated good compliance with the World Health Organisation) five moments for hand hygiene guidelines.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We rated ED at the Princess Royal Hospital as 'Requires Improvement' for 'effective' because:

- Staff generally followed established patient pathways and national guidance for care and treatment. However, they did not always complete pain assessments and band five nurses were not authorised to administer oral pain relief under the trust's patient group directions (PGD). This meant patients sometimes experienced a delay in pain relief.
- Mandatory training attendance was low and we saw that some specific training needs were not met. For example, there were low levels of nursing and medical staff with specialist resuscitation and trauma courses.
- Appraisal arrangements were in place, but compliance was low and accountability for these lapses was unclear. The matron post was vacant and we were told this was the primary reason for a lack of training and appraisal records. We were not provided with evidence of appraisal rates of medical staff.
- **Evidence-based care and treatment**
- Scores for the trust in the severe sepsis and septic shock 2013/14 audit were within the upper England quartile for two, in the lower quartile for four and between the upper and lower quartile for the remainder of the 12 measures audited.
- The trust scores in the assessing for cognitive impairment in older people audit 2014/15 were within the upper and lower England quartile for the five measures audited.
- We reviewed a sample of patient records of patients who had attended the ED. We found that most patients had received care in line with national guidance, although we did find lapses. We saw some good examples of guidance having been followed for patients with a patient who was septic (had an infection) who had been treated in line with the relevant National Institute for Health and Care Excellence (NICE) guidance.
- Staff were not able to give us examples of changes to treatment that was evidence based with the exception of the introduction of the 'sepsis champion'.
- Evidence based care and treatment was limited due to restrictions on the restrictions with the departmental computer system.
- The trust maintained a system of scorecards for monitoring targets; for example, national performance targets, patient experience and clinical quality.
- **Pain relief**
- Staff used a scoring tool of 0-10 (meaning no pain and 10 extreme pain) to assess pain levels. We reviewed a sample of patient records and noted staff had not recorded pain scores consistently.
- The trust did not permit band five nurses to administer analgesia using a PGD due to a previous error at RSCH. This meant a more senior nurse had to be called to approve pain relief and we were told this led to delayed administration.
- We noted the absence of a nurse rounding system (NRS) and staff told us it was not undertaken. One of the features of an NRS check (often performed hourly) is that patients have frequent pain monitoring.
- There was not a 24/7 pain service
- **Nutrition and hydration**
- Staff used the Malnutrition Universal Screening Tool (MUST) to assess patient's risk of being under nourished routinely however we did not see evidence of dietician input.
- We saw that there was provision made for refreshments to be served to patients during their time in ED, although this was inconsistent.
- Nurses and support staff we spoke to understand the needs of patients they were caring for and the importance of ensuring they had adequate food and drink; however we did not see evidence of this in practice.
- There was very limited documentation about who had been offered food and drink and what their intake had been.
- **Patient outcomes**

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- Staff had developed clinical pathways for a number of conditions and they referred to national guidance. For example pathways for patients who had broken their hip. They were available on the intranet which staff, including agency and locum staff could access.
- Staff understood the National Institute for Health and Care Excellence (NICE) guidelines and stated these were referred to in discussions about care and treatment.
- Staff told us they were able to assess relevant NICE guidelines on the trust's internet.
- The trust benchmarked their performance against national comparisons such as the national fracture hip database.
- The average percentage of unplanned re-attendances to RSCH and PRH departments, within seven days, between September 2013 to October 2015 was 8.4% this was worse than the standard of 5% and worse than the National average of 7.2%.
- We saw policies and guidelines were in place to help staff in the management of patients who presented with, or who were suspected of being septic (a potentially life threatening condition).
- Staff told us that a minimal number of audits were undertaken due to the electronic patient record system's lack of an audit function. This was a risk because patient outcomes were not monitored and areas for improvement were not identified. In addition staff told us that they have not received any feedback on performance on previous audits and they have not seen any changes in practice as a result of audits.

Competent staff

- We reviewed 14 appraisals chosen at random, of which six were out of date. None had six-monthly progress reviews. We were told appraisals for medical staff were held at RSCH, but we were unable to obtain medical sight of them. This meant we could not verify how often doctors had appraisals or how they were used to improve performance and patient outcomes.

- Across all staff groups the combined annual appraisal average was 52%, which was worse than the trust target of 100%.
- There was an adequate local induction process in place for agency staff and students, the department tried to use regular agency staff that were familiar with the department.
- Locum doctors and agency staff had not had training in the Alert system and did not have access to the Alert computer system which meant an increased work load for the nursing staff.
- There was no practice educator or matron in post and staff told us this led to a lack of training, clinical supervision and accurate mandatory training records.

Seven-day services

- Consultant cover was provided on a seven day basis between the hours of 9am and 5pm. The trust was seeking approval to increase the medical workforce presence to support the increasing number of attendances seen, especially in the evenings.
- Part of the response had been the introduction of GP's into the department to support primary care work.
- In addition, earlier this year the trust rostered an additional middle grade doctor in ED to provide extra cover from 4pm to 2am, seven days a week.
- There was no pharmacy service at weekends or bank holidays.

Access to information

- The Hospital used a computer software system that was different form the rest of the hospital. This meant there was a lack of consistency in notes and documented observations when patients were transferred between services.
- There was no link between the Alert system and other services such as GP's therefore GP's had to wait for the discharge summary to be sent to them via post.
- Staff reported that they had pathways for frequent attenders which were stored within the Alert computer system and such patients were flagged up on the system. We saw evidence of this and with a frequent attender patient; we saw staff access the RSCH system to see recent attendances there.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a consent policy in place, which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details of the Mental Capacity Act 2005 (MCA) guidance and treatment checklists ,however we did not see this used.
- Training on consent and the Mental Capacity Act 2005 was available, 53% of staff had completed the training.

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- Staff were aware of their responsibilities under the Mental Capacity Act 2005 and DoLS and were able to describe the arrangements in place should the legislation need to be applied.

Are urgent and emergency services caring?

Good

We rated ED at the Princess Royal Hospital as Requires improvement for 'Caring' because:

- The majority of patients we spoke with felt involved in their care and participated in decisions regarding their treatment. They said staff were aware of the need for emotional support to help them cope with their treatment.
- We saw compassionate care given to patients in the department, including children.
- Staff maintained patient privacy and dignity, including with the use of curtains.
- We saw the needs of patients who attended with complex needs or significant pain had individualised care and relative involvement.

However:

- We saw no comfort rounds taking place whilst we were in the department. This meant patients who were waiting to be treated may not have been offered a drink nor have their pressure areas checked.

- **Compassionate care**

- The Friends and Family Test (FFT) is a feedback tool that gives people who use NHS services the opportunity to provide feedback on their experience. The latest results available for this department related to January 2015 to December 2015
- In this period, 90% of patients out of 642 respondents would strongly recommended or recommend the service.
- We saw that FFT information was not displayed on notice boards in the department; however it was displayed in staff areas.
- The trust was rated as "about the same as other trusts "for all questions in the ED survey 2014.

- Patients and relatives we spoke with were complimentary about the nursing and medical staff. We observed care given was considerate and kind.
- During our inspection the team followed the treatment of a patient who had been admitted with a fractured hip. We saw good examples of compassionate care with this patient. For example the patient needed to go for an x-ray and when the porter arrived, he introduced himself and explained to the patient where he was taking them and that the patient's relative could go with them. The porter reassured the patient the x-ray would not take long and that he would go back and collect them. The porter checked the patient's name against the x-ray request form and asked the patient what they preferred to be called.
- The same patient said "everybody is very nice" and that the occupational therapist was "very reassuring."
- Patients told us staff gave them enough time to discuss anxieties or fears.
- We saw numerous thank-you cards from patients displayed.
- Throughout our inspection, we witnessed good staff interaction with patients. We observed how the nurses assisted patients compassionately and with kindness.

- **Understanding and involvement of patients and those close to them**

- The relative of a patient said they were treated with care and compassion however she felt too much information was asked for on each admission rather than referring to previous information as their family member found this over whelming.
- Patients we spoke with said they felt involved in their care and participated in the decisions regarding their treatment. Staff were aware of the need for emotional support to help them cope with their treatment and demonstrated this by.
- ED had arrangements in place to provide emotional support to patients and their families when needed.
- There was no bereavement room or viewing room in the department where relatives could spend time with a recently deceased loved one

- **Emotional support**

- Posters displayed details of a variety of support groups or services which could be accessed, including for domestic violence support, mental health support and community social support for elderly people.

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- The patient with the broken hip that we were following was accompanied by a relative. Her relative was given a form by the occupational therapist to take to the patient's house to measure the furniture to ensure the equipment the patient was sent home with was the correct height. We considered this to be an excellent way to start discharge planning and good involvement of relatives.
- The occupational therapist said that they assessed patients when they were first admitted as patients, communicated better then and were able to give more accurate information regarding their home situation and their normal level of activity.
- The hospital offered a 'take home and settle service', whereby patients were escorted home and helped to settle in at home. The service ensured that patients had a support network in place, a supply of everyday items such as milk and bread and that the home was suitable.
- Staff confirmed they had access to the end of life team and previous referrals had been acted upon promptly.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement

We rated ED at the Princess Royal Hospital as requires improvement for 'Responsive' because:

- Issues around the department's inability to meet surges in demand; escalation protocols, leadership and record keeping all caused delays to assessment and treatment.
- Many of the issues were longstanding and had been brought to the trust's attention previously. While there had been some improvements, the trust needed to demonstrate sustained progress.

Service planning and delivery to meet the needs of local people

- The area was undergoing a steady year on year increase in population which was anticipated to continue. There was a lack of evidence that this had been planned for.
- There is a misconception with the local people of the paediatric services provided at PRH, as being a full ED rather than a walk-in centre. There was a lack of signage and information to ensure parents and relatives are educated.

Meeting people's individual needs

- Patients and staff who cared for them had access to translation services via a telephone interpreter system. Staff reported that this system worked well whenever they were required to use it.
- Care and treatment was coordinated with other services and other providers, for example staff had access to a mental health liaison team to provide input to any patients who required mental health assessments.
- There were limited patient information leaflets about specific injuries or conditions available for patients to take home and they were only available in English.
- Facilities and premises were not appropriate for the services being delivered for example;
  - A room designed as a place for applying plaster casts was used to care for two patients, and only one privacy barrier separating patients.
  - There was no piped oxygen or suction in the major treatment cubicles.
  - There was not a dedicated minor treatment area just one cubicle.
  - The resuscitation area was unsuitable to care for critically ill patients because it was too small to accommodate three patients and the equipment required to care for critically ill patients.
- We saw that there were no visible waiting times so patients did not know how long they might have to wait.

Access and flow

- Data provided to us by the trust was not split by hospital site and is trust wide.
- The total time spend in ED was consistently longer than the national average for England throughout the period September 2013 - October 2015.
- The percentage of patients waiting four hours from 'decision to admit' to being admitted through the ED were consistently worse than the England average for the period January 2015 - to December 2015.

Urgent and emergency services

- Between June 2015 and March 2016, 84 patients waited over 12 hours from the time of the "decision to admit" to the time of hospital admission. The most amount of breaches was in October 2015 (37) and the least amount was in September, November and December 2015 (2)
- Between June 2015 and March 2016 the trust performance of the 90% standard of patients seen within four hours in ED was varied. The best performance (88.6%) was in November 2015 and the worst performance (80.9%) was in June 2015.The average performance for this time period was 83.99% this is worse than the 90% standard and worse than the National average of 87%.There was an improvement in performance in November (88.6%) and December (88%) 2015 this was better than the National average.
- The national average for percentage of patients that leave the department before being seen was between 2%-3% from September 2013 to November 2015. Data provided to us indicated that the ED consistently performed worse in this outcome apart from a three-month period during the winter of 2013.
- From April 2014 to July 2015 ambulance median time to initial assessment was significantly higher than the England average of five minutes and fell to below the England average from August 2015 to October 2015.
- Ambulance turnaround times were consistently in the region of 30 minutes between June 2014 and May 2015, which exceeded the target of 15 minutes.
- The trust falls within the upper quarter of all trusts for handover delays over 30minutes during winter periods.
- Between January 2015 and December 2015, the trust reported 998 black breaches. A black breach is where the handover from time of arrival by ambulance to ED exceeded 60 minutes. The trust had an average of 80 black breaches per month**.**
- Between January 2015 – December 2015, 92.2% of patients had a full set of observations (vital signs for example blood pressure and pulse) undertaken within 15 minutes of admission to the department**.**

- **Learning from complaints and concerns**

- Complaints were handled in line with the trust policy. We were told that if a patient or relative wanted to make an informal complaint, then they would speak to the shift coordinator. If staff could not resolve this locally, patients were referred to the Patient Advice and Liaison Service (PALS), who would formally log their complaint and would attempt to resolve their issue within a set period.
- The complaints process was outlined in information leaflets, which were available in the department.
- Senior staff such as the clinical lead investigated complaints related to a member of the medical team.
- The matron monitored complaints and discussed these at departmental clinical governance meetings. There were mechanisms in place for shared learning from complaints through the staff meetings, trust briefings and safety briefings.
- Between November 2014 and October 2015, the ED received 17 formal complaints. This is slightly less than the 22 complaints made the year previously.
- The most frequent problems related to triage, clinical care and diagnosis. Analysis of the complaints monitoring system was limited as they were combined across sites and investigating staff often attributed multiple categories to them.
- By comparison, during the same period 24 'plaudits' were logged for the ED. This was consistent with the positive verbal feedback our inspectors obtained from patients and their families.
- We did not see any evidence of learning from a complaint.
- The staff we spoke with had a good understanding of how to care for patients with dementia. Some staff told us that patients with dementia would need to be spoken with calmly and cared for in a quiet area. When the department was busy it was noisy and it was not always possible to provide patients with a quiet place to wait.
- There was a separate paediatric waiting area which was child friendly and had toys for children to play with.

Are urgent and emergency services well-led?

Inadequate

We rated ED at the Princess Royal Hospital as Inadequate for 'well-led' because:

- Senior medical leadership was visible in the department but it was not clear how they provided overall support to the department.
- The delivery of high quality care was not assured by the leadership, governance or culture in place
- There was no matron in ED however one has since been appointed.
- Strategic nursing leadership was absent however we saw signs of potential improvement with the recent appointment of a divisional nurse manager.
- Staff told us they rarely saw tangible help from senior members of staff when they escalated concerns such as capacity issues.
- Nurses said they felt unsupported in their role as managers spent the majority of their time at RSCH.
- Staff told us that there was managerial support up to the level of matron (post now vacant), but there was a lack of support beyond that level.
- Risks, issues and poor performance were not always dealt with appropriately or in a timely way.
- Staff told us there was a disconnection between staff and the executive board and they were out of touch with the demands and problems of working in the ED.
- There was limited audits undertaken which prohibited improvements to patient care and best practice. Staff were unable to give an example of a change in practice as a result of audits.
- There was no evidence that feedback from staff and patients were acted upon.
- There was a local governance structure in place in conjunction with RSCH but it was not clear how this fed into the overarching governance structure. There was regular clinical governance meetings but there was a lack of action points which meant the effectiveness of these meetings to improve safety and patient care is unclear.

- **Vision and strategy for this service**

- The clinical director had developed a new strategy for the acute floor, this had been submitted to the executive committee but to date no feedback had been received.
- The department had developed a performance recovery plan for the ED with support from external experts.
- The vision and values of the organisation were not well developed or understood by staff. Staff did not understand how their role contributed to achieving the strategy.
- The ED department had a philosophy of care which was displayed and enacted by staff at all levels.

- **Governance, risk management and quality measurement**

- A governance committee structure was in place, at local level however, it was unclear how this fed into the overall governance structure.
- Clinical governance was at local level with structured standard agendas complete with minutes of meetings but lacked action logs.
- ED maintained a risk register; however it was unclear how this fed into the directorate risk and trust register. This was because we did not see evidence of information sharing among the multiple directorates. The register included actions undertaken, although these were brief and, in places, not specific.
- The highest scored risk on the register was the increase in admissions and delays in discharges, which resulted in longer waiting times for patients and an increased risk. There were no documented updates in February 2016, which was the planned review date.
- The department produced weekly operational performance dashboard data which was shared with staff and discussed at governance meetings up until recently the matron led monthly emergency department operational and safety quality meetings.
- We reviewed the minutes from these meetings, which had detailed action logs but did not contain a record of who had attended the meetings.
- Managers within the department met regularly to discuss the progress of ED and issues that affected the department. This included the use of a communication diary and shift handover documents.
- Staff described a recent incident when a patient had become unwell and subsequently died, which was distressing for the staff involved. The lead consultant organised a debrief session for staff and offered them the opportunity to discuss their concerns and anxieties. Staff described this as a valuable session as they were able to discuss what had gone well and highlighted where lessons could be learnt.
- Staff said they considered one of the highest risks in the department to be the electronic patient system and despite repeatedly raising their concerns to managers no action had been taken to mitigate the risk. In addition an extra nurse had been rostered on each shift to help with the risk and burden of the system when it

was introduced however this extra nurse had been removed. Staff felt frustrated and thought that managers were not listening to their concerns and that it had taken months before it was added to the risk register.
- The impact of service changes on the quality of care was not understood for example the nurse staffing had not be reviewed to ensure it was in line with the service needs.

- **Leadership of service**

- We observed the medical management from the clinical lead was developing and staff we spoke with reported they had good relationships with their immediate manager.
- Junior medical staff reported to the consultant or a senior registrar for advice and support and told us this worked well.
- Nursing leadership in the department functioned on a day-to-day basis but the strategic leadership of the nursing workforce was lacking. However we did see signs of improvement with the recent appointment of the divisional nurse manager.
- Staff told us they were not aware of an escalation policy that may improve the flow and service provided within ED.
- Staff told us they rarely received help from senior members of the trust when they escalated concerns such as capacity issues.
- Staff told us they felt senior managers were not visible in the department and said they felt not as important as the RSCH staff.
- Senior nursing staff encouraging supportive, co-operative relationships among staff and teams was lacking.
- There was a lack of ownership and investment in nursing staff to ensure they were up to date with mandatory training, appraised, competent to fulfil their role and developed.
- The role of leaders was not clear regarding their roles and their accountability for quality.
- **Culture within the service**
- The results of the most recent staff survey continued to raise concerns about staff welfare, moral and organisational culture at the trust.
- In the 2014 staff survey over 50% of staff said their last experience of harassment or bullying was not reported by themselves.
- Numerous members of staff told us they felt poor behaviour and poor performance of other staff members was tolerated and went unchallenged.
- We saw positive interactions between all staff groups, including between nurses and doctors.
- Staff told us the culture was reactive rather than proactive and they were always crisis- managing.
- We witnessed three members of staff talking in their native language together. Staff told us this occurred frequently and they disliked it as they felt excluded and feared they were being talked about.
- Staff told us that they were not recognised for reaching targets and felt, “we are used as a cushion for the poor performance of the ED at RSCH”. Staff were, “resentful of this” and told us they were dismissively referred to as, “the farm” by staff at RSCH. Some cited examples when RSCH ED staff were unhelpful or rude on the phone.
- We were told there was no funding to make improvements that may influence change and long-term outcomes, and staff felt this was because all the investment was going into the RSCH ED. Staff told us that poor behaviour and poor performance of staff was tolerated and not challenged.
- Improving the culture or staff satisfaction was not seen as a high priority.
- Leaders were out of touch with what was happening on the front line.
- There were low levels of staff satisfaction, high levels of stress and work overload.

- **Public engagement**

- The hospital used various means of engaging with patients and their families including surveys such as the FFT and ED surveys.
- Patients and the public were given a wide range of information from the trust’s website, NHS choices and performance outcomes.
- We read a trust publication called ‘Best of BSUH’ which was a valuable and interesting publication and it highlighted areas of good practice in the trust.
- FFT test results were not displayed in patient areas; patients received a text message containing the FFT test after their visit to ED.

- **Staff engagement**

- There were staff notice boards available throughout staff areas giving staff information about local and trust wide issues including training, development and team meeting minutes.
- There were weekly chief executive bulletins published on Fridays on the local internet.
- Staff were encouraged to complete the NHS Staff survey.
- Staff told us they did not feel engaged with the board or the senior management team.
- Staff did not always feel actively engaged or empowered and morale was low.
- Staff told us that the department had been on under a lot of pressure for an extended period of time, and they felt that their concerns were not listened to because the focus was on RSCH.

- **Innovation, improvement and sustainability**

- The trust said they encouraged local initiatives to improve patient experience, care and treatment. However staff told us that there was a lack of investment in initiatives by the executive board and they often gave up as so many obstacles were put in the way.
- We did not see robust evidence of continuous learning, improvement and innovation throughout the ED.
- Staff told us they aspired to continually improve the quality of care but current staffing pressures impacted
- on this.

Medical care (including older people's care)

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

Information about the service

The Princess Royal Hospital is a location 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.

The medical services within the trust are divided into six of the different directorates: the acute floor, abdominal surgery and medicine, cancer services, cardiovascular, neurosciences and stroke services and the specialty medicine directorates.

Between September 2014 and August 2015 across the trust there were 43,455 medical admissions. At the Princess Royal Hospital there were over 12,400 admissions, the majority of which (54%) were emergencies. Day cases accounted for 39% with 7% elective admissions, 14% general medicine, 24% geriatric medicine, 20% neurology and 43% 'other' conditions.

During our inspection, we reviewed information from a wide range of sources to get a balanced and proportionate view of the service. We reviewed data supplied by the trust, visited each of the general and specialist medical inpatient wards, the rapid access medical unit, the endoscopy suite and the discharge ward. As part of the inspection we visited all five wards and other units where medical care was being given and observed care being delivered by staff.

The Care Quality Commission held 29 focus groups and additional drop-in sessions where staff could talk to inspectors and share their experiences of working at the hospital. We spoke with over 39 members of staff working in a wide variety of roles including divisional directors, the chief nurse, matrons, ward managers, nurses, health care assistants, ward clerks, and housekeeping and domestic staff. We spoke with patients and their relatives. We reviewed 12 sets of patients' records as well as other documentation. We also received information from members of the public who contacted us to tell us about their experiences both prior to and during the inspection.

Medical care (including older people's care)

Summary of findings

Overall we found the medical services at the Princess Royal Hospital required improvement because:

- There was understaffing throughout most of the medical services. Although there had been some improvement with the recruitment of a large number of overseas nursing staff this had placed additional burden on existing staff who provided the new recruits with mentoring and support.
- The trust had a complex vision and strategy which staff did not feel engaged with. There was a lack of cohesive strategy for the medical services either within their separate directorates or within the trust as a whole. Whilst there were governance systems in place they were complex and operating in silos. There was little cross directorate working, few standard practices and ineffective leadership in bringing the many directorates together.
- The trust had not been effective in challenging of poor behaviour and performance. This had created significant tensions and a culture of fear of doing the wrong thing. This was compounded by ineffective HR policies and lack of leadership support. Many of the trust's policies and procedures had not been recently reviewed.
- The management of incident reporting was variable across the directorates with limited feedback or learning identified. We found there was under reporting across the medical services. Although staff were good at recording any clinical incident, non-clinical events such as understaffing were not always being recorded.

However:

- We saw that patients' care needs were assessed, planned and delivered in a way that protected their rights. Medical care was evidence- based and adhered to national and best practice guidance. The care delivered was routinely measured to ensure quality and adherence to national guidance and to improve quality and patient outcomes. Patient outcomes were monitored and reviewed through formal national and local audits.
- Patients told us that staff were kind and considerate and usually involved them in decisions about their care, and were kept up-to-date with their progress. The majority of feedback received was positive and the kind and caring attitude of the staff praised. We saw that patients were treated with dignity and respect.
- The majority of the records and medical notes we reviewed were well completed. Each month a number of records were reviewed from each ward and feedback given to the ward managers on how well they had been completed. The hospital had systems in place to review a number of records each month to ensure identify when patients who were becoming increasingly unwell, and provide increased support. Recognised tools were used for assessing and responding to patient's' risk.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We rated the Princess Royal Hospital's medical services as requires improvement for safe because:

- We found that there were nursing shortages across the medical directorates. Although the situation had improved due to substantial numbers of overseas nurses who had recently been recruited, there were additional concerns with the available resources for mentoring and supporting the new recruits. The majority of medical wards reported there continued to be severe staffing problems.
- The management of incident reporting was variable across the directorates with limited feedback or learning identified. Whilst staff knew how to report incidents and told us that reporting was encouraged, we found staffing shortages were rarely reported and there was no evidence of learning as a result of reported incidents. Responding to the incidents, safeguarding and complaints was different across the medical directorates and relied on individual managers to be proactive and disseminate information rather than having a formal system in place.
- Although medicines were usually supplied, stored and disposed of appropriately they were not always held securely. For example, on Ardingly ward we found the medicine cupboard unlocked with patients' money and jewellery stored in the cupboard. We also observed an unlocked medicine trolley left unattended.
- There was a lack of storage facilities and space throughout the hospital. This meant corridors, including the main corridor, were cluttered with equipment. Staff told us that it was difficult moving the manual hoists up and down the corridors.
- We found that there were no robust systems in place to monitor fire safety in the hospital. We found inappropriate signage with fire doors and equipment that would not be able to provide protection for patients, visitors and staff in the event of a fire.

However we also found:

- The medical and nursing records provided an accurate personalised record of each patient's care and treatment. Risk assessments and care plans were in place and were completed appropriately, with appropriate action taken when a change in the patient's condition was detected.
- Each ward received a monthly safety and quality summary which included patient feedback and safety thermometer information. The information gathered was used to inform priorities and develop strategies for reducing harm.
- Staff training was prioritised which ensured staff had the skills and knowledge to provide safe care and treatment for patients. Staff were aware of safeguarding principles and able to follow the correct procedures. Staff were aware of their role in relation to safeguarding children and adults living in vulnerable circumstances and acted according to local policies when abuse was suspected.
- **Incidents**
- There was an incident reporting policy and procedure in place that was readily available to all staff on the trust's intranet. The staff we spoke with were aware of the policy and were confident in using the system to report incidents, this included bank and agency staff.
- It is mandatory for NHS trusts to monitor and report all patient safety incidents through the National Reporting and Learning System (NRLS). If an incident is assessed as a serious incident it is also reported using Strategic Executive Information System (StEIS). Serious incidents can include but are not limited to patient safety incidents, for example loss of confidential information. Any serious incident which meets the definition of a patient safety incident should be reported to both StEIS and NRLS.
- The trust reported 21 serious incidents between January 2015 and January 2016. Site specific information was not available. Seven never events were reported between January 2015 to January 2016 however none these were attributable to the medical directorates. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The electronic system involved a manager reviewing each reported incident and escalating where indicated. We reviewed various managers' reports on the online reporting system and noted that managers did not always get sufficient managerial time to undertake

timely reviews of all the incidents. Managers told us that serious incidents were prioritised and the others were done when time allowed. For example on one of the wards 31 of the 36 records on the system were outstanding awaiting review

- Incidents were included for discussion at each directorate's clinical governance meeting. We reviewed a sample of minutes and noted the format for reviewing the incidents was different in each directorate with some simply noting the incident and others discussing the actions taken.
- Each ward also received a monthly safety and quality summary which included details of incidents reported or closed during the past month. Recently the speciality medicine directorate had implemented a safety newsletter which included learning points and actions to take to improve care. We were told there were also various trust wide initiatives in place to share the learning from incidents such as a serious incident directory on the trust's intranet and monthly trust wide safety publications.
- None of the front line ward staff we spoke with felt they had received feedback following reporting an incident and told us there was little trust wide learning. We found that learning from incidents was inconsistent across the medical services. There was little cross directorate or trust wide learning from incidents. The current system relied on the individual managers to be proactive and disseminate information rather than having a formal system in place
- Managers were not aware of any meetings where incidents were discussed or trends identified. They told us that they used to have Sisters' meetings which were a valuable forum to look at trends however these stopped over two years ago. Not all managers attended managers meetings and information was not disseminated.
- Patient information meetings were held on a weekly basis and individual patient incidents were discussed. Minutes were not kept of these.
- Staff had access to training on incident reporting and this included duty of candour training. We saw examples where patients and their families had been informed of incidents and the majority of staff we spoke with were aware of the duty of candour and what it meant for them.
- Both staff and managers told us across the medical services that they very rarely reported staff shortages on the electronic reporting system. They told us, "It's pointless – it takes up a lot of time and nothing ever changes". We were told that low staffing was only reported if it was critically low or if lack of staff compromised patient care. We did see several incidences where low staffing had been reported on the electronic system over the past year. However the numbers were low and did not reflect the amount of time wards were short staffed.
- Regular mortality and morbidity meetings and case reviews took place across the medical services in order to identify risk and areas for improvement. We noted there were no mortality outliers or particular risks highlighted for this trust.
- We reviewed a sample of morbidity and mortality minutes from across the medical directorates and found there were different methods and formats of recording the findings and the discussions that took place. Some directorates documented the findings and any action and learning points in a standard template; others had little information about the incident recorded or were more of a discussion without clear action points or learning identified.

- **Safety thermometer**

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism. We found that the NHS Safety Thermometer information was available on all of the medical wards we inspected.
- We saw evidence that safety thermometer data was being routinely used to improve the quality of care, such as the number of 'harm free days' in each area. For example: Ardingly ward reported it was 31 days since last fall and there had been four falls since January; Hurstpierpoint and Poynings wards recorded there was a fall the previous night. We noted that these wards had the second highest rate of falls in the specialist directorate with 22 in last 12 months. Four of the falls resulted in the patient sustaining a fractured neck of femur. These were all investigated as serious incidents.
- The monthly safety and quality reports issued to each ward included safety thermometer information. The report compared the ward's falls rate for the current year and compared this to the trust as a whole. The report also compared the data with the previous year.

- For example, over the past 12 months the rate of falls on Balcombe ward had decreased by nearly 6%. The ward reported no pressure damage incidents and of the 280 patients seen, 260 had experienced harm free care.

Cleanliness, infection control and hygiene

- The trust had infection prevention and control policies readily available for staff to access on the intranet. These included waste management policies. We saw that clinical and domestic waste bins were available and clearly marked for appropriate disposal. Disposable sharps were managed and disposed of safely.
- The trust had arrangements in place to support the management of infection prevention and control. These included an infection prevention team with qualified infection control nurses and a doctor with infection control responsibilities. The team worked across the trust coordinating with other health-care professionals, patients and visitors to prevent and control infections.
- The teams' responsibilities included giving specialist infection control advice, providing education and training, monitoring infection rates and auditing infection prevention and control practice. The infection control team reported to the chief nurse and the trust board.
- The Patients' Voice survey asked the question "How clean is the ward"? We reviewed the February 2016 feedback summaries on each of the wards we inspected and noted the feedback on ward cleanliness was consistently rated between four and five on a scale of one to five with five being excellent.
- We noted that the hospital's infection rates were consistent with the national average for bacterial infections such as MRSA and C. difficile. There were no reportable healthcare associated infections attributed to the trust in 2015/2016.
- Infection prevention and control was included in the trust's mandatory training programme. Those staff we spoke with all confirmed they had completed this training.
- The hospital employed its own cleaners after a period of using outside contractors. We were told that there had been some issues during the handover period as there were insufficient staff employed, but most of the issues were now resolved.
- We spoke with cleaners who explained how the cleaning system worked. They were each responsible for designated areas however they did not complete any form of checklist. They told us this was what their managers did. The ward managers told us that the cleaning supervisors regularly checked the standard of cleanliness and reported back if there were problems.
- The majority of areas we inspected where patients had access to were visibly clean and tidy. For example, linen cupboards were visibly clean and tidy with bed linen managed in accordance with best practices. On Hurstpierpoint and Poynings wards we found the sluice was clean and tidy. The commodes were visibly clean with 'I am clean' stickers attached. We noted the clinical stores were well organised with good shelf labelling. This all contributed to ensuring stocks were used in rotation and a good standard of hygiene maintained.
- However we did find areas where infection control was not managed according to best practice. For example the curtains in the endoscopy suite recovery area were not disposable and there was no date or information as to when they were last changed.
- We saw that personal protective equipment such as disposable gloves and aprons were readily available for staff to use. There were hand washing sinks with sanitising hand gel available. The majority of staff followed infection control principles and were seen to wash their hands and use hand gel appropriately. We observed the matron and staff wearing personal protective equipment when disinfecting beds between patients and we generally observed good hand washing techniques.

Environment and equipment

- The environment where patients were seen and treated was generally well designed and appropriately maintained. For example the rapid access medical unit was spacious and well laid out providing a suitable area for acute assessment.
- We noted access corridors were light and airy with good signage. Emergency call bells were in place in each room and by each bed.
- At the entrance to Hurstpierpoint and Poynings ward there were screens to prevent patients with dementia from absconding. Staff told us that this had proved an effective measure but had increased the risk of falls. Although there were no falls directly related to the screens this was being monitored.

- Lack of storage facilities and space was an issue throughout the hospital. For example on Balcombe ward the main corridor was cluttered with equipment. Staff told us that it was difficult moving the manual hoists up and down the corridors.
- On our unannounced inspection of Ardingly ward we found a fire door with a sign for it to be kept locked because of the risk of patients leaving the ward. Although the door was unlocked it should never be locked as it was a designated fire door. We also found a fire door with a missing pane of glass and zimmer frames stacked against fire extinguishers. This indicated that there were not robust systems in place to monitor fire safety in the hospital.
- The recovery bays in the endoscopy suite had suitable resuscitation available including oxygen and suction. The emergency trolley was appropriately checked with all the equipment in date, clean and dust free.
- The endoscopy suite was compliant with the Joint Advisory Group national standards until March 2016. We were told that the data had been submitted for the current year but they had not been advised of the outcome. We did note that because the dirty sluice was outside the endoscopy suite the used endoscopes were exposed when transported from the clean to dirty area. This was not best practice in infection prevention and control.
- There was a medical device management policy together with systems to monitor, check and maintain equipment. This included a medical equipment and devices management group which met every three months to review the use of equipment in the trust.
- There was a wide range of appropriate equipment available. The staff we spoke with confirmed they had access to the necessary equipment they required to meet peoples' care needs.
- Equipment was logged on an asset register which was supported by an outside contractor for maintenance purposes. This included both medical and estates equipment such as the lifts, air handling, water safety and generators. All the equipment we saw had been labelled to verify it had been electrically tested within the past year.
- Emergency resuscitation equipment, oxygen and suction equipment was available and checked as being in working order in each area with tamper proof seals in place. Some wards, such as Hurstpierpoint and Poynings, had complete records for equipment checks done in March and April. For other wards such as Ardingly the equipment checks had been inconsistently completed since January 2016.
- There were arrangements in place to provide staff with training on the equipment and medical devices in use. Although we did not see the equipment training records, staff told us they had received relevant training on how to use equipment and felt confident and competent to use it. Medical device training took place over the past year although the training at the Princess Royal Hospital had been cancelled and rebooked at the Brighton hospital. This had led to 250 staff being trained rather than the planned 600. Further roadshows had been planned for training in monitors, diagnostic and anaesthetic machines.
- Single use equipment such as syringes, needles, oxygen masks and suction tubes were readily available and stored in an organised, efficient manner.
- We found anomalies in the reporting of mixed sex breaches. The data available from NHS England indicated that the trust had reported no mixed sex accommodation breaches. We noted that in the 2014 inpatient survey, 20% of patients reported that they shared a bath and shower area with patients of the opposite sex which was much worse that the national figure of 12%.

- **Medicines**

- The hospital had medicines management policies together with protocols for high risk procedures involving medicines such as the intravenous administration of antibiotics. These were readily available for staff to access. Staff had access to relevant resources on medicines management such an electronic copy of the British National Formulary.
- We found that although medicines were supplied and disposed of securely and appropriately they were not always held securely. For example on Ardingly ward we found the medicine cupboard unlocked. It was normal practice for staff to store patients' money and jewellery in the cupboard. We found a patient's possessions in the drug cupboard dated October 2013. We also observed an unlocked medicine trolley left unattended. This trolley also contained a controlled drug.
- However we also observed good practice on Hurstpierpoint and Poynings wards where the treatment

room where medicines were stored was locked. Medicines were stored in locked cupboards within this room. The medicines here were neatly organised, safe and securely stored.

- We found that none of the medical wards routinely measured the ambient temperature of rooms where the medications were stored. The majority of medicines have a maximum and minimum temperature which they should be stored at otherwise they may deteriorate more quickly or become ineffective. Several of the clean utility rooms where the medicines were stored were noted to be exceptionally hot and staff told us this became worse in the hot weather.
- We observed staff administering medications and noted generally staff followed the medicines management policy. However we noted there were no systems to prevent interruptions for staff undertaking medicine administration rounds.
- We undertook random medicine checks on the wards and units we inspected and found that in general medicine management met current best practice guidance. The charts were well laid out and clearly documented. However we did note on Balcombe ward the doctors General Medical Council number was not included on the medicine charts and we could not decipher the doctor's signature. This meant that in the event of a query or incident it may not be possible to determine who the doctor was that prescribed the medication to be given.
- We reviewed the untoward incidents recorded over the past year and noted that staff in general reported medicine related incidents. The staff we spoke with understood how to recognise and report medicines related incidents. They described how shared learning had led to improvement in practice in medicine management.
- We spoke with a number of pharmacists and pharmacy technicians during our inspection and found that medicines on the wards were subject to close scrutiny and regular audit. Each ward was visited on a regular basis by either a pharmacist or a pharmacy technician who undertook regular audits and security checks.
- There was a shortage of pharmacists. We were told that some days three pharmacists covered 40 to 50 patients. The pharmacists told us that a new head of pharmacy had been appointed and that action was now being taken to address the issue.
- The pharmacy technicians told us they worked Monday to Friday checking the medication histories and reviewing the medicines records on each ward. Any anomalies would be flagged up with the pharmacist. They made sure that each patient had two weeks medication available so patients discharge would not be delayed by waiting for medication.

- **Records**

- We looked at a sample of records on each of the wards and units we inspected. We found that both nursing and medical records provided an accurate personalised record of each patient's care and treatment.
- The trust used a mainly paper based system of recording patient care and treatment. Where electronic records were used they did not always link in with other systems used in the hospital. For example the discharge letters, bloods, X rays and echo angiograms, endoscopy reports, rheumatology and diabetes letters were on separate systems that were not accessible by doctors not from that speciality.
- The majority of medical notes were legible and well completed in accordance with the General Medical Council guidance Keeping Records. We found that the paper based medical notes were in large overfull sets which made it difficult to find relevant information quickly. Some of the records had separated out the acute notes which made it easier to find recent information.
- Both nursing and medical records were generally well completed. We found that signatures were in place, complete with staff designation and date. The records were legible with up to date risk assessments and care bundles. For example in one set of records we observed the initial clerking by the doctor was completed to a good standard. The patient's condition was quickly identified as being unwell and then regularly reviewed. The nursing instructions were appropriately recorded, carried out eland then regularly reviewed. The medical and nursing records presented a clear picture of the patient's condition, care and treatment.
- The exceptions were eight of the ten sets of notes we reviewed on Pyecombe ward. These did not have a completed social history. On Ardingly ward the records were in unlocked trollies outside the bays. We saw a

computer terminal unattended with patient identifiable information on the screen. This could potentially lead to personal and confidential information being accessed by people not involved in the patient's care.

- Each ward undertook a monthly documentation audit where ten sets of patients' notes were reviewed to audit the quality of documentation. We noted that the audit scores were measured against the trust as a whole and the wards' past performances. We noted there were high scores across all wards for general documentation, and risk assessments apart from transfer documentation, which scored consistently low across the medical services and for the trust as a whole. We did not see any actions to improve transfer documentation.

- **Safeguarding**

- The trust had a safeguarding vulnerable adults and children policy with guidelines readily available to staff on the intranet. We saw that information on how to report safeguarding was available on the wards.
- There were safeguarding leads in the hospital that acted as a resource for staff and linked in with the trust's safeguarding team.
- We reviewed the copies of three sets of the trust wide safeguarding team minutes and noted there was robust oversight of safeguarding in the trust. The minutes confirmed that all aspects of protecting vulnerable patients whilst in hospital were considered. The minutes included an overview of recent safeguarding referrals, staff training, new guidance and reviewing how vulnerable patients, such of those with a learning disability or living with dementia, were cared for in the hospital.
- We noted that the safeguarding minutes documented that safe discharge and protecting patients from the damage of pressure ulcers remained the top two safeguarding risks. From the minutes we noted that the trust's safeguarding team worked closely with other hospital teams such as the dementia team, mental health liaison team, hospital social work team and the complaints and patient safety teams. They also worked together with external stakeholders.
- The safeguarding team monitored the outcomes from local safeguarding board investigations and ensured that any learning was disseminated to staff. The minutes documented the findings from recent safeguarding investigations and the actions required to reduce the risk of reoccurrence. For example 'Lessons learned' tips for preventing pressure damage were included in an edition of the Safeguarding Adults newsletter.
- We noted there were 19 Section 42 inquiries over the past year. 58% of these came from the speciality medicine division. Section 42 inquiries relate to the local authority having specific duties and responsibilities to investigate allegations of abuse. We noted that no themes of specific wards or departments were identified in the reviews.
- Safeguarding training was included in the trust's mandatory training programme. We were told that all staff undertook basic safeguarding training. Those staff with additional responsibilities undertook level two and three training. The trust's safeguarding reports documented a good take up of safeguarding training although the reports detailed specific numbers and not an overall total or percentage.
- All the staff we spoke with confirmed they had received safeguarding training as part of annual mandatory training. They were aware of the safeguarding policy and how to access it and told us they would report their concerns to the nurse in charge and contact the safeguarding lead if needed.

- **Mandatory training**

- All staff including bank staff had access to on-line and face to face mandatory training. The trust had recently moved to an on-line mandatory training records system.
- Staff, managers and practice educators told us that the changeover to the electronic system had not been well communicated and most wards were "playing catch up". They told us that they were maintaining both paper and electronic training records until the new system was in place and fully embedded.
- We spoke with staff who told us training and development was the responsibility of the individual practitioner. Lists of training were available and it was the individual staff member's responsibility to organise their own training. They told us this was not monitored by their manager although they did receive emails to remind them to do their training.
- Managers told us that staff compliance with mandatory training would be addressed at appraisal.
- We spoke with overseas nurses who were new to the hospital. They were full of praise for the support they had been given in adjusting to the British culture and

different way of nursing. They told us that they had received a good induction and worked supernumerary until they were competent in the role. They had been shown how to use the computer system including how to report incidents electronically. They each had an allocated mentor and were working under supervision. They knew who to contact should they have any concerns. They told us it was a really good learning process and had given them opportunities to grow as nurses and as people.

- **Assessing and responding to patient risk**

- The hospital used the national early warning scoring system (NEWS) to identify patients whose condition was deteriorating. We reviewed a sample of NEWS observation charts and saw that the charts were routinely used and patients usually escalated appropriately. The monthly records audits demonstrated that observation documentation was usually well completed.
- We reviewed the February nursing metric observations across all the wards we visited and noted that observation documentation usually scored high. This indicated that the observations used to inform the NEWS scores would normally be available. Appropriate escalation was not included in the nursing metric reports but the NEWS scores were audited and the audit results did not identify any issues.
- There were individual risk assessments in all of the patient records we reviewed. These included assessing the risks of falling, pressure damage, nutrition and continence. In the sample of records we reviewed the risk assessments were completed appropriately.
- The monthly patient records audits included reviewing risk assessments. We noted that in February 2016 risk assessment documentation on Pycombe and Balcombe wards was below the trust average with 75% of patients on Balcombe ward and 81% of patients on Pyecombe ward having appropriately completed falls assessments. This was worse that the trust average of 92%. It was a similar picture for all the risk assessments. We did not see any action plans relating to improving documentation.
- Staff across the trust told us they felt well supported by doctors when a patient's deterioration was sudden and resulted in an emergency. There were also clinical outreach teams who could support staff on the wards if needed.

- **Nursing staffing**

- The majority of medical wards reported they were short staffed, carrying vacancies or were covering for sickness. We found this was the case during our inspection. For example on the day of the inspection Balcombe ward was understaffed by one qualified nurse and the ward sister was working on the floor. The ward had three staff on maternity leave and other staff on annual leave. Ardingly ward had two closed beds because of lack of staff.
- We visited the care of the elderly, acute medical and specialist medical wards and found shifts had not been covered and staff were working short. We looked at a sample of rotas from each of the wards we inspected and found that very few of the shifts were fully staffed.
- The trust's incident reporting system showed many examples where staff had reported being critically understaffed. However staff told us that they did not often report this through the incident reporting system as it was so common and nothing ever changed as a result of reporting staffing shortages.
- The exception was the dementia unit, Hurstpierpoint and Poynings ward, where they reported few staffing problems. The manager told us that sickness and absence levels were low and if there were gaps in the rota these were largely filled by ward staff working on the 'bank'. The dementia unit was also supported by a psychiatric nurse and a psychiatrist, together with one to one sessions with a registered mental nurse.
- The trust told us that the situation was improving as a large number of overseas nurses had recently been recruited. However this had not been undertaken in a planned and structured way that engaged with the ward leaders. The induction, mentoring, supervision and support of new staff was putting an extra burden on already overstretched staff. We did not see any risk assessments, controls or strategies in place for the recruitment, competency assessment and integration of the new nurses.
- We were told that the trust had put in some measures to support the overseas staff such as a two week English course. Some of the wards had been able to extend the supernumerary periods until the new staff could demonstrate competency. We heard from other wards that any new staff had to be part of the ward team within two weeks following induction as the wards were under so much pressure.

- The trust used agency and bank nurses to fill vacancies. Any agency use had to be first authorised by the chief nurse. Although agency staff received an induction to the wards and there was a checklist to confirm this, staff told us it was rare they had the same staff which staff found frustrating and very time consuming.
- The trust told us that nurse staffing levels were calculated with the use of a dependency tool. However in reality there were never enough staff for the tool to be a meaningful way of ensuring there were enough staff on the ward. The staff were not aware of an acuity tool being used.
- Staff told us that there were rarely enough staff for vulnerable, confused or aggressive patients to be cared for on a on a one to one basis. They normally cared for these patients within the allocated ward numbers.
- We saw that ratios of the number of staff to patients were displayed on the wards. We noted that this was misleading as the nurse in charge was included in the overall numbers. This meant that they were not available to attend to patients' care needs as they were managing the ward, attending ward rounds and liaising with other healthcare professionals and speaking with relatives.
- The band seven ward managers told us that there had been an initiative the previous year to make 'Super 7's', which meant that they were supernumerary and given sufficient time to manage their ward and unit appropriately. They told us that this didn't last long and within weeks they were back to being counted as part of the ward team with little allocated managerial time.
- Managers told us the recruitment process often took over three months during which time the wards were working understaffed. Although shifts could be filled with bank and sometimes agency staff we were told there were often shifts understaffed.
- The trust board were aware of the staffing challenges as the chief nurse provided a detailed report on the nursing workforce to the board every six months. This report focused on national guidance for nursing and midwifery staffing and compared this with the current position of the trust.
- Staffing was reviewed by each clinical directorate and speciality. Where there was no national guidance, the NICE standard was used, Safe staffing for nursing in adult inpatient wards (2015).
- We noted the report stated that the national guidance was aspirational, rather than an index of safe staffing and high quality care and that the guidance also used different parameters for calculating staff which inflated the staffing requirements and could not be universally applied in every setting. The report also acknowledged there was evidence of increased harm associated with a registered nurse caring for more than eight patients during the day shifts and this excluded the nurse in charge. The report also acknowledged that there should be a minimum of two trained nurses on duty at all times day and night.
- The most recent report detailed the wards and directorates that were understaffed and stated that staff sickness levels peaked at 26% and turnover at 22% in September 2015. In February 2016 the report stated there were 258 whole time equivalent vacancies across the trust.
- The therapy teams told us that there had been a problem with not enough physiotherapists due to maternity leave but locum therapists had been brought in to cover and the situation was now resolved. They told us that there were no vacancies, with low sickness and absence; agency staff were not used.

- **Medical staffing**

- The trust had a lower percentage of consultants and middle career doctors (4% lower) and a higher percentage of registrars and junior doctors than the England average. For example, the medical staffing percentages for registrars was 44%, higher than an England average of 39% and junior doctors made up 24% of medical staff compared to an England average of 22%. This meant the trust's medical workforce was more reliant on junior staff than the national average.
- The General Medical Council informed us that there were 639 doctors working at Brighton and Sussex University Hospitals Trust with 396 trainee doctors. In February 2016 there were 11 open fitness to practice cases and six doctors with on-going sanctions.
- This inspection was carried out over the period of the junior doctors' strike. This meant there were less junior doctors available to interview than usual. However most of the doctors we spoke with on the day with felt there was usually adequate numbers of doctors on the wards during the day and out of hours.
- We viewed medical staffing rotas and saw these related to the actual medical staffing levels and the established number of medical staff required to staff the department

Medical care (including older people's care)

- All the doctors we spoke with told us that there was a friendly working environment, the consultants worked well together and were helpful. They told us, "We get things organised by mutual consent."
- For example the junior doctors had identified that handover could be improved and had started a junior doctors handover first thing in the morning in order to triage the more unwell patients. All the medical teams attended this meeting and the initiative was encouraged by the consultants.
- The junior doctors told us that when consultants did not attend a ward round they were always available by telephone for advice and consultation. They told us, "They [the consultants] are very approachable and the nurses supportive". We were told the consultants work well together and there was a collaborative atmosphere,.
- The doctors and consultants told us that the medical night shifts were well covered and there were effective night team meetings that involved the intensive care outreach team, medicine, surgery and other night workers.
- They said that it was easy to make referrals to other specialities within the trust or to the Royal Sussex County Hospital in Brighton.
- We spoke with the medical registrar on call. They told us they usually saw and treated 20 to 30 patients over the 24 hour period. Although it could get busy, especially in the evenings, generally patients were seen promptly.
- However we were also told that sometimes there were gaps in the rota which created problems.
- They also told us that some of the consultants did not stay in the evening after 5pm. This meant that patients seen by junior doctors after 5pm could wait more than 14 hours to be seen by a consultant. This did not meet the Royal College of Physicians guidelines.
- Although they were in the same trust there were different models of care between the Royal Sussex County Hospital and the Princess Royal Hospital. The doctors told us the morning rounds were less organised at the Princess Royal Hospital with less specialist input. Daily consultant rounds did not always happen. However it was more collaborative and the care was good.
- The dementia unit had psychiatrist input for two afternoons a week. The unit also operated an outreach service for other patients in the hospital living with dementia.

- **Major incident awareness and training**

- The trust had business continuity plans which included major incidents, emergency preparedness, cold and hot weather plans, pandemic influenza plans and the patient flow and escalation policy.
- Staff were made aware of these through both electronic and paper means. The current policy was available on the trust's intranet with hard copies on the wards. There was also a major incident planning and business continuity leaflet for staff to act as a prompt for the policy and the actions to take. The hospital did not undertake scenario training to prepare staff in the event of a major incident.
- The hospital was not designated as a trauma centre but was located close to motorway networks and an international airport. This meant that any major incident would have an impact on the day to day activities of the hospital.
- Staff described three recent occasions when the major incident/business continuity policy had been instigated. There were major road incidents and an incident at a local airfield. We were told that following any incident there was a staff debrief and the process was reviewed.
- The medical directorates would usually be involved in a major incident through either the acute medical unit admitting patients from the emergency department or through taking patients from other areas and specialities to free up trauma beds.
- We saw an example of emergency planning taking effect during our inspection as not only was there a junior doctors' strike but the trust was dealing with problems caused by a change in the patient transport provider.
- The hospital had time to prepare for the junior doctors strike and make alternative arrangements. Although a consultant told us there had not been any real plan in place for doctor's strike, they were just covering for their colleagues.
- We did not see any indication that patients' medical care had been compromised because of the strike however elective endoscopy investigations were cancelled.
- The unexpected problems with the non-emergency transport service had affected patients requiring medical services throughout the South East. This had

led to patients missing appointments and not being discharged home in a timely fashion. The staff had minimised the impact on patients through working flexibly and proactively.

Are medical care services effective?

Requires improvement

We rated the Princess Royal Hospital's medical services as requires improvement for effective because:

- Accessing valid appraisals was variable depending on the ward or directorate. Not all staff had received an annual performance review or had opportunities to discuss and identify learning and development needs through this review. Staff reported that staffing shortages had impacted on the appraisal process and, although this was improving, time to undertake appraisals was still an issue.
- We had concerns that due to staff shortages overseas or newly qualified nurses without appropriate skills and competencies, with poor language and communication skills were left in charge of wards at night.
- We found that the hospital was not yet offering a full seven-day service. Constraints with capacity and staffing had yet to be addressed. Consultants and support services such as therapies operated an on-call system over the weekend and out of hours. This limited the responsiveness and effectiveness of the service the hospital was able to offer.

However we also found:

- Medical care was evidence-based and adhered to national and best practice guidance. The trust's policies and guidance were readily available to staff through the trust's intranet. The care delivered was routinely measured to ensure quality and adherence to national guidance and to improve quality and patient outcomes.
- The medical wards had clinical pathways in place for a range of medical conditions based on current legislation and guidance.
- Consultants led on patient care and there were arrangements for supporting the delivery of treatment and care through multidisciplinary teams and specialists.
- There were suitable arrangements to ensure that further training and development was available for staff to enable them to improve their skills and develop their competencies. The majority of staff we spoke with told us they felt well supported and encouraged to develop.
- Throughout the medical services we found effective multidisciplinary working. Medical and nursing staff as well as support workers worked well as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- **Evidence-based care and treatment**
- Staff were able to access national and local guidelines through the trust's intranet. This was readily available to all staff. Staff demonstrated how they could access the system to look for the current trust guidelines. We noted there were appropriate links in place to access national guidelines if needed. We saw that guideline reviews were included in some of the clinical governance meeting minutes we reviewed and were included in update briefings for staff.
- We reviewed samples of guidelines and noted these were consultant led and were routinely checked by a nurse consultant and updated by the consultants.
- The different medical directorates participated in both national and local audits which demonstrated compliance with best practice and national guidelines such as the National Institute for Health and Care Excellence clinical guidelines. We saw the trust maintained a schedule of planned clinical audits and noted that for 2016/17 this involved nine acute medicine audits, nine cancer audits, 37 cardiology audits, five dermatology audits, 15 diabetes and endocrinology audits and 13 care of the elderly audits. We noted that the audits were used to inform practice and improve the quality of care provided. For example the diabetic nurse specialist carried out audits in 2015 to map compliance against best practice in diabetes care. We saw that continuous data collection and auditing had identified that improvements had been made since the original audit in 2014. The audit also identified outstanding areas such as the lack of an inpatient foot team and podiatry service and more work was needed in educating staff.
- Staff told us that the audit programmes were embedded on the wards. Staff on Balcombe ward told us there were no problems with undertaking audits. They gave examples of the monthly records audits where the results were fed back to the wards for action.

- **Pain relief**

- There were protocols and guidance available for staff on managing patients' pain. There was a pain scoring tool available for staff to assess adult pain levels. In the records we reviewed we noted these were completed appropriately and pain relief was given when needed.
- Staff told us the trust's pain team visited the wards if requested and there was no problem with access.
- All the patients we spoke with, including those who had recently undergone procedures, told us they had no problems in obtaining prompt, adequate pain relief.
- We saw in patient records that pain scores were recorded where indicated.
- Each month each ward received patient feedback which included responses to the question "Do you think the hospital staff do everything they can to manage your pain?" This enabled the ward managers and staff to make sure they were treating patients' pain management appropriately.
- We reviewed the feedback sheets for each ward for February 2016 and there were no concerns indicated on pain management across the medical services.

- **Nutrition and hydration**

- The trust was using a nationally recognised tool to assess patients' nutrition and hydration. We reviewed a sample of risk assessments on each of the wards we visited which included nutritional assessments.
- We found that in general the assessments were up-to-date and additional support from the dietician service had been sought when needed. A dietician was available on referral to the hospital's dietetic service. Dieticians provided specialist support to some medical services such as stroke patients.
- The majority of nutrition and fluid balance sheets had been scored and acted upon appropriately. We noted that the wards reviewed a sample of ten nursing records each month and the completeness of nutritional assessments were included in the review.
- We reviewed the nursing records audits for nutritional documentation across all of the medical wards for February 2016 and noted that in general they were well completed. Some wards such as Balcombe ward scored 83% with Pyecombe ward scoring worse at 76%. The average across the trust was 84%.
- Patients were offered three main meals and snacks were available if needed. There was a choice of food available and the hospital was able to cater for specialist diets if required. The menu lists included the patients' dietary requirements and food choices.
- The discharge lounge was able to provide food and drinks to patients with their own discharge menu.
- There was no overarching protected mealtime policy although some wards ensured that patients were not interrupted during mealtimes.
- The hospital used colour coded water jugs to indicate what hydration needs patients had. This was an unobtrusive way of ensuring patients individual hydration needs were met.

- **Patient outcomes**

- The trust routinely reviewed the effectiveness of care and treatment through the use of performance dashboards, local and national audits.
- Mortality and morbidity trends were monitored monthly through Summary Hospital-level Mortality Indicator (SHIMI). Reviews of mortality and morbidity took place at local, speciality and directorate level within a quality dashboard framework to highlight concerns and actions to resolve issues. There was little evidence of cross directorate or cross speciality learning or sharing of information.
- The hospital episode statistics (HES) covering the period September 2014 to August 2015 showed the standardised relative risk of readmission at the Princess Royal Hospital for both elective and non-elective procedures were mostly the same as the England average. Apart from elective general medicine, which was 33% higher than the national average. This meant there were more readmissions than expected over the period in question.
- The average elective medical readmission was a score of 150 with a score below 100 interpreted as a positive finding. For this an outlier was elective general medicine, which scored 446. The managers we spoke with told us this did not reflect their experience of emergency readmissions and queried the data. They did acknowledge that pressure on beds meant that elective admissions were sometimes cancelled but could not provide a definitive reason for this.

Medical care (including older people's care)

- The HES statistics for standardised relative risk of readmission for non-elective medical admissions was an overall score of 109 for this hospital. General and geriatric medicine scored 117 and diabetic medicine scored 107 against an England average of 100.
- The hospital's performance in the sentinel stroke national audit programme (SSNAP) had deteriorated from previous audits. The Princess Royal Hospital's overall SSNAP score from July to September 2015 had declined from a C to a D rating (A is the highest and E the lowest level of attainment) for both patient centred and team centred key indicators. The main cause was the lack of availability of therapy services such as speech and language and occupational therapy.
- In the 2012/13 heart failure audit the Princess Royal Hospital scored below the England average for in hospital care measures and better than the England average for two of the seven discharge care measures.

- **Competent staff**

- The trust had recruitment and employment policies and procedures together with job descriptions. Recruitment checks were made to ensure new staff were appropriately experienced, qualified and suitable for the post. On-going checks took place to ensure continuing registration with professional bodies.
- All new employees undertook both corporate and local induction with additional support and training when required. We spoke with newly appointed staff who confirmed their induction training gave them a good basic understanding of their role and responsibilities. One newly appointed overseas nurse told us about their induction and was full of praise for how the hospital had integrated and acclimatized them into the working of an English hospital.
- We found that staff had access to further training and development. The only constraints were the lack of staff to cover their release for training.
- Staff told us there was no problem in applying for funding for additional training. The only issue was taking the time off to study. Staff on Hurstpierpoint and Poynings wards gave examples of attending Brighton University for certain modules. On Balcombe ward we heard how two staff were undertaking mentorship training and an acute care module at university.
- Although the majority of staff we spoke with told us they felt well supported and encouraged to develop, one group of therapists told us that although the trust considered itself to be a training trust, in reality there was very little training available.
- Learning and development needs were identified during the appraisal process. The trust collected data on this and used it to inform managers.
- In the 2015 staff survey the trust was in the lowest 20% nationally for the quality of appraisals. Although the percentage of staff appraised had increased from the previous year from 73% to 82% this was still below the national average. Trust wide the appraisal rate for all staff was 68% April 2015 to January 2016 with a target of 75%. The trust did not provide appraisal completion rates specific to the individual medical services.
- We had varying reports from staff about accessing valid appraisals. Many of the staff we spoke with told us they had recently had their appraisals or they were planned within the next week. However one manager we spoke with told us they had not had an appraisal in over three years and staff on Ardingly ward told us they never had enough time to do appraisals.
- Registered nurses we spoke with told us they were supported with preparing their revalidation.
- Most staff we spoke with told us they had regular team meetings and were supported with their continuous professional development.
- Junior medical staff reported good access to teaching opportunities and said they were encouraged to attend education events. The junior doctors we spoke with told us they received good educational supervision and said the consultant staff took an active interest in their learning and development.

- **Multidisciplinary working**

- Throughout the medical services we found effective multidisciplinary working. This included effective working relations with speciality doctors, nurses, therapists, specialist nurses and GPs. Medical and nursing staff, and support workers worked well as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- We found the handover sheets provided comprehensive information with good clinical and discharge escalation plans in place.

Medical care (including older people's care)

- We observed positive and proactive engagement between all members of the multidisciplinary team. We attended multidisciplinary ward rounds on Balcombe, Hurstpierpoint and Poynings wards. We found that the ward rounds were well organised and well attended by all members of the multidisciplinary team.
- For example, the Hurstpierpoint and Poynings ward daily multi-disciplinary team meeting involved the discharge coordinator, ward manager, ward sisters, physiotherapist, occupational therapist and social worker. The attendees went through the list of patients and discussed each one individually. The meeting was very much nurse lead but the other professions had the opportunity to contribute when and where appropriate. The meeting was an effective way of improving patient flow through the hospital.
- We spoke with an occupational therapist who explained they felt very much part of the team. They told us that should they be away for any reason there was support available from the Royal Sussex County Hospital and vice versa should the need arise.
- We spoke with the therapists who told us there was a good working relationship between the healthcare disciplines. They told us that everyone respected and listen to each other with good communication.
- On Balcombe ward we observed how good multidisciplinary work and good communication between therapy teams such as speech and language therapists, tissue viability and critical care outreach teams improved the continuity of care.
- Physiotherapists told us that the trust worked well with the local community trust rehabilitation teams to ensure that patients received continuity of rehabilitation once they returned home. However the lack of resources in the community often led to patients being readmitted. We were given examples where patients had improved on the ward but relapsed once they returned home and were subsequently readmitted.
- There were outreach teams of specialist staff who attended outlier patients who had not been admitted to their speciality ward but were placed elsewhere in the hospital. For example the critical care, oncology and frailty teams attended outlier patients to provide support to both the patients and staff on their care and management.
- **Seven-day services**
- The hospital did not yet offer a full seven day service across all medical services and specialties. We were told there were challenges related to capacity, staffing and the financial implications of providing additional seven day services.
- General and specialist medical consultant cover was available every day including weekends, with on-call arrangements for out of hours and ad-hoc cover on bank holidays.
- Where seven day cover was not available for the support services such as radiology and therapy services, the weekend and out of hours services were provided by either on-call, agency or locum staff supplementing the permanent members of staff.
- The physiotherapists told us there were issues with the on-call physiotherapy rota. This was because it was possible for a physiotherapist to be called out at night when on call and then working the next day. They felt this was dangerous for driving if they had been called out to work at night and then worked the following day. They said the trust did have on call rooms available but charged £20. The on call rate was £11 per night, staff felt this was not realistic so ended up driving backwards and forwards when really tired. One physiotherapist told us they had worked from 08.30 on Saturday morning and were then on call for the rest of the weekend. They said it was very tiring and a 'grey' area that the trust had not yet resolved. The therapists told us the trust's response to any dispute of this kind was "Go to the unions if you are unhappy".
- **Access to information**
- The hospital used mainly paper based records. This meant there were sometimes delays when sharing information across sites and with with other providers who used electronic records and means of communication.
- When we asked how quickly the wards received the results from medical tests there were different answers across the directorates. The rapid access medical unit told us there no problems getting microbiology results while we observed staff on Balcombe ward trying multiple times to obtain test results for over an hour with no luck.
- Across the hospital we saw that there were leaflets and useful information available to help patients and their

relatives understand their conditions and the treatment options available. These were easily accessible and prominently displayed on most of the wards we inspected.

- There was inconsistency in wards using team meetings to disseminate information. We were told by some staff that departmental and ward meetings took place on a regular basis. They told us that this was a good forum for disseminating information. We saw the minutes from many different meetings which confirmed this. Other staff told us that team meetings were often cancelled because of pressure of work. Staff on one ward told us that ward meetings had not happened for some time.
- We saw that most clinical information and guidance was available on the intranet. Staff also had access to information and guidance from specialist nurses, such as the diabetic, stoma and tissue viability nurses and the link nurses for dementia care, infection control and safeguarding.
- The wards also used a white board at the nursing stations to maintain at a glance information about patients. We noted on Ardingly ward that this information was not current as it showed all but three patients ready for discharge. When we queried this with staff none of the patients were ready to go home.

- **Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- The trust had a consent policy in place which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details on the Mental Capacity Act 2005 (MCA) guidance, and checklists.
- Training on consent and the MCA was available and staff reported there was no problem with accessing the training.
- We observed that consent was obtained for any invasive procedures such as endoscopy investigations.
- The staff we spoke with had good awareness of the legislation and best practice regarding consent, MCA and deprivation of liberty safeguards (DoLS). They were clear about their responsibilities in relation to gaining consent from people, including patients who lacked capacity to consent to their care and treatment. Staff on Balcombe ward told us that because of the high turnover of patients there was never a need to renew applications. They told us there was very little external support for staff when undertaking DoLS applications.
- Staff demonstrated good understanding of both written and verbal consent where consent was implied, such as taking of bloods.
- We were told that best interest decisions and DoLS decisions were taken where indicated and these were formally documented. This could not be verified as there were no patients who had current DoLS applications in force during our inspection. On Hurstpierpoint and Poynings wards staff told us that any patient with a DoLS in place would be risk assessed as there was no provision for automatic one to one nursing support for confused patients.
- In November 2015 a safeguarding report noted that there had been an increase in DoLS applications which had led to a problem with notifying CQC in a timely fashion. The report also highlighted an increased staff awareness and better communication with staff around capacity and consent issues.
- The trust had produced a 'handy hints' guide for staff to aid them in following the correct procedure when assessing capacity and considering a DoLS application.

Are medical care services caring?

Good

We rated the Princess Royal Hospital as good for caring because:

- The patients we spoke with during the inspection told us that they were treated with dignity and respect and had their care needs met by caring and compassionate staff. The Patients' Voice and Family and Friends feedback indicated that this was not unusual and the majority of patients had a positive experience.
- Staff treated patients with dignity and respect. We observed patients being treated in a professional and considerate manner by staff. We observed staff treating patients with kindness, professionalism and courtesy.
- Patients were usually satisfied with the quality and standard of care they received from doctors and nurses and reported they were involved in decisions about their treatment and care. There was access to counselling, chaplaincy and specialist nursing services, where patients required additional emotional and psychological support.
- **Compassionate care**

Medical care (including older people's care)

- Medical care services participated in the national friends and family test scheme to gather patient feedback. The Friends and Family Test is a feedback tool that gives people who use NHS services the opportunity to provide feedback on their experience.
- The results averaged 80. A score above 50 is considered a positive indication that patients would recommend the hospital to family and friends.
- The trust's response rate for patients completing the feedback was better than the national average at 22.4% for the period July 2014 to June 2015. We noted that some wards such as Lingfield ward scored particularly well with a 90% response rate and a score of 90 or higher.
- There were Patient Voice boxes located outside all wards. This enabled patients and their relatives to give instant feedback. We looked at 15 of these during inspection and the responses were all positive about the care patients had received.
- Analysis of Patient Voice feedback from June 2105 to December 2015 showed some concern over the quality and variety of food. The comments also frequently mentioned a need for more staff across both the Princess Royal Hospital and the Royal Sussex County Hospital.
- Each ward received monthly summaries on their Patient Voice feedback. We reviewed the February 2016 feedback summaries on each of the wards we inspected. Comments were universally positive with the majority of patients stating that staff "always" treated them with kindness and compassion.
- During our inspection we spoke with eight patients receiving care in the hospital and some of their relatives. They all told us of their positive experiences in the hospital. For example one patient we spoke with said she felt well informed about her treatment and told us, "I wouldn't change a thing."
- During the inspection we observed staff ensuring that patients' privacy and dignity was met. For example staff always pulled curtains around patients to maintain privacy and dignity when care interventions were carried out. We observed staff asking before they entered if the curtains around the bed were drawn.
- During the inspection we observed patients being treated with kindness and respect. For example we saw a healthcare assistant helping a patient walk to the toilet, the patient expressed concern about not having been mobile for a while and the staff member was reassuring and encouraging.
- We witnessed a ward manager interacting with patients and staff in a personal and caring way, using their first names and with courtesy.
- Staff performed comfort rounds several times a day. These rounds were an opportunity for staff to interact on a one to one basis with patients, to ask them if they were all right and had everything they needed; that they were comfortable, pain free, and had adequate hydration.
  - **Understanding and involvement of patients and those close to them**
  - We spoke with eight patients receiving medical care at the Princess Royal Hospital, we also reviewed samples of patient feedback over the past year. The majority of patients stated they felt involved in their care and in decision making about their treatment. Most patients knew why they were in hospital and understood their care and treatment. However the patient records did not always record patient involvement and this wasn't a metric included on the monthly records audits.
- We saw from the monthly Patient Voice summaries for each ward that most patients felt they were involved as much as they wanted to be in making decisions about their care and treatment. Most patients fed back that when they asked questions regarding their treatment and care they received answers they could understand. Out of a possible score of five, with five being excellent, most wards scored between four and five.
- Staff members were seen introducing themselves to patients and their relatives. We saw staff photographs placed outside individual bays, enabling patients to familiarise themselves with the staff members working in that area.
- Patients and their families were involved in planning their discharge arrangements. For example we spoke with a patient who described a meeting that took place involving her family, doctors and other healthcare professionals to decide if she was ready for discharge. She felt they were all involved in this decision.

- We observed staff making sure that patients were involved in their care and understood what was happening. We saw a doctor explaining in detail a procedure he was going to perform on a patient and making sure they fully understood the process.
- There were printed information leaflets and useful information available to support patients in understanding their condition and their care and treatment options. These were clearly displayed and easily accessible for patients on several wards.
- The trust's website also had information such as contact telephone numbers and visiting hours for the inpatient wards with links to other websites where additional information could be found.

- **Emotional support**

- The Princess Royal Hospital had arrangements in place to provide emotional support to patients and their families when needed. This included support from clinical nurse specialists who all provided emotional support and practical help. We witnessed several ward handover meetings where staff from all disciplines were involved in reviewing the support patients needed. This included emotional support.
- We noted that in the Patient Voice feedback, out of a possible score of five, with five being excellent, most wards scored between four and five for the question, "Is there someone on the hospital staff available to talk with about your worries and fears?"
- The trust and clinical commissioning group recently commissioned a report on improving support for patients with learning disabilities. The report aimed to provide intelligence from Brighton and Hove residents with learning disabilities on their experiences of health services and how these could be improved.
- We saw cards on the walls of several wards from patients expressing their gratitude for the care and support they received.
- There was a carer support service on the dementia ward. This meant that patients could receive care and support from a familiar face and carers felt involved in their relatives' personal acre and daily routine. This helped vulnerable and confused patients to feel settled and helped to avoid stress.
- On the majority of wards there were quiet rooms or spaces available for patients who wished to use them, as well as a chapel for multi-faith worship.
- The hospital provided a chaplaincy service which provided spiritual, pastoral and religious support for patients, relatives, carers and staff. Chaplains were available 24hours throughout the week and were contactable by staff, relatives or carers through the hospital switchboard.

Are medical care services responsive?

Requires improvement

We rated medical care services at the Princess Royal Hospital as requires improvement for responsiveness, this is because:

- The data available for average cancer wait times was not site specific and instead reflected the overall performance of the trust. Just over 91% of patients saw a specialist within 14 days. This was worse than the England average of just over 94% and below the 96% national standard.

However we also found:

- Good examples of how the hospital cared and treated patients living with dementia and their families. The main ward that treated people living with dementia provided a broad range of activities to stimulate the patients. Staff from the dementia ward also provided an outreach service to other wards that were caring for people living with dementia. We observed good multi-disciplinary team working aimed at improving flow through the ward.
- The average length of stay for both elective and non-elective patients was better than the England average.

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

- The Brighton and Sussex University Hospitals NHS Trust provide services to the local populations in and around the City of 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 Royal Sussex County Hospital is the tertiary and trauma centre for the region, whilst the Princess Royal Hospital is the centre for planned care.

Medical care (including older people's care)

- The cancer service across the trust consisted of four specialities. These were: end of life care, oncology, haematology and breast. The service was Sussex wide and operated from five hospitals. The team made efforts to travel to where the patients were, due to the elderly demographic and poor travel links in the area. This presented a challenge in terms of managing the service.
- Flow through the hospital and delayed discharges were a concern. Although this was complex and reliant on many internal and external factors, there had been improvements supported by various initiatives internally and by external partners. There continued to be a need for a more proactive approach to discharge planning across all wards with timely planning for complex discharges and maximising communications with patients, relatives and external support agencies.
- We were told that some consultants on the rapid access medical unit did not stay after 5pm in the evening. This meant that patients who were seen by a junior doctor after 5pm could wait up to 14 hours before seeing a consultant.
- We were also told that Ardingly ward had closed two beds because of lack of staff.

- **Access and flow**

- There was no site specific data for the Princess Royal Hospital. However, in the 12 months from September 2014 to August 2015 the trust had a total of 43,455 admissions to medical care services.
- We were told that patients were admitted to the general medicine wards either direct from the emergency department and the rapid access medical unit or were transferred from other wards. There were no booked admissions.
- The Princess Royal Hospital medicine department made 383 transfers out of hours in the six months prior to the inspection. Out of hours means patients transferred after 10pm.
- The average length of stay for all the medical specialties at the Princess Royal Hospital was better than the England average between September 2014 and August 2015 for both elective and non-elective stays.
- For example for elective patients the average length of stay was 1.9 days, against the England average of 3.8 days. For non-elective patients this was 6.6 days, better than the England average of 6.8 days.
- The top three reasons for delays in transfer of care between April 2013 and August 2015 were: waiting for further non acute NHS care (46.6%), patient or family choice (20.7%) and awaiting care package in own home (12.3%).
- The Princess Royal Hospital dealt with four main local authorities when discharging patients home. We were told provision of social care packages and placements varied across the different local authorities. This could lead to delays in discharge for some patients while awaiting social care input
- The dementia ward employed an occupational therapist to aid early discharge. This was a successful initiative and another occupational therapist and an occupational therapy assistant had been recently recruited.
- Other wards told us that limited occupational therapy support had delayed discharges on occasion.
- There was no site specific data available for referral to treatment times. However, seven of the eight specialities within the trust met the 90% referral to treatment time for nine of the 12 months from December 2014 to December 2015. Only dermatology was slightly below the national standard of 90% being referred to treatment 18 weeks (89.4%).
- There were no site specific figures for cancer wait times for this trust. However, of the 4,286 patients seen in quarter three of 2015/16 (October, November and December), 3,914 were seen by a specialist with 14 days. Of the 372 who were seen outside of 14 days, 91 were in 15-16 days, 168 in 17-21 days, 71 in 22-28 days and 42 after 28 days. This meant that 91.32% of all patients were seen within 14 days. This was worse than the England average of 94.76% and did not meet the 96% national standard.

- **Meeting people's individual needs**

- The Princess Royal Hospital was generally able to meet patients' individual needs. In particular the dementia ward had a number of initiatives specifically designed for those living with dementia. This included a reminiscence room containing various items from the different eras of the 20th century as well as games and other items that were important to the patients. There were also activities available such as knitting, painting and doll therapy.
- We saw there was a computer available where family members could take photographs of themselves with

patients. This allowed patients to see that their relatives had visited them recently. This in turn reduced anxiety when a patient believed that they hadn't seen their relative. The computer also allowed access to programmes which facilitated visual communication over the internet and helped patients to communicate with friends and relatives who could not attend the hospital to visit or perhaps lived overseas.

- The dementia ward also had a bus stop in the corridor that acted as a focal point for the patients to meet and socialise. This was an initiative of the ward manager who had got an old temporary bus stop from the council to put in the ward. Music was also playing near the bus stop. We observed the end of a daily group session that provided various activities. The activities could be either physically or mentally stimulating. The patients appeared very happy and content with what they had been doing in the session. Nursing staff also told us about the annual Christmas carol service that was put on in the ward where patients and relatives can come together to sing Christmas carols.
- We observed that the individual needs of patients were discussed in the daily multi-disciplinary team meetings that were attended by the ward manager, ward sisters, occupational therapist, social worker and physiotherapist. This included discussions on the packages of care needed to support the needs of the patients once they were discharged home.
- The dementia ward also provided a psychiatrist visit two afternoons per week to look after patients' mental health needs.
- However we saw a retractable screen across the entrance of the dementia ward. Staff told us that this was used to reduce the risk of patients wandering from the ward. Although this was working it was also a trip hazard. Staff told us that this was a temporary measure although we found no immediate plans to replace it.
- The specialist dementia unit did not provide an alcohol service for those with Korsakoff's syndrome. Korsakoff's syndrome is a type of dementia that is commonly caused by alcohol misuse.
- The ward did not undertake any type of acuity scoring for the patients and they did not provided 1:1 special care for those who were subject to a deprivation of liberty decision. However managers told us that the ward was well staffed and was able to allocate additional staff to support patients with challenging behaviour if required. We did not see any reported incidents where lack of staff meant the dementia ward was unable to meet the needs of the patients.
- We saw another ward had one shower and one bath available. All patients were given one shower or bath a week but the patients could book in for more if they wanted to as there was a rota on the door of the bathroom. It was explained that this was done to try to encourage independence. Bedside washing for patients between their bath or shower was provided as needed. We were told that patients gave positive feedback about the systems in place.
- During the inspection, we visited all areas where patients received medical care and spoke with eight patients and relatives. They were generally positive about the quality of food, and told us they had enough to drink and sufficient help from staff.
- We saw that patients were offered a choice of meals and that the hospital was able to cater for religious and dietary preferences such as gluten free and halal. We saw a copy of the menu, which included bed number, dietary requirements and the food choices available. There was also a 'lite-bite' option available which could be arranged through the kitchen.
- Some of the patients we spoke with were not happy with the food service at the hospital. One patient told us there "isn't enough". They told us the timings of meals meant that between the evening meal at 5pm and breakfast at 9am they often felt hungry. They also said that squash to add to the water would be nice.
- Food and nutrition issues were mentioned in the Patient's Voice regarding choice. Managers told us that if there was a particular concern they would speak to the catering staff and try to rectify it. The ward kitchens could provide toast and snacks if needed.
- Hurstpierpoint and Poynings wards offered patients a cooked breakfast option which was very well received. Staff told us that when patients were offered a cooked breakfast they were "all smiles" and very happy.
- We were shown a cook book with recipes developed by a consultant. The hospital also held a nutrition week for patients to provide support and information.
- Interpreters are available for those patients whose first language was not English. This was arranged either face to face or through a telephone interpreter. Staff told us that under no circumstances would a family member be able to act as an interpreter where a clinical decision

needed to be made or consent needed to be given. Using a relative is not good practice, unless the patient specifically requests it, as there are issues of confidentiality. It is not always possible to be certain that the interpretation is correct and unbiased.
- We saw patient information literature readily available on the wards. Information was also available on the hospital's website.

Learning from complaints and concerns

- The hospital had a complaints policy and procedure that was readily available to staff on the intranet.
- Information on making a complaint and raising concerns was available to patients on the wards. We observed that the complaints procedure and the Patient First feedback box were clearly visible on entering the wards. The patient first box is a box where the patients, friends or relatives can leave comments about a range of aspects of the care that has been provided.
- Complaints were normally dealt with on an informal basis and at ward level. They were also dealt with through the patient advice and liaison service (PALS).
- Concerns were normally raised through the patient voice feedback forms which were available on each ward and clearly displayed. Observation by the inspection team showed that these were well used.
- We observed staff dealing with a telephone complaint about the patient transport services during the inspection. The nurse dealing with the complaint was aware of the duty of candour and was honest with the complainant as to what had happened.
- The duty of candour is a requirement on NHS services to provide support and relevant information to patients and their families when a reportable patient safety incident occurs.
- The wards received monthly feedback on the number of complaints and compliments they received in the Patients Voice feedback and the safety and quality summary sheets. This did not include any analysis of themes or trends at ward or unit level.
- For example between February and March 2016 six complaints and 22 PALS contacts were recorded on Balcombe ward. We noted this had increased from the same period last year when there were four complaints and 12 PALs contacts. There was no recorded investigation into why this was.
- Complaints were also monitored at most of the divisional and unit clinical governance meetings. We reviewed a sample from each directorate and noted that not all clinical governance meetings covered complaints and none that we reviewed included an analysis of themes or trends or identified actions to take to reduce similar complaints in the future.
- We did not see there were any mechanisms in place for shared learning across directorates. We did not see evidence that complaints were being managed with a view to reducing further similar complaints.

Are medical care services well-led?

Requires improvement

Overall we rated The Princess Royal Hospital's medical services as requires improvement for well led because:

- The trust had a complex vision and strategy which staff did not feel engaged with.
- We did not identify a cohesive strategy for the medical services either within their separate directorates or within the trust as a whole.
- The frequent changes of management at senior level had led to stasis where nothing had happened for a long time. Those staff who were looking to innovate and move the trust forward found this very frustrating.
- Although there were governance systems in place they were complex and operating in silos. There was little cross directorate working, few standard practices and ineffective leadership bringing the many directorates together.
- The trust had not dealt effectively with poor staff behaviour. There was a culture of fear of doing the wrong thing so nothing was done. There had been lack of support from the HR department and senior management which led to staffing issues not being addressed early. We heard how many of the HR policies were ineffective.

However

- The staff generally felt supported by their immediate managers but told us there was a disconnect between the wards and senior managers. Managers spoke enthusiastically about their ward or department and were proud of the hard working and committed staff they had working with them.
- There were systems in place to gather information and produce data sets and dashboards.

Medical care (including older people's care)

- **Vision and strategy for this service**
- The trust had developed five key objectives and seven 'fundamentals' that were needed to meet the objectives. In addition there were ten programmes to support the 2015/16 objectives. The trust's annual plan also identified six challenges that the 12 new directorates would work to address.
- This was a complex vision and strategy and none of the staff we spoke with could articulate what it was. They were unaware or any corporate or medical directorate strategy they could be working towards or that might impact on how they delivered care in the future.
- We spoke with the divisional leads and they told us there was no vision or strategy for the individual medical directorates but they were included in the overall organisational strategy.
- We looked at the organisational strategy and noted the acute medical unit, stroke, digestive diseases and renal services were the only medical services specifically identified with key impact programmes in the 2015/16 annual report. The business as usual functions were not included.
- The other medical services did not have a formal vision, strategy or direction of travel included in the annual report.
- We heard that a recent senior management away day had included reviewing the strategic direction of the trust but staff still did not feel engaged with the process.

- **Governance, risk management and quality measurement**

- In 2014 the trust introduced twelve new disease based clinical directorates with a new trust-wide governance structure that was put in place in 2015.
- The medical services were included in six of the different directorates: the acute floor, abdominal surgery and medicine; cancer services; cardiovascular; neurosciences and stroke services and the specialty medicine directorates. We found that there was little cross directorate working with the directorates spending much of their time fire-fighting and dealing with urgent issues within their own directorate.
- The Executive Team (ET) was the main committee for approval of trust policy and procedure, and for discussing and agreeing major strategic and policy decisions prior to approval by the Board of Directors.
- The Clinical Management Board (CMB) reported to the ET and was responsible for the delivery of operational, income and budgetary performance, co-ordination between clinical services, and changes to operational and clinical practice required as a result of decisions made by the Board of Directors. The membership included the executive directors and clinical directors.
- The Change Board (CB) reported to the ET, and its key functions were approving new change initiatives, subsequent plans to move into delivery, monitoring actual delivery against delivery plans, and providing oversight to trust-wide developments, including agreed objectives and priorities. The CB's remit was to ensure alignment between all the various programmes of work and identify opportunities for improved efficiency and quality in the delivery of clinical services. The membership of this committee was drawn from the executive directors, director of strategy and change, operational director of HR and two appointed clinical directors.
- The trust board received quarterly progress reports on the action plans for the five trust objectives. This was underpinned by the board assurance framework and the monthly trust dashboard showing progress against key national and local quality standards.
- The divisional dashboards provided clear indicators for quality measurement in the trust.
- We found that there was a corporate risk register available but there was no system of recording risks at ward and divisional level that fed into the corporate risk register. Several wards had developed their own action plans for specific risks such as for the CQC inspection. There was no formal process to escalate these risks to corporate level.
- The divisional leads told us they felt the biggest risk was triangulation of evidence and the lack of shared learning from incidents. They told us they worked closely with the head of patient safety as there were often anomalies in the data which did not help when assessing patient risk.
- The effectiveness of the trust's management of risk depended heavily on which directorate the medical service was in and the time and resources allocated. For example the dementia unit was the only service in the specialist services directorate to be based at The Princess Royal Hospital. Staff working on this ward told us they felt isolated and not part of the wider trust team. Visits from the senior management teams were irregular and didn't always happen although support was available by telephone.

- We reviewed a sample of clinical governance meeting minutes across the medical directorates and noted there was no standard template used or standing items to be discussed at every meeting. For example some minutes documented audit results, others the findings from mortality and morbidity meetings. Some such as the respiratory clinical governance meeting did not include details of any incidents or complaints, others minuted incident investigations but the format was disorganised and did not always make clear what the actions or recommendations were. Some directorates held monthly clinical governance meetings, others were bi monthly or quarterly. This meant that it was difficult to benchmark the different directorates and gain a clear picture of the current clinical governance arrangements within the trust.

- **Leadership of service**

- Staff across the medical divisions reported that leadership up to band eight was generally clear and supportive. Staff knew their managers and felt free to contact them. They felt valued and that their opinions counted. All the ward managers we spoke with knew what their wards were doing well and could clearly articulate the challenges and risks their ward faced in delivering good care.
- This was not the same for the senior management of the trust. Staff told us there was a real problem with stability of leadership within the trust. There were several long term vacancies of key staff. For example on Balcombe ward there was no matron in post. This left staff feeling isolated and unsupported.
- There was awareness that a new chief executive had been appointed and some managers had met her. However there was a strong belief that some of the trust board were not accessible or accountable. There was an overarching concern that the trust was very much Brighton focused and that the Princess Royal Hospital was the 'poor relation'. Staff on Hurstpierpoint and Poynings wards gave the example that the matron for specialist services was based in Brighton and only seen on the ward at the Princess Royal Hospital every four to five weeks. Across the medical directorates they told us that The Royal Sussex County Hospital at Brighton was "more important".
- The therapists told us that there was generally a lack of visibility of the senior trust team and that they did not feel they had any impact on their day to day work. They said the previous chief executive visited the wards regularly but the new chief executive officer had only been in post a few days so it was "too soon to tell".
- Staff told us of the benefit of having senior trust board members visit the wards. For example in March the trust chair and senior team visited Plumpton ward which was the short stay medical pathway to discharge. They spoke with staff and patients and reviewed the general environment. A number of issues were identified during the visit such as nursing and administrative vacancies, poor signage and tired environment. We were told that a list of the required maintenance issues had been passed onto the executive lead. The chair was subsequently informed of the plans to address the areas of concern. Minutes from board meetings confirmed that members of the executive and non-executive team had visited hospital wards and departments and gave verbal feedback to the board on what they found during their visit.
- Staff told us about a lack of communication. Although there was 'all hospital/trust staff' information circulated this was vague and did not relate specifically to the hospital or individual wards such as the weekly blogs and newsletters from the chief nurse.
- Senior staff, managers and directorate leads told us that a better governance structure was needed. Ward managers told us their route to escalate their concerns to the board was through the chief nurse. They told us that she did not visit the wards at the Princess Royal Hospital very often they did not always feel listened to and that nothing changed. They gave examples of raising serious concerns with senior management but there was no action taken and no support offered to the staff involved.

- **Culture within the service**

- Senior managers and directorate leads told us they felt for a long time that the Princess Royal Hospital had been "abandoned". However they were now taking steps to improve their identity within the trust.
- We spoke with staff from all disciplines, banding grades and levels of responsibilities across the trust. They told us that the trust had a problem in managing poor behaviour. We heard several incidents where bullying behaviour had gone unchallenged.

Medical care (including older people's care)

- Staff told us there was a culture of fear of doing the wrong thing so nothing was done. They told us this was divisive and did not lead to a healthy work place where everyone was treated equally.
- Ward mangers and senior staff reported that they received little support from the trust's HR department in managing difficult consultants or staff disciplinary and capability issues. They told us that HR advised staff to put in a grievance as a first step in resolving any issue.
- We were told that the HR policies lacked clarity and were open to interpretation. Many policies stated "at the manager's discretion" which they felt was open to misinterpretation, allegations of favouritism and lack of consistency.
- The trade unions confirmed that it was difficult to manage staff behaviours and address poor behaviour when the trust's HR policies were ineffective.
- We spoke with site managers, consultants and ward staff who told us that due to the stresses and challenges of managing the bed capacity there had been incidents of poor behaviour. We were told there was an undercurrent at managerial level of staff being aggressive and belittling each other. One person told us, "The higher up you go the worse it gets."
- However we were told that after the trust had implemented values and behaviours training this had improved as there was now zero tolerance of bad behaviour. There were no incidents of bullying on the electronic reporting system and no current grievances for bullying within the medical directorates.
- Our findings at inspection were reflected in the 2015 staff survey results where the trust performed worse than the national average for the majority of questions asked. For example the percentage of staff who had experienced recent harassment, bullying or abuse from staff in last 12 months was worse than the national average.
- The culture on the different wards varied. Some wards, such as Hurstpierpoint and Poynings wards, had a positive and open culture. Staffing was generally stable and morale was good.
- Other wards such as Ardingly, morale was low due to staffing problems. All staff in the hospital including the junior doctors were aware of the problems on the ward but very little was being done to address the issues.

- **Public engagement**

- The trust's website provided safety and quality performance reports and links to other web sites such as NHS Choices. This gave patients and the public a wide range of information about the safety and governance of the hospital.
- The trust involved patients and the public in developing services by involving them in the planning, designing, delivering and improvement of services. The various means of engagement included a range of patient participation groups including the Stakeholder Forum, League of Friends and Healthwatch., There was also feedback from the Friends and Family Test, inpatient surveys, complaints and the 'How Are We Doing?' initiative.
- We were told that the patient experience panel was to be refreshed with an integrated experience report being developed for each clinical directorate. This this was not in place for our inspection.
- We heard how the board met patients to listen to their stories. The aim was to improve the board's understanding of the issues that were important to patients.
- Results from the patient voice feedback were shared with the wards and departments monthly. This information was fed back to staff to improve understanding of how their actions and attitude impacted on the patient's experience. A new specialist divisional newsletter had been started which included the patient voice feedback.

- **Staff engagement**

- In the NHS Staff survey 2015 the trust had improved its scores across most measures. For example the trust scored better than other trusts in 17 of the measures compared to the 2014 survey, when the trust scored worse than other trusts for 20 of the measures and was found to be similar to other trusts for all other questions. This indicated that there was an improvement in how staff perceived working at the trust.
- The staff survey 2015 action plan indicated that the main areas which required improvement were employee engagement, working conditions, reporting errors and near misses, relations with others, feedback, promoting respect and low job satisfaction. These scores were in the lowest 20% nationally. The action plan devolved responsibility to the local directorates for improvement.

Medical care (including older people's care)

- Staff told us that there was no cross over or communication between the 12 different directorates. They told us there were no communication systems in place and that if certain key members of staff were not available there was a real problem with communication.
- Other senior staff and directorate leads told us they did not always feel listened to. They told us although there were forums where concerns could be raised such as the performance reviews these felt disjointed and all the issues could not be discussed in this one session.
- Several of the medical wards had not held team meetings for some time due to staffing pressures.
- There was a monthly managers meeting held which was for senior nurses. However staff told us this was often cancelled.
- Staff told us they felt able to raise concerns with their immediate line managers but very little ever changed.
- The Royal College of Nursing told us that the trust were open to listening to concerns and engaged with the trade unions in addressing issues.

Innovation, improvement and sustainability

- The trust had received numerous national awards for the specialised care and support they provided for in patients with dementia.
- The therapists told us they were supported to be innovative. They gave examples of presentations that had been given to nurses and therapists and the joint teaching that took place and told us they would like more interdisciplinary teaching.

Surgery

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

Information about the service

Brighton and Sussex University Hospitals Trust surgical services (the service) delivers services to the local populations in and around the City of Brighton and Hove, Mid Sussex and the western part of East Sussex and some specialised services for patients across Sussex and the south east of England.

The service provides surgical services across two sites, the Royal Sussex County Hospital (RSCH) at Brighton and the Princess Royal Hospital (PRH) at Hove and was made up of four directorates, head & neck, abdominal surgery and medicine, musculoskeletal and perioperative directorates.

The head & neck directorate manage audiology, ear, nose and throat (ENT), oral and maxillofacial, clinical media centre, ophthalmology and out patients department (OPD).

Cardiac and vascular surgery are managed in the Cardiology and Renal Directorate,

The Surgical Directorate provides abominable surgery and also includes emergency surgery and Surgical Assessment Unit.

The Neurosciences directorate undertake surgery at PRH for spinal patients.

The musculoskeletal directorate provide trauma, major trauma, orthopaedics, pain management and rheumatology services and the perioperative directorate provided operating theatres, anaesthetics and general surgery.

Between September 2014 and August 2015 there was a total of 35,173 spells (a spell refers to a continuous stay of a patient using a hospital bed) across both sites with 8,000 taking place on the PRH site. Approximately 160,000 operations were carried out yearly, 34% was day case activity, 15 % elective activity and 50% emergency activity across both sites.

The service has 30 theatres split between its two principal sites, enabling surgery provision in all major disciplines with five main theatres at PRH, one day surgery and four in the Sussex Orthopaedic Treatment Centre (SOTC). Both centres undertake emergency, elective inpatient and day case surgery, with four dedicated day case theatres on site. There are 115 surgical beds across four wards (Ansty 26 beds, Albourne 15 beds, Newick 31 beds and Twineham 43 beds), a day case ward and a SOTC.

There is a pre assessment clinic which is based at the PRH and assesses approximately 13,000 patients per year for all elective and day surgery patients for both sites apart from vascular services which is carried out on the RSCH site.

The service's neurosurgery unit had relocated 10 months previously from the PRH site to the RSCH main theatre group, in order to provide a fully-integrated major trauma surgery service and the fractured neck of femur (broken hip) service had relocated to PRH from RSCH.

We visited all surgical services as part of this inspection, and spoke with 38 staff including staff on the wards and in theatres, nurses, health care assistants, doctors,

consultants, therapists, ward managers, porters and other health care professionals. We spoke with 10 patients, and examined 16 patient records, including medical and nursing notes and medication charts.

Summary of findings

Overall we rated surgery at The Princess Royal Hospital as requires improvement. This was because:

The service was not meeting its referral to treatment targets (RTT) of being seen by the service within 18 weeks, the only specialty to meet this target was cardiology surgery.

Patient referrals on the waiting list for specific colon surgery could not be found in the outpatient system. The service did not fully understand why these referrals had been lost and had started work to identify them and review treatment.

Not all staff had received annual appraisals and less than 50% of staff had the opportunity to complete statutory and mandatory training provided by the trust.

The service had experienced a reconfiguration of its services and had started to get its governance systems in place but this was in its early stages and needed further embedding. Additional reconfiguration was being planned to further focus elective and non-elective activity into specific sites.

However we also found:

The service's wards and departments were clean and staff adhered to infection control policies and protocols. Record keeping was comprehensive and audited regularly. Decision making about the care and treatment of a patient was clearly documented.

There was a high number of nursing vacancies; agency and bank staff were used and sometimes staff worked additional hours to cover shifts. Patients' needs were met at the time of the inspection.

Medicines including controlled drugs and medicines related stationary (prescription pads) were held securely and appropriate records kept. There were regular safe, secure storage of medicine's audits which included areas such as fridges, medicines trolleys, drug cupboards, controlled drug cabinet and storage of intravenous drugs.

Treatment and care were provided in accordance with the National Institute of Health and Care Excellence

Surgery

(NICE) evidence-based national guidelines. There was good practice, for example, assessments of patient needs, monitoring of nutrition and falls risk assessments. Multidisciplinary working was effective.

Access to further development and clinical training was accessible and there was evidence of staff being supported and developed in order to improve outcomes for patients.

Performance against national audits such as patients with a fractured neck of femur (broken hip) audit showed evidence of good outcomes for patients.

The service worked well with its seven clinical commissioning groups (CCGs).

Leadership at a local level was good and staff told us about being supported and enjoyed being part of a team. There was evidence of innovative multi-disciplinary working with staff working together to problem solve and develop patient centred evidence based services which improved outcomes for patients.

Are surgery services safe?

Good

We rated surgery at The Princess Royal Hospital as good for safe. This was because:

- Staff knew how to report incidents and felt confident that when incidents were reported they were listened to and acted upon. We were given examples where learning had taken place such as a splash injury resulted in reinforcing the use of protective equipment. All incidents were analysed and reported to the monthly departmental meetings for further discussion and action.
- Nursing staff numbers, skill mix review and workforce indicators such as sickness and staff turnover were assessed using the electronic rostering tool, the Safer Nursing Care Tool, The planned and actual staffing numbers were displayed on the wards visited.
- There was a high number of nursing vacancies; agency and bank staff were used and sometimes staff worked additional hours to cover shifts.
- Minimum and maximum medicines refrigerator and current room temperature records provided assurance that medicines requiring refrigeration were kept within their recommended temperature ranges. There were regular safe, secure storage of medicine's audits which included areas such as fridges, medicines trolleys, drug cupboards, controlled drug cabinet and storage of intravenous drugs.
- Staff used Schwartz ward rounds which meant that once the ward round was completed each patient was reviewed to check what had been agreed and a plan of action was put in place.

However we also found:

- The service had experienced seven never events over a seven month period in 2015, two of these took place at the PRH and involved implanting the wrong prosthesis. These had been rigorously analysed and changes had been made in order to ensure they were not repeated.
- Uptake of statutory and mandatory training across the service was poor with the majority of training being less than 50% compliant.

Incidents

Surgery

- The service had experienced two never events over a seven month period in 2015 and involved implanting the wrong prosthesis. Never events are serious wholly preventable patient safety incidents that should not occur if the available preventable measures have been implemented by healthcare providers (Serious Incident Framework, NHS England March 2015).
- The never events had been reported to the appropriate agencies as well as the National Joint Registry. Both events had been reviewed by independent orthopaedic consultants. Both patients were informed and no further action was required. One patient didn't require further surgery as the implant was in the correct position.
- Changes resulting from the two never events included the development of a local standard for prosthesis verification based on the National Safety Standards for Invasive Procedures (NatSSIPS). The surgeon and scrub nurse now verbally read out the information on the packaging, with the rest of the room in silence.
- The service had also reinforced a system for checking the stock, including expiry dates and highlightingitems with less than six months expiry date and separating the stock.
- A human factors scientist and forensic investigator from an external safety industry had jointly investigated the never events with an investigator from the trusts safety and quality team. Staff told us this had helped to provide assurance regardingthe robustness of the root cause analysis investigations as well as providing independent scrutiny.
- These never events had been discussed at the Perioperative Standards Forumand learning and action plans had been agreed. The learning from the never event reports had been distilled into teaching sessions and shared with all theatre staff.
- We were told that specific training on 'Human Factors' had been developed for the perioperative theatres teams which linked the theory of human factors with the incidents in theatres. This was a three hour session which had been delivered to approximately 80 staff.
- Two training films had also been produced, to show the new standard for World Health Organisation (WHO) sign in and 'stop before you block' which was going to be used in future teaching sessions and a film showing the prosthesis verification procedure was being planned.
- In early April 2016, we were told there was a multi-disciplinary clinical governance session where learning from never events would be shared and the full launch of the services national safety standards for invasive procedures (NatSSIPs) work. All theatre staff, surgeons and anaesthetist had been invited with180 members of staff already booked to attend.
- We saw the services Perioperative Safety Newsletters, which highlighted the learning from the never events.
- The learning from the never events was shared with the Trust Board on 29th March. An update was also provided to the trust's Quality and Risk Committee (QRM) (a subcommittee of the board) andregular updates had been given to QRM (The trust'smonthly safety and quality assurance meeting with the CCG) regarding these incidents and actions arising.
- To provide further assurance to the trust board the service had commissioned a revisit to theatres following a review in 2014.
- There were a total of 1619 incidents across both sites one resulting in death, six rated as severe, 20 moderate, three unpreventable adverse incidents, 261 low and 1,348 causing no harm. 488 related to the PRH site.
- A system and process for reporting of incidents was in place. Staff understood the mechanism of reporting incidents both at junior and senior level. The incident reporting form was accessible via an electronic online system. We saw the duty of candour was being addressed in the incident reporting system.
- The service reported a total of 52 serious incidents in the period January 2015 to January 2016 with seven classed as a never event.
- 15 of all serious incidents reported were attributed to surgical invasive incidents and four to slips/trips and falls. One incident reported was due to confidential information leaks. These were reported through the Strategic Executive Information System (STEIS).
- 33% of all incidents reported were at the PRH site. 7% of incidents occurred at the SOTC and 7% in the operating theatres with the remaining occurring across the wards.
- The highest number of incidents reported was experienced in trauma and orthopaedics (643) followed by operating theatres (281) and digestive diseases (202).
- The service used the trusts internal safety alerts when a serious incident had occurred to share the incident with all staff and to ensure staff were updated in the actions taken from the incident. There was also a 'patients first' monthly bulletin which told the story of specific patient incidents.

Surgery

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents andprovide reasonable support to that person.
- Staff understood their responsibilities with regard to the duty of candour legislation. Staff said the dissemination of information was through electronic communications and their attendance at staff meetings.
- Mortality and morbidity meetings took place on a monthly basis and reviewed any deaths that had occurred in the division. Root cause analyses following incidents were discussed, and any lessons to be learnt were shared and distributed to the staff team.
- **Patient Safety Thermometer**
- The NHS Safety Thermometer is a monthly point prevalent audit of avoidable including new pressure ulcers, catheter urinary tract infections (C.UTIs) and falls.
- The NHS Safety Thermometer information for measuring, monitoring and analysing harm to patients and harm free care was collected monthly. Some of this information was displayed on the wards, such as number of falls and pressure ulcers.
- For the period January 2015 to January 2016 there were ten new pressure ulcers, 11 falls with harm and 16 new catheter acquired urinary tract infections (UTI's) reported.
- Venous thrombo-embolism (VTE) risk assessment documentation audits were undertaken monthly which showed a fall in performance over the period April 2015 to February 2016 compared with April 2014 to March 2015. For example the overall average was 97% for 2014/2015 but in 2015/2016 the average was 84%. VTE is the formation of blood clots in the vein. When a clot forms in a deep vein, usually in the leg, it is called a deep vein thrombosis or DVT. If that clot breaks loose and travels to the lungs, it is called a pulmonary embolism or PE.
- The fall in performance was due to the way data had been collected and reported to the CCG. The trust told us there was a change in how the data was collected which would show an improvement in their performance.
- A recent audit had found a small number of patients that had not been reassessed 24 hours after admission for VTE which was not compliant with guidance from the National Institute of Health and Care Excellence (NICE 2010) for reducing the risk of venous thromboembolism in adults. This was to be re-audited to see if improvements had been made.
- However, we saw VTE assessments were recorded on the electronic drug charts and were clear and evidence-based, ensuring best practice in assessment and prevention.
- **Cleanliness, infection control and hygiene**
- Guidelines on infection control were in use and staff adhered to the trust's infection control policies.
- Between April and January 2016 the service met the trust target of 95% for hand hygiene audits and demonstrated musculoskeletal was 96% compliant, head and neck 94% compliant, abdominal surgery and medicine 93% compliant and perioperative 95% compliant.
- However, Albourne ward was 93% compliant, Ansty ward 83% compliant, Twineham ward 81% compliant and the SOTC 83% compliant. This meant these wards did not meet the trust standard of 95% and action plans were in place to improve their performance.
- In September 2015 the trust had a Patient Led Assessment of the Care Environment (PLACE) survey and visited Albourne ward and the Hickstead unit. The trust scored 99.87% for cleanliness.
- Hand hygiene gels were available throughout the wards and theatres. There was access to hand-wash sinks in bays and side rooms on the wards.
- There was awareness amongst staff about infection control and we observed staff washing their hands and using hand gel between treating patients. We observed all staff using alcohol hand gel when entering and exiting wards and theatres.
- Personal protective equipment (PPE), such as gloves and aprons were used appropriately and were available in sufficient quantities.
- We observed that theatre staff wore the appropriate theatre attire, such as theatre blues, hats and masks. Theatre staff did not leave the theatre environment in their theatre attire and all clothing was laundered by the hospital.

- An audit of visual infusion phlebitis was undertaken in July 2015 on Albourne ward which found the documentation was not always completed. Feedback was given at the time of the audit and there were plans to re-audit in the near future.
- Surgical site infection data between April and June 2015 indicated that infection rates for hip replacements were better than the national benchmark. However infection rates following knee replacements were higher than the national benchmark of 1.6% at 9.5% for the same time period. Staff told us action plans had been implemented to reduce surgical site infection rates such as ensuring theatre doors remained closed during the operation and regular wound reviews.
- There was no evidence of curtains being changed since February 2016 on the wards. A lack of curtain changing could be a risk to cross contamination from curtains to hands when staff open and close them.
- **Environment and equipment**
- The service undertook an audit of commodes on Ansty, Albourne and Newick wards found them to be clean and structurally good.
- We saw on Albourne ward there were two beds that did not have their own permanent provision of oxygen and suction. Staff told us this had been raised as a risk and was on the risk register. Portable oxygen and suction equipment was being used to reduce the risk.
- Resuscitation equipment, for use in an emergency in operating theatres and ward areas, was checked daily and documented as complete and ready for use. Whilst the service had standardised crash / emergency trolleys they were not tamper evident therefore a daily check may not provide assurance that all equipment and medicines were always available.
- Storage of equipment in operating theatres was raised as a concern on the perioperative risk register as equipment was being stored over fire exits and prevented access to medical gas isolation valves. Actions such as making sure there was clearer signage about storage and moving an instrument cupboard away from the fire exit to try and reduce the risk
- The perioperative risk register included concerns about the inhalation of surgical smoke from the use of diathermy. Diathermy is a surgical technique which uses heat from an electric current to cut tissue or seal bleeding vessels. Diathermy emissions can contain numerous toxic gases, particles and vapours and are usually invisible to the naked eye. Their inhalation can adversely affect surgeons' and theatre staff's respiratory system. The risks vary according to individual circumstances, such as the procedure, equipment, environment, technique and patient. The trust was trialling some smoke extractors with the intention of purchasing systems to reduce smoke emissions.
- There was good management and segregation of waste. All bins were labelled to indicate the type of waste to be disposed and were emptied regularly.
- **Medicines**
- Some prescription medicines are controlled under the Misuse of Drugs legislation 2001. These medicines are called controlled drugs (CDs). We examined the CD cupboards and found that storage was appropriate with no other items in the cupboards. The CD registers on the wards were found to be appropriately completed and checked.
- We observed nursing staff locking medication trolleys when they administered medicines to patients. Nursing staff wore a red apron to indicate they were administering medicines to alert staff not to disturb them to prevent drug errors.
- We saw medicines were checked and reconciled by pharmacy staff on a weekly basis, and an audit was completed monthly to check stock and utilisation.
- The temperature of medicine fridges were monitored daily. Medicines requiring refrigeration can be very sensitive to temperature fluctuation and therefore must be maintained between 2ºC and 8ºC. We saw all areas complied with this as daily temperatures were recorded. The room temperatures were also monitored and were within the desired limits of 15ºC and 25 ºC.
- Monthly patient first bulletins were circulated across the trust when there had been medication errors such as an oral medication being given intravenously by mistake. This anonymised incident was used in pharmacy teaching sessions to highlight the importance of prescription being written for a single route only.
- There was a total of 277 medication errors across the service, the highest area was experienced in trauma and orthopaedics (135), followed by 48 in digestive diseases and 28 in vascular services. 263 were rated as causing no harm to the patient and 14 causing low harm.
- Staff on Albourne ward told us there had been a concern with the correct amount of oromorph (an opioid which

is a type of medicine to treat moderate to severe pain), spot checks were now carried out and we saw a prompt sheet was used to ensure the correct amounts of oromorph was being used.
- We looked at six medication charts which were completed comprehensively, dated, signed and had no missing doses.
- The trust carried out a medicines security in October 2015 audit with the SOTC and Newick ward scoring 98%. Twineham ward scored 73% and Albourne ward scored 72% both were worse than the trust standard of 80%. Verbal feedback was given at the time of the audit for staff to review and develop an action plan for improvement.
- **Records**

- We looked at 10 sets of patient's records. These were comprehensive and well documented and included diagnosis and management plans, consent forms, evidence of multi-disciplinary input and evidence of discussion with the patient and families.
- We checked three sets of records at the SOTC which showed other information was documented at pre-assessment such as MRSA screening, consent, any allergies, medications, social history and next of kin.
- The records we reviewed showed that the Five Steps to Safer Surgery checklist record, designed to prevent avoidable harm was completed for all patients. An audit of the World Health Organisation (WHO) checklist was reported to the trust board which showed compliance of 98% for signing in, time out documented was 98% and sign out was 94%. The national target was 100%.
- Medical records were stored securely in trolleys behind the nurse's station; nursing notes were stored at the patient's bedside.
- Records included details of the patient's admission, risk assessments, treatment plans and records of therapies provided. Preoperative records were seen, including completed preoperative assessment forms. Records were legible, accurate and up to date. The service used a number of patient pathway documents which followed the path the patient took through a specific surgical episode such as a fractured neck of femur, knee and hip replacement and cardiac surgery.
- National early warning scores (NEWS) were regularly audited for completeness. Where there was some information missing this was fed back verbally at the time of the audit.
- The service carried out an audit post-operative medical notes which demonstrated they did not comply with the Royal College of Surgeons Good Standards of Clinical Practice for record keeping 2014. The audit consisted of 52 sets of medical case notes and included 14 consultants, five registrars and three senior house officers. Of the 52 notes audited 48 sets of notes were not signed, 49 sets of notes were not dated and 45 sets of notes mentioned what indications were for surgery. Teaching sessions were planned to improve practice. However, we did not see any dates or numbers of staff booked on training for these sessions.
- **Safeguarding**

- The chief nurse was the executive lead for safeguarding. Adult safeguarding was managed by the deputy chief nurse and had 1.6 whole time equivalent (wte) band seven nurses for safeguarding, learning disability and Mental Capacity Act and Deprivation of Liberty.
- The trust had a safeguarding adult's policy. Safeguarding was part of mandatory training for all staff and this was monitored by managers. Safeguarding adults training across the overall service was 50% ranging from 30% in the head and neck service, 39% in the abdominal surgery and medicine service, 49% in the musculoskeletal service and 63% in the perioperative service. These did not meet the trust standard of 90%.
- Safeguarding children level one training across the overall service was 62%, level two (57%) and level three (65%). There were no figures for level three training in three out of the four services with the head and neck service being the only service to compete 65% of this training. These did not meet the trust standard of 90%.
- Training in the Mental Capacity Act (MCA) was perioperative directorate 72%, musculoskeletal directorate 80%, abdominal surgery and medicine directorate 67% and head and neck directorate 70%. These did not meet the trusts standards of 90%.
- **Mandatory training**

- The trust had a trust wide induction programme for permanent and temporary staff and a mandatory and statutory training plan. There was a combination of E learning and face to face learning.
- Mandatory training was 46% which was lower than the trust standard of 100%. For example basic life support training was 33% and infection control (for clinical staff) was 58%.

Surgery

- Statutory training overall for surgery was 50% which was lower than the trust standard of 95%. For example patient moving and handling was 24% and equality diversity was 42%.
- **Assessing and responding to patient risk**
- Patients having elective surgery attended a preoperative assessment clinic (Hickstead unit) where all required tests were undertaken. For example, MRSA screening and any blood tests. This was a nurse led service and if required, patients were able to be reviewed by an anaesthetist.
- Risk assessments were undertaken in areas such as venous thromboembolism (VTE), falls, malnutrition and pressure sores. These were documented in the patient's records and included actions to mitigate the risks identified.
- Schwartz ward rounds were carried out daily which provided an opportunity for professionals from all disciplines to come together and review their work.
- The service used a communication tool called Situation Background Assessment Recommendations (SBAR) for both medical and nursing staff to use when escalating concerns about a patient's condition to their seniors.
- We saw staff completing the NEWS scores and watched one nurse escalate to a doctor as the score was indicating the patient's condition was deteriorating.
- We spoke with staff in the anaesthetic and recovery areas, and found they were competent in recognising deteriorating patients. The national early warning system (NEWS) was in place across the service to monitor acutely ill patients in accordance with NICE clinical guidance CG50.
- Nursing handovers occurred at the change of shift. We observed a handover which was carried out in the ward office for all staff and patient privacy, dignity and confidentiality were maintained. Staff were then allocated to bays and a more detailed handover took place at the patient's bedside, when staff introduced themselves to patients and involved the patients in discussion. The ward sister reviewed the nursing notes to ensure all assessment and care plans were up to date.
- The handovers were well structured and information discussed included patients going to theatre, patients requiring appointments for investigations, patients being discharged, pain management, medication and Deprivation of Liberty Safeguards (DoLS) assessments.
- We followed a patient through their surgical pathway from being admitted to the ward, to the operating theatre and into the recovery area. Staff followed a systematic enquiry as per the divisions' pre assessment proforma. The patient was seen by the consultant carrying out the operation and marked the operation site, all details were checked with the patient, nil by mouth was confirmed and the patient was seen and checked again by the anaesthetist.
- **Nurse staffing**
- Nurse staffing across the service was variable with some wards and areas being understaffed and some being over staffed.
- Nursing staff numbers, skill mix review and workforce indicators such as sickness and staff turnover were assessed using the electronic rostering tool, the Safer Nursing Care Tool. The planned and actual staffing numbers were displayed on the wards visited.
- There was a shortage of theatre staff post reconfiguration in the operating theatres as a number of staff did not want to move to Brighton. Overall operating theatres had been understaffed with 15 band 5 vacancies (75%). Successful recruitment had now reduced and there were five vacant posts.
- The service's overall vacancy rate for trained nursing staff was 8% which ranged from 1% in the abdominal surgery and medicine division, 9% in the general surgery and perioperative divisions to 15% in the head and neck and musculoskeletal divisions. For other clinical services the rate ranged from 4% in the musculoskeletal division to 11% in the abdominal surgery and medicine division.
- Sickness rates for both staff groups (clinical and non-clinical) were slightly higher than the trust averages of 5%.
- The overall sickness rate was 9% for trained staff and 4% for other clinical staff. The highest sickness rate was 9% in head and neck and perioperative divisions for other clinical services and 9% in the abdominal surgery and medicine division for trained nursing staff.
- Both staff groups had a turnover rate higher than trust averages, though the rate for nursing was only slightly higher than the trust average of 12%.
- The overall turnover rate for the service was 12% which was similar to the trust average ranged from 9% in the musculoskeletal division for trained nursing staff to 20%

in the head and neck division and for other clinical staff ranged from 15% in the perioperative and musculoskeletal divisions to 25% in the abdominal and medicine division.
- The average staffing across all wards in surgery was 94%. Out of the 40 wards 20 were understaffed by more than one whole time equivalent (wte) and of these nine wards were understaffed by more than five wtes. However ten wards had more staff in place than planned for.
- The overall use of agency and bank staff was 14% which was better than the trust average of 20%.
- The average vacancy rate for both additional clinical services and nursing was 10% and better than the trust average of 11%.

- **Medical staffing**

- Use of locum staff was 7% which was worse than the trust average of 5%.
- The abdominal digestive diseases surgery service had three teams in place; emergency, upper gastro-intestinal and lower gastro-intestinal. Core trainees and Foundation Year 1s supported these rotas.
- For the emergency service there was a consultant of the week with two days as theatre lead, two days on the SAU and one day administration. There were specialist associate specialists doctors per week with two days theatre, two days SAU and one day administration.
- There was no consultant at night or at weekends. Staff told us there was a plan to extend this service in order to cover the nights and weekends but there were no current plans at the time of the inspection. A consultant would be on call from home to cover any emergencies should they arise.
- For the upper and lower gastro-intestinal service there was one consultant and registrar covering ward duties in a one week in five rota.
- Nights were covered by one registrar on a one week in ten rota with a consultant and registrar on call on a one week in ten rota. There was a one week in ten rota for a consultant and registrar on call with a registrar on a long day shift, plus an additional registrar on a long day shift.
- The service had a higher percentage of wte consultants and registrars and a lower percentage of middle career and junior doctors in place than the England average.
- **Major incident awareness and training**

- There was a trust wide Major Incident Plan (2015) which set out a framework for ensuring that the trust had appropriate emergency arrangements which were in line with the Civil Contingencies Act 2004 statutory duties.
- Emergency planning was a mandatory training subject for all staff. Staff told us there was a major incident exercise planned for July 2016.
- Command and control training was being presented with the aim to understand the principles of command and control in order that staff were able to respond
- appropriately in their role during an emergency.

Are surgery services effective?

Good

We rated surgery at The Princess Royal Hospital as good for effective. This was because:

- The treatment by all staff including therapists, doctors and nurses was delivered in accordance with best practice and recognised national guidelines and patients received treatment and care according to guidelines.
- Policies and procedures were in line with national guidance and were easily accessible on the intranet.
- Patients' pain was addressed and national nutritional tools were used to monitor those patients who may be at risk of malnutrition.
- The nutritional needs of patients were assessed at the beginning of their care in pre-assessment through to their discharge from the trust. Patients were supported to eat and drink according to their needs. There was access to dieticians and medical or cultural diets were catered for.
- The service had a consultant-led, seven day service, with some elective lists on Saturdays and Sundays.
- There were a range of Clinical Nurse Specialists and Advanced Nurse Specialists who supported teams and patients in specific areas, bringing their own expertise and knowledge to develop innovative and individualistic ways of improving services.
- Staff and teams were committed to working collaboratively and found ways to deliver more joined-up care to patients. There was a range of examples of working collaboratively and the service

used efficient ways to deliver more joined-up care to people who used services. There was a holistic approach to planning people's discharge and transfer to other services.

However we also found:

- Consent practices and records were monitored and reviewed to improve how patients were involved in making decisions about their care and treatment but audit activity showed poor compliance with recording consent procedures.
- The service had a good pain service which supported medical and nursing staff in maintaining effective pain relief for patients but the service did not work out of hours or at weekends and had a restricted chronic pain service.
- Staff had an awareness of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) but the uptake of training was poor.
- **Evidence-based care and treatment**
- Patients' care and treatment was assessed during their stay and delivered along national and best-practice guidelines. For example, the NEWS with a graded response strategy to patients' deterioration complied with the recommendations within NICE guidance 50 acutely ill patients in hospital.
- Policies were up to date and followed guidance from the NICE and other professional associations for example, the Association of Peri-operative Practice (AfPP). Local policies, such as the infection control policies were written in line with national guidelines. Staff we spoke with were aware of these policies and knew how to access them on the trust's intranet.
- The service participated in the National Hip Fracture Database (NHFD) which is part of the national falls and fragility fracture audit programme.
- The service also took part in national audits, such as the elective surgery PROMS programme, and the National Joint Registry.
- Policies were up to date and followed guidance from the NICE and other professional associations such as the AfPP. Staff we spoke with were aware of these policies and knew how to access them on the trust's intranet.
- Staff followed the NICE guidance on preparing and prevention of surgical site infection prior to surgery.
- **Pain relief**
- The service undertook a patient controlled analgesia (PCA) pump audit in 2015.This was a re-audit from 2011and demonstrated whilst action plans had been achieved in all areas except improving compliance with hourly checks as per the trust medical devices policy of 60% there was an overall reduction in compliance with the PCA policy since 2011.
- The conclusions from this audit showed documentation as per the trust policy and hourly pump checks were poor. Action plans to improve this position included continuing education via the acute pain study day and continuing education in recovery areas on completing the essential documentation. this
- Nurses on the medication ward rounds would ask each patent if they were in any pain and would give prescribed analgesia if necessary.
- The service had a nurse led acute pain team (APT) with two named consultants to support the team and covered both sites.
- The consultants had not completed the advanced pain training which was a recommendation from the Faculty of Pain Medicines core standards and were not always available to attend ward rounds. There were no plans to undertake this training. However members from the APT attended the wards daily and would check on all post-operative patients and other patients as needed.
- The APT was available Monday to Friday and did not provide cover out of hours and at weekends due to the lack of staff. This did not comply with the Faculty of Pain Medicines core standards and was on the services risk register for review. Trainee anaesthetists covered the out of hour's provision. There was also a small inpatient chronic pain service but this was due to finish due to the lack of staff.
- The APT had written a paper for the perioperative directorate on the vision for the pain management team based on the 2015 Core Standards for Pain Management in the UK highlighting the need to increase staffing so pain management could be covered out of hours and weekends. This was an action on the risk register.
- The APT told us they worked with the surgical and orthopaedic consultants and fed into the enhanced recovery plan. They told us they felt they were able to make suggestions about pain relief and the consultants listened.
- The service also undertook an epidural (an injection into the back which produces loss of sensation below the waist) chart documentation audit in 2014 which

demonstrated an improvement from a previous audit in 2012. However the audit showed poor compliance in areas such as sensory testing on the start of a PCA pump (38%), further testing at 12 hours (26%), sensory check after a bolus and rechecked after a rate change (43%). A re-audit was agreed and further education was to be delivered in the recovery area which was planned for ;later in 2016.

- We saw patients' records which showed that pain had been risk assessed using the scale found within the NEWS chart and medication was given as prescribed. We observed staff asking patients if they were in pain and patients told us they were provided with pain relief in a timely manner and staff returned to ask if their pain had been relieved.
- The APT told us about their work with the ortho-geriatrician (a consultant with a combined role in orthopaedics and elderly medicine) and finding that reducing opioids (a type of medicine to treat moderate to severe pain) for elderly patients resulted the patients being less confused and a reduced length of stay in hospital.
- For the patients voice survey when asked 'Do you think the hospital staff do everything they can to manage your pain' the service performed similar (4.66) to the trusts performance (4.74).
- **Nutrition and hydration**
- The Malnutrition Universal Screening Tool (MUST) was used to assess patient's risk of malnutrition and if a patient was at risk of malnutrition or had specific dietary needs they were referred to a dietician.
- Dietitians attended the wards daily and staff on the wards used a referral book so the dietitians could pick up any concerns and would then see patients on the day.
- The dietitians would attend the wards daily where patients were receiving parental nutrition. Parental nutrition is a method of getting nutrition into the body though the veins.
- We saw food was delivered at meal times to the patient's bedside and patients told us the food was hot. However, two patients told us hot meals were already plated up, they had to wait a long time for the food and when it arrived it was cold.
- We saw one patient who had their operation cancelled and had to stay overnight, was given meals and drinks up until four hours before their surgery was due .
- The patient-led assessment of the care environment (PLACE) survey showed the trust scored 93% which was better than the England average (88%) for the quality of food.
- For the patients voice survey 2015 when asked 'How would you rate the hospital food' the service performed similar (3.77) to the trust (3.76)
- **Patient outcomes**
- The Hospital Standardised Mortality Ratio (HSMR) for the trust was 97.3% for 2013/2014 and 90.5 for 2014/2015. HSMR is a calculation used to monitor death rates in a trust and is based on a subset of diagnoses which give rise to around 80% of in hospital deaths. The trust's ratio for HSMR was better than the national average of 80%.
- Mortality and morbidity meetings occurred monthly across the surgical specialities. The information was reported through the governance structure to ensure early intervention. The trust had an action plan to improve its mortality and morbidity rates.
- Based on the criteria used by the National Hip Fracture Database (NHFD), the directorate's most recent performance for admitting patients within four hours to Twineham ward was 69.76%. The time the patient was in the ED was an average of 2.38hrs. Staff told us the delays experienced were related to patients requiring further imagining, other specialist medical assessment or clinical stabilisation prior to ward transfer.
- The fractured neck of femur (NoF) service was transferred in June 2015 from the RSCH site to the PRH site to create a specialist unit on Twineham ward providing dedicated care to patients following a fractured NoF. The ward also looked after patients with more complex joint replacements.
- Due to this reconfiguration the directorate experienced an improvement in seven of the nine measures audited for this condition. For example between July and December 2015 the average time for a patient staying in the ED had reduced to just over five hours which was still slightly longer than the four hour standard. The average time to theatre was just under 21 hours and the average time to be seen by an ortho-geriatrician was just under 28 hours.
- In the 2015 NHFD audit for hospital acquired pressure ulcer incidence the directorate had a percentage rate of

1.4% which was better than the national rate of 2.8%. We were told that in February 2015 the rate was 2.3% which was related to one patient admitted in that time period.

- To reduce the incidence of hospital acquired patient pressure ulcers once they have sustained a fractured NoF, Twineham ward had implemented the following, on admission the patient would be nursed on an air mattress; pressure areas were assessed when the patient was transferred from the ED trolley to the ward bed. Nursing interventions were then implemented to reduce the risk of pressure damage such as regular comfort rounds, turning regimes, the use of pressure reliving equipment such as chair cushions and ankle protectors.
- Nutritional scoring and dietician reviews also were used so that nutritional support was provided to promote skin integrity and wound healing. The need for pressure ulcer review/assessment/monitoring was also highlighted in the nursing safety booklet and the MDT NoF proforma.
- The standardised relative risk of re-admission were mostly the same as England averages for both elective and non-elective patients. For example elective colorectal surgery was 97% compared with the England average of 100 and for non-elective trauma this was 98% compared with the England average of 100%.
- At the SOTC the relative risk of re-admission for non-elective patients was higher (138) than the England average of 100.
- PROMS are a series of questions or a questionnaire that seeks the views of patient on their health, or the impact that any received healthcare has had on their health. For this trust during the period April 2014 to March 2015, there was no evidence to indicate any risks related to surgery when assessed as part of PROMS for hip and knee surgery, as well as varicose vein and groin hernia surgery undertaken.
- However recently published data (May 2016) indicated that for the period April to December 2015, there was evidence that the trust achieved outcomes worse when compared to the England average for hip replacement, knee replacement and varicose vein procedures. The trust scored much worse than the England average and was seen as a negative outlier against 95% of services audited for groin hernia procedures.
- We were told the directorate teams were meeting to review the published data over the next month and would make add any further additional actions following review of the data and would update the action plan at that time.
- Between 2014 and 2015 seven of the nine measures audited had improved in the hip fracture audit. Such as surgery taking place on the same day of admission which was 88% and better than the England average of 76% and the length of stay was 7.5 days and was better than the England average of 15 days. The only one measure that had not improved was being admitted to a ward within four hours which was 26% and was worse than the England average of 46%.
- Cancelled operations as a percentage of elective admissions had been variable over the time period, and been above the England average for four quarters between quarter four 4 2014/15 to quarter three 2015/16. For example quarter two was 1.4% which was worse than the England average of 0.6% and quarter three was 1.3% which was worse than the England average of 0.6%.
- From September 2014 to August 2015 the average length of stay at trust level was mostly worse than the England average for both elective and non-elective patients. For example for trauma and orthopaedics the length of stay was seven days for elective patients which was worse than the England average of three days. For non-elective patients in trauma and orthopaedics the length of stay was 18 days which was worse than the England average of nine days.
- The percentage of patients whose operations were cancelled and not treated within 28 days was consistently worse than the England average from quarter four 2013/14 to quarter three 2015/16. In the most recent data (quarter three 2015/16) the trust was three times higher than the national average at around 15% and had been as high as six times above the average in quarter three during the whole time period.
- In April 2010, the United Kingdom's Medicines and Healthcare products Regulatory Agency (MHRA) issued a medical device alert that included specific follow-up recommendations for patients with metal on metal (MoM) hip replacements. The recommendations included blood tests and imaging for patients with

painful MoM hip implants. In February 2012, MHRA published a medical device alert and updated it in June 2012 with advice on the management and monitoring of patients with MoM hip systems.

- The musculoskeletal directorate was compiling a database of patients who had metal on metal implants so they could review their patients and ensure they receive the most effective care if they were experiencing signs of MoM symptoms. This was on the directorates risk register and data was still being collated.
- **Competent staff**
- Overall compliance with appraisal rates for surgery was 72% with abdominal surgery and medicine 44%, head and neck 83%, musculoskeletal 77% and perioperative 79% which did not meet the trust target of 85%.
- Of the 38 medical staff, 22 had revalidated and 16 were deferred and the service had monitoring processes in place to ensure consultants were supported through their revalidation periods.
- Junior doctors within surgery all reported good surgical supervision, they each had a specific personal development plan which they felt enhanced their training opportunities.
- Junior medical staff told us they felt supported and had access to their consultants when needed.
- We spoke with four newly appointed nurses who were extremely happy with the support they received by their mentors. They told us their mentors were easily accessible, spent time with them explaining each patient with them and what plans there were to care for each patient. They felt confident they could go to their mentor if they were unsure about what they had to do.
- The service had nurse educators, two clinical nurse educators in the abdominal surgery and medicine directorate, two nurse educator in the musculoskeletal directorate and two junior sister practice development posts in the perioperative directorate.
- Staff could access information on the local intranet about how they could revalidate.
- Newly appointed staff and staff from overseas were given a session on nutrition and hydration by the dietetic team.
- Bank staff had an induction to their area prior to starting work on the ward. We spoke with one bank nurse who told us she had been given an orientation to the ward as she hadn't worked on the specific ward for four weeks.
- Health care assistants had started a competency based learning programme which was a national programme validated by Health Education England. This was a four month course with 15 core standards such as the Duty of Candour, privacy and dignity, safeguarding basic life support and infection control and prevention.
- **Multidisciplinary working**
- Multi- disciplinary meetings took place weekly for a number of clinical areas such as the lung cancer pathway where consultants in radiology, chest physician, surgeon and the clinical nurse specialist.
- There were daily trauma meetings at both sites. These were established to review the unscheduled care admissions admitted over a 24 hour period and to plan the day's activity. These were attended by the trauma and orthopaedic (T&O) and ED consultants, T&O registrars, T&O junior doctors, poly-trauma nurse practitioners, trauma nurse co-ordinators and poly-trauma physiotherapists.
- Newick ward had daily MDT meetings at 11:00 Monday-Friday to discuss and plan patients discharge and rehabilitation needs. In attendance was the nurse In-charge, physiotherapist and occupational therapist and the ward doctor. The MDT on Newick Ward was well established and there was a good collaborative culture in place.
- Enhanced Recovery Pathway Joint Schools were held Monday to Friday 12:00-12:30. These teaching sessions were presented by the MDT and included the ERP nurse, physiotherapist and occupational therapist. The team provided information to patients undergoing hip and knee replacements and set expectations following their surgery outlining the rehabilitation process leading to their discharge.
- On Twineham ward there were MDT rounds in the morning at 09:00 to discuss and plan patients discharge and rehabilitation needs. This meeting was attended by the ortho-geriatric consultant, the nurse in-charge, ward junior doctor, ward physiotherapist, occupational therapist, ward discharge co-ordinator, discharge liaison nurse and social workers twice a week.
- The Twineham MDT was also an established team with close professional relationships working collaboratively at the start of a patient admission to facilitate their recovery. There was a microbiology meeting every

Friday attended by the on-call consultant, junior doctors, nurse in-charge, matron, microbiologist consultant. Actions and plans were recorded in the patients notes.
- Best interest meetings for patient discharge planning was attended by relevant MDT with actions documented in medical notes when appropriate.
- The ward had strong links with community services such as Carers Support, Hospital at Home, (CSTS) Brighton, Sussex Community Trust.
- There was a complex revision arthroplasty meeting held every two weeks to discuss all revision surgery for hip and knee patients. It was attended by three orthopaedic consultants, a representative from microbiology, T&O Foundation one1, PRH orthopaedic nursing/out patient lead and a sister representing the musculoskeletal directorate. The meeting had a set agenda reviewing the urgent elective cases, elective cases waiting on the list and cases currently on the ward. A log of the patients discussed was maintained on an electronic database.
- The service provided a multi-disciplinary super clinic for patients living with irritable bowel disease (IBD) with IBD doctors, surgeons, nurses, pharmacists and stoma nurses. This allowed cross referrals and advice between disciplines within one clinic and improved the patients experience and reduced the number of attendances for the patients.
- **Seven-day services**

- There was one orthopaedic list at PRH every Saturday and Sunday. There were no permanent elective lists at weekends but there were occasional lists when possible and staff were exploring the possibility of this becoming permanent.
- Approximately 100 staff serviced the theatres with sterile instruments, providing a 24 hour turnaround cycle when required to meet tight operating schedules.
- All theatres were run 50 weeks per year, Monday to Friday 08.00 – 17.30. In addition emergency and trauma services were maintained 24 hours seven days a week at the two sites, with elective activity scheduled at weekends to cope with increasing demand when it outstrips planned weekday capacity.
- The service had access to the physiotherapy service 24 hours a day and seven days a week. The out of hours such as weekends and public holidays was provided by 13 physiotherapists and six assistants. From 4.45pm to 8.30am, three physiotherapists were on-call.
- **Access to information**

- There were computers throughout the individual ward areas to access patient information including test results, diagnostics and records systems. Staff were able to demonstrate how they accessed information on the trust's electronic system.
- Staff had good access to patient-related information and records whenever required. We saw staff using the services electronic emergency surgery theatre system where staff on the ward could see where their patients were in the surgical process, for example green showed the patient was in theatre, white showed the patient was in recovery, aqua showed the patient had returned to the ward and yellow told staff that the patients operation had been cancelled.
- Medical staff used the Patient Archive and Communication System (PACS) system to download and view images of patients x-rays and tests. The PAC system is a central repository for radiology and medical images and objects.
- Staff had access to an electronic system (blood hound) for requesting and receiving blood tests. The service had seconded a Band 3 to manage the process of requesting and receiving blood tests to see whether these could be managed quicker, expedite decision making and reduce the workload for junior doctors.
- **Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- The trust had consent to examination or treatment policy dated November 2014.
- The trust wide consent audit in July 2015 included 89 patients (81 elective and eight emergencies) showed a number of patients consented on the day of procedure (95%), there was a lack of written patient information (7%), alternatives/consequences of not having treatment were not discussed/recorded and there were a number of abbreviations on the consent forms (12%).
- This audit resulted in consent champions being identified from each directorate and consent workshops had been instigated. Re-audits were planned for later in 2016.
- We spoke to staff on the wards who told us they knew the process for making an application for requesting a DoLS for patients and when these needed to be reviewed.

Surgery

Are surgery services caring?

Good

We rated surgery at The Princess Royal Hospital as good for caring. This was because:

- Staff were caring and compassionate to patients' needs, and treated patients with dignity and respect.
- Patients and relatives told us they received a good care and they felt well looked after by staff.
- The staff on the wards and in theatre areas respected confidentiality, privacy and dignity.
- Surgical and nursing staff kept patients up to date with their condition and how they were progressing.
- Information about their surgery was shared with patients, and patients were able to ask questions.
- **Compassionate care**
- Patients and relatives told us they received a good standard of care and they felt well looked after by nursing, medical and allied professional staff.
- Information about their surgery was shared with patients, and patients were able to ask questions.
- Patients and most relatives said they were kept informed and felt involved in the treatment received.
- The staff were kind and had a caring, compassionate attitude and had positive relationships with people using the service and those close to them. Staff spent time talking to people, or those close to them.
- Albourne and Newick wards scored 100% for the Friends and Family Test but for Twineham ward their score had worsened consistently from August to December 2015 and was 69% at December 2015.
- In September 2015 the trust had a Patient Led Assessment of the Care Environment (PLACE) survey and visited Albourne ward and the Hickstead unit and scored 87% for privacy dignity and well-being which was worse than the average of 100%.
- **Understanding and involvement of patients and those close to them**
- Patients said they felt involved in their care. They had been given the opportunity to speak with the consultant looking after them.
- Patients said the doctors had explained their diagnosis and that they were fully aware of what was happening. None of the patients had any concerns regarding the way they had been spoken to. All were very complimentary about the way they had been treated.
- We observed most nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their relatives about the care and treatment options.
- **Emotional support**
- We saw some evidence in care records that communication with the patient and their relatives was maintained throughout the patient's care.
- We saw patients treated with care, compassion and respect as we followed them through the peri-operative pathway.
- We saw the staff on the wards and in theatre areas respected confidentiality, privacy and dignity.
- The service could access the chaplaincy team which had Christian staff plus Roman Catholic provision and over 30 ward-based volunteers from a variety of faith traditions, who made weekly visits to most of the hospital.
- There was access to 28 volunteer on-call representatives of a variety of faith and belief groups from the immediate area.
- We saw the results of the Friends and Family Test displayed on all the wards we visited. The NHS Friends and Family test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. We saw posters encouraging patients to give feedback so the service could improve the service it provided.
- We saw that the response rate varied across the service. The response rate for friends and family test across the service was below the national average of 36% with a response rate of 29% between December 2014 and November 2015. 64% of patients that did respond would recommend the hospital to family and friends.

Are surgery services responsive?

Requires improvement

We rated surgery at The Princess Royal Hospital as requiring improvement for responsive. This was because:

Surgery

- The admitted referral to treatment time (RTT) was consistently below the national standard of 90% for all specialties apart from cardiac surgery.
- The length of stay for non-elective surgery was worse than the national average of for trauma and orthopaedics, colo-rectal surgery and urology
- The percentage of patients whose operations were cancelled and not treated within 28 days was consistently higher than the England average.
- The percentage (31%) of admitted patients moved wards during the night, (between 10 pm and 6 am).
- Patients on the waiting list for a specific colon surgery could not be found in the outpatient system. The service did not fully understand why these patients had been lost and had started work to identify them and review treatment.

However we also found:

- Amalgamating the care and treatment for patients suffering from a fractured hip onto one location with dedicated theatres and wards showed a significant improvement in outcomes for these patients.
- The service regularly carried out operations on Saturdays and Sundays to meet local need.
- There was support for people living with a learning disability and a variety of specialist nurses and practitioners to care for those patients with complex trauma and complex diseases.
- **Service planning and delivery to meet the needs of local people**
- The service understood the different needs of the people it served and acted on these to plan, design and deliver services there was a range of appropriate provision to meet needs, supported people to access and receive care as close to their home as possible.
- The service had reconfigured its major trauma service to include neurosurgery and plastic surgery on one site to enable a more patient centred approach to patients suffering major trauma.
- Virtual clinics were being provided for patients suffering orthopaedic traumas resulting in the reduction of attendances for patients allowing care and treatment to be provided in or near the patient's home.
- In order to improve the patient experience and meet the needs of local people the service had opened a SAU in Brighton in September 2015. The SAU was opened to reduce unnecessary surgical admissions to the surgical wards by providing quicker access to a surgical medical team and improve the flow of patients through the surgical pathway. However the SAU only had three beds as the remainder of the unit was used by the rapid assessment cardiac outreach team. This reduced the opportunity to fully utilise this service and assist in addressing the issues concerning the flow of patients through the system.
- **Access and flow**
- RTT within 18 weeks was below the 90% standard and England average for the whole time period January to December 2015. Seven out of eight specialties fell short of the standard only meeting it for cardiothoracic surgery. For example oral surgery (31%), general surgery 64%, trauma and orthopaedics 69.5%, urology 71.5% ENT 75.5% and neuro surgery 77%.
- We were told directorates met with the executive team at performance review where issues relating to RTT were discussed directly. The directorates had weekly meetings which linked into the trust wide patient access meeting and were completing capacity and demand modelling for all subspecialties. Daily monitoring was undertaken by the access team to ensure patient access policy was being adhered to.
- An area of improvement from the National Bowel Cancer Audit 2014 was to improve on the standard of 65% of patients having their stomas reversed within 18 months. Patients with a stoma were waiting more than 18 months for a reversal of their stomas and staff still could not determine how many patients were waiting or how long they had been waiting. A stoma is an opening on the front of the abdomen which is made using surgery. It diverts faeces or urine into a pouch (bag) on the outside of the body. A stoma is a bud-like structure, which sits on the surface of the skin on the abdomen.
- We were told patients presenting at PRH may require clinical services at RSCH for example those patients needing renal, cardiac or poly-trauma treatment. South East Coast Ambulance service would clinically assess the patient prior to making a decision as to which site the patient was transported to.
- Cancelled operations as a percentage of elective admissions had been variable over the time period and been above the England average of 0.5% for four quarters between quarter four 2014/15 to quarter three 2015/16. Average theatre utilisation rate was 81% which was below the trust standard of 85%.

Surgery

- Between March 2015 and February 2016 there were 24% of operations cancelled with an average of 32 patients cancelled on the day of surgery every month. 40% of cancellations were due to the patients cancelling themselves.
- The percentage of patients whose operations were cancelled and not treated within 28 days was 20% which was consistently higher than the England average of 5% from quarter four 2013/2014 to quarter 2015/2016. In the most recent data quarter 2015/2016 the service was three times higher than the national average at around 15% and had been as high as six times above the average at one point during the whole time period.
- Between September 2014 and August 2015 the overall average length of stay for elective surgery was 2.9 days which was better than the England average of 3.3 days.
- The overall length of stay for non-elective surgery was 9.5 days and worse than the England average of 5.2 days. All three specialities were worse than the England average with trauma and orthopaedics having a length of stay of 18.7 compared with the England average of 8.7, colorectal surgery was 7.8 compared with the England average of 4.7 and urology was slightly worse with a length of stay of 3.3 compared with the England average of 3.1.
- For the SOTC the length of stay for elective surgery was 3.1 days which was better than the England average of 3.4 days. However the length of stay for non-elective surgery was 6.0 days which was worse than the England average of 5.2 days.
- Between January 2015 and January 2016 there were 844 (surgical outliers) patients being cared for on other wards apart from a surgical ward which equated to 32,176 bed days with an average length of stay of 2.6 days. Surgical outliers are where patients are receiving care on a different speciality ward.
- During our inspection we saw a number of outliers across the service. For example Albourne ward (a ward dedicated to patients undergoing spinal surgery and joint replacement surgery) had eight of the 15 beds taken up by patients having had other surgical interventions. This could cause a risk of infection for those patients having spinal and joint surgery. However the ward did not accept any patient having major abdominal surgery or infection to reduce contamination.
- We saw there were systems in place to monitor surgical outliers throughout the trust. Nursing staff on these wards told us these patients were reviewed on a daily basis by the ward doctors and had access to specialist consultants when required. The service told us that between January and December 2015, 31% of admitted patients moved wards of which 1,633 took place during the night, (between 10 pm and 6 am).
- The average theatre utilisation rate was 87.2% which was better than the trust standard of 85%.
- **Meeting people's individual needs**
- The service had 36 specialist nurses in post, 26 in the abdominal surgical and medicine directorate, one in the head and neck directorate, eleven in the musculoskeletal directorate and three in the perioperative directorate.
- The abdominal and medicine directorate had 10 digestive diseases clinical nurse specialists, six bowel screening nurse specialists, four urology nurse specialists, four stoma nurse specialists and two endoscopy nurse specialists.
- The head and neck directorate had one specialist ophthalmology nurse practitioner.
- The musculoskeletal directorate had three trauma practitioners, two nurse practitioners, one major trauma lead and three trauma coordinators.
- The perioperative directorate had two pain nurse specialists and one theatre perioperative nurse practitioner facilitator.
- The service used the trusts butterfly scheme where a butterfly symbol was placed by the patient's name to identify those patients living with dementia or memory-impairment. Its purpose was to improve patient safety and well-being in hospital.
- Wards and theatres were accessible to individuals living with a disability and technical equipment was available to support individuals where required. This included operating tables being appropriate for bariatric patients to meet the needs of patients with a high body mass index (BMI). Bariatrics is a branch of medicine that deals with the causes, prevention, and treatment of obesity.
- Twineham ward had a five bedded bay dedicated for those patients living with dementia which allowed more intensive care could be provided to ensure these patients were safe. Staff used specific care plans for patients living with dementia called 'reach out to me'.
- The service had reconfigured and all patients with a fractured neck of femur were cared for on one dedicated

ward at PRH. This resulted in seven of the nine measures audited for this condition improving. For example between July 2015 and December 2015 the average time in the emergency department had reduced to just over five hours. The average time to theatre was just under the 21 hours and the average time to be seen by a geriatrician just less than 28 hours.

- The trust had a policy for caring for adult patients with a learning disability in the acute hospital which included responsibilities and duties. The learning disabilities team would accept referrals from any source whether it was direct from the patient, their carers, community services, ward staff or GP's.
- Staff working on the SOTC told us there was good support from the learning disabilities liaison team and any patient living with a learning disability attending the hospital for pre-assessment would be flagged up with the theatre staff prior to them having surgery. The Brighton and Hove 'speak out' advocacy agency report January 2016 noted surgical services needed improvement in order to meet the needs of people living with a learning disability. Such as one patient feeling lonely as they had a single room and wanted to be able to talk with other patients and another felt the consultants on their wards didn't have time to talk with them and they didn't have time to ask questions.
- However there were examples of positive feedback from the report such as a person described as being afraid of having an anaesthetic, staff were able to keep the patient awake and said the nurses were reassuring and talked to the patient throughout the procedure.
- The service had action plans to address these issues which included the actions needed to be taken and who was responsible to complete the actions.
- **Learning from complaints and concerns**
- The chief nurse was the executive lead for patient experience and complaints. The chief of safety and quality and deputy chief nurse shared the responsibility for the line management of the head of patient experience, PALS and complaints who were responsible for the operational management of the services and line management of the complaints and PALS teams.
- The patient experience PALS and complaints team comprised of six complaint investigation managers, two complaints/PALS coordinators and three PALS advisors who worked closely with the complaints team.
- There was a monthly serious complaints and safeguarding meeting held by the head of patient experience, PALS and complaints, deputy chief nurse, patient experience, safeguarding lead nurse and chief of safety and quality.
- A patient experience report was produced quarterly for submission to the quality and risk committee and the board. An annual report was produced and shared at both meetings.
- The chief executive officer received copies of all complaints relating to clinical treatment and care. These were discussed at monthly meetings with the head of patient experience, PALS and complaints to discuss actions arising, themes and learning.
- Patient information that advised patients how to make a complaint or raise a concern with PALS was available on the trust website. There was an easy to read leaflet 'comments, concerns and complaints' which was available throughout the trust and was available in other languages upon request. A poster 'Have you got a concern or complaint and don't know where to turn' was displayed throughout the hospital.
- Between March 2015 and February 2016 there was a total 404 complaints across the service, 166 within the abdominal and medicine directorate, 134 musculoskeletal, 60 head and neck, 42 neurosurgery and two in the perioperative directorate.
- For the PRH site the abdominal surgery and medicine directorate was 15, head and neck directorate was 9, musculoskeletal directorate was 40 and perioperative directorate was two.
- 30% of complaints related to cancellations and waiting times, 27% clinical treatment, 19% treatment pathways, 14% communication, five staff attitude and four classed as other complaints.
- The trust had a lessons learned folder on its website where examples of learning from a compliant would be presented.
- Staff told us the complaints team also met with each of the directorates monthly to discuss their incidents and the safety and quality team provided a monthly report. The teams then used this within their areas to share learning. Some wards do this through nursing handovers, some wards attach to their staff boards and some use in team meetings.

Are surgery services well-led?

Surgery

Requires improvement

We rated surgery at The Princess Royal Hospital as requiring improvement for well led. This was because:

- There was no overriding strategy for the service and each directorate had their own individual strategy, this gave a perception of the service being disjointed.
- The service had experienced a reconfiguration of its neurological and fractured neck of femur services and had started to get its governance systems in place but this was in its early stages and needed further embedding.

However:

- Leadership at a local level was good and staff told us about being supported and enjoyed being part of a team. There was evidence of excellent innovative multi-disciplinary working with staff working together to problem solve and develop patient centred evidence based services which improved outcomes for patients.
- There were comprehensive risk registers for all surgical areas, which included all known areas of risk identified in surgical services.
- **Vision and strategy for this service**
- There was no one overriding strategy and vision for the surgical services. However each directorate had either a strategy or business plan for their services. For example the perioperative directorate had future objectives for their service such as the expansion of opening times of the temporary theatres admissions unit to improve flow and patient experience and building a new theatre admissions unit at the RSCH.
- The ENT service within the head and neck directorate had a strategy based on increasing medical staffing, improving its activity and RTT performance, reviewing its estates facilities and reviewing its communication processes.
- The abdominal surgery and medicine directorate did not have a specific strategy document as there were multiple specialities within the directorate.
- However the abdominal surgery and medicine directorate's had objectives which included creating a strong leadership team, implementing a new model which split emergency from elective activity in the digestive diseases surgery, realigning urology to deliver the best outcomes in newly designed facilities and recruiting the right staff and implement a variety of other new service improvements.
- The musculoskeletal directorate did not have an overarching strategy; however their objectives aligned to the trust clinical strategy and the safety agenda. They were continuing to embed their site reconfiguration for fractured neck of femur pathway and developing a Sussex musculoskeletal partnership.
- **Governance, risk management and quality measurement**

- Departmental governance meetings fed in to the four directorate's safety and quality (S&Q) meetings. How frequently and in what format was determined by the individual directorate management teams. The directorates had S&Q reviews which reported into the executive S&Q committee. Other concerns/issues raised between these quarterly reviews were reported into the executive by the S&Q facilitators. The service had regular board meetings with representation from all areas of surgery including consultants, matrons, and theatre managers. We saw minutes of meetings where quality issues such as complaints, incidents, risks and audits were discussed.
- Clinical leaders in the directorates told us they had oversight of all incidents and met with matrons and ward sisters to discuss these. We saw minutes of these meetings where incidents and complaints were discussed.
- Staff said they received information regarding serious incidents but did not always receive feedback on all incidents they had raised.
- The service had completed local as well as national audits. For example, a regular audit had been completed to ensure that compliance with the consent process and pain control was monitored and acted upon in line with the trust's policy and national standards.
- Each directorate had its own governance and performance monitoring systems for example the perioperative directorate had 10 governance meetings per year, directorate meetings and S&Q meetings every two months and a trust theatre group meeting every two months.
- The head and neck directorate had monthly governance meetings and planned to have quarterly directorate

wide governance meetings. The ENT directorate had their own quarterly newsletters and included 'you said we listened' forums and gave the opportunity for staff to contribute to the newsletter

- The musculoskeletal directorate had monthly clinical governance for T&O and a subspecialty monthly governance arrangement for the fractured hip service. Pain and rheumatology clinical governance meetings were in place, however they were not monthly but run to meet the needs of the services.
- There were comprehensive risk registers for all surgical areas, which included all known areas of risk identified in surgical services. These risks were documented, and a record of the action being taken to reduce the level of risk was maintained.
- The service had risk registers for the four directorates with a total of 37 risks across the service. Abdominal surgery and medicine directorate (9), head and neck directorate (12), perioperative directorate (13) and musculoskeletal directorate (3). These were reviewed monthly with the main risks relating to lack of equipment and lack of adequate staffing levels.
- The register was up to date, identified the risk, the impact to the patient, the controls in place, with a nominated lead for each risk. The risk register was discussed at each directorate clinical governance meetings
- Matrons and ward sisters also had daily meetings to discuss staffing levels, patients' safety concerns and bed occupancy.
- **Leadership of service**

- Each of the four directorates had a clinical lead, nursing lead and directorate manager. We met some of the management team who were dedicated, experienced leaders and committed to their roles and responsibilities.
- We saw strong leadership, commitment and support from the senior team at ward level within the service. The senior staff were often responsive, accessible and available to support staff during challenging situations.
- Senior managers we spoke with appeared knowledgeable about their patient's needs, as well as their staff needs. They were dedicated, experienced leaders and committed to their roles and responsibilities.
- Members of the directorate and local leadership teams were visible. Junior surgical doctors reported consultant surgeons to be supportive and encouraging. Junior doctors told us they felt well supervised by consultants.
- Each ward had a ward sister, supported by a surgical matron, who provided day-to-day leadership to members of staff on the ward Staff said they attended the engagement events held by the service which updated them of what was happening in the trust.
- Ward staff told us that senior nursing staff, consultants and doctors could be seen on the wards and they were approachable and helpful.
- The SOTC had previously been managed by a private company; staff told us they felt much better supported since the centre had been taken over by the trust. Senior managers were very approachable and the local manager was visible and very informative.
- We observed the theatres were well managed with good leadership. We saw all staff working as a team with defined roles to ensure the safe care of a patient entering theatre.
- There was general agreement from management and staff in the wards and theatres that recruitment and retention of nursing staff was seen as a priority by the trust.
- **Culture within the service**

- The perioperative directorate recently undertook a culture audit in the operating theatres which showed improvements were needed and plans were being developed. A detailed analysis was to be published for all staff to access so staff could see the service had
- listened to their staff.

- The service was continuing to run Human Factors training sessions, continuing with the roll-out of local versions of NatSSIPS and carrying out a repeat audit in 2017 to ensure improvements were made.
- A 'You said , we did, poster campaign was to be published to clarify responses to issues , for example leadership development and communication strategy , running a multi-disciplinary perioperative safety conference in April, running focus group sessions with staff to discuss concerns, seeking agreement and funding for multidisciplinary simulation training for all theatre staff.
- Across all wards and theatres staff consistently told us of their commitment to provide safe and caring services, and spoke positively about the care they delivered.

Surgery

- Staff in the SOTC told us they, “loved” working there and wouldn’t want to move.
- **Public and staff engagement**
- Staff told us about the significant changes when the neurology and fractured hip services had been reconfigured. There had been challenges around staff relocation and managing the new structures. Some staff moved in order to continue in the specialty of their choice and some staff stayed at their original hospital site but moved specialty. This caused a lack of structure and cohesion for the teams resulting in a large number of vacancies through August 2015 to November 2015.
- Staff told us these vacancies were now being filled, the majority being newly qualified staff. Leaders had set up protected time for away days for these services in order to promote better team work and support the newly formed teams. Staff told us about now feeling more positive about their futures. Leaders told us how proud they were about how staff responded to the changes.
- Patient satisfaction questionnaires were available on each ward and patients were encouraged to complete these. This provided the opportunity to patients to give feedback on any areas they felt needed improvement.
- The average response rate in the FFT for the period January to December 2015 was worse than the England average; 20% compared with 35%. Response rates for individual wards were, Newick ward 28%, Twineham ward 33%, Albourne ward17% and Ansty ward 4%.
- **Innovation, improvement and sustainability**
- The service’s approach to the care and treatment of patients with a fractured neck of femur. The service had moved the service onto one site where a MDT approach showed better outcomes for patients. The time for patients to be seen, admitted and operated upon had reduced and patients were discharge from the hospital in a timelier manner.

Critical care

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

Information about the service

The critical care unit at the Princess Royal Hospital has 12 bed spaces, including one isolation room and is funded for three level 3 patients and nine level 2 patients. The Intensive Care Society classifies patients' level of need based on their acuity. The unit can be staffed and equipped flexibly to meet the needs of patients, which means the numbers of patients requiring different levels of care can be changed responsively. Four of the bed spaces are newly-funded and situated in a bright and modern area separated by a short corridor from the main unit. This area has a dedicated nurses and doctors' station and is fully funded. At the time of our inspection the four beds were not in regular use due to a lack of available staff to operate them safely.

Critical care is located next door to theatre recovery, which provides easy access for patients after surgery.

Patients are admitted to critical care through the medical take from specialist inpatient services, including for patients who present with chronic obstructive pulmonary disease, diabetic ketoacidosis or drugs overdoses. Patients are also admitted following elective surgical work. Princess Royal Hospital is not a designated major trauma unit. Trauma patients can be admitted to critical care to be stabilised prior to being transferred to the trust's other critical care site at the Royal Sussex Hospital.

Between January 2015 and December 2015, 494 patients were treated in the unit which reflected an occupancy rate of between 60% and 90%.

Several staff roles and responsibilities, clinical governance and some care pathways and protocols are shared with the unit's sister site at the Royal Sussex Hospital. This includes a shared nurse practice educator team, critical care outreach team and consultant team. Both sites contribute to national and local data audits, led by a dedicated audit nurse.

Critical care

Summary of findings

Overall we rated critical care as requires improvement. This reflects inconsistent nurse staffing levels that did not always meet the safe standards established by the Faculty of Intensive Care Medicine and the Royal College of Nursing. A dedicated nurse practice educator was available in the unit on a part time basis only, which meant staff did not always have timely or regular access to a suitable range of clinical education.

Staff did not always understand or use incident reporting processes and investigations did not always result in demonstrable learning. There was a lack of governance in relation to the management and resolution of risks identified on the risk register. However, local leadership at the unit level demonstrated passion for safe care and treatment and for developing the unit to meet increasing demand. This included the successful implementation of four additional high dependency beds in the unit to increase capacity. The beds were funded but the executive team had not yet approved the recruitment of new nurses required to staff the beds. This meant they were unused.

There was inconsistent and sometimes limited input from a multidisciplinary team of specialists with significant shortfalls in pharmacy, dietician and occupational therapist cover. The unit did not fulfil the requirements of national guidance in relation to the rehabilitation of patients through a follow up clinic. A dedicated audit nurse worked between critical care sites and there was a local audit plan in place. Although this demonstrated a focus on improving evidence-based care, there was inconsistent evidence outcomes and learning were used to improve practice.

A critical care outreach team was available 24-hours, seven days a week and provided hospital-wide support for patients with deteriorating conditions. This team also education sessions for staff and followed-up with patients after they were discharged from the critical care unit to a ward.

Staff were encouraged and supported to lead research projects, which they were able to present at national conferences as a knowledge-sharing strategy and were used to plan changes in practice.

Dedicated housekeeping staff and an infection control lead nurse maintained a high level of cleanliness, hygiene and infection control.

There was a demonstrable lack of communication and understanding between the executive team and local leadership. Staff did not feel engaged with the trust and could not identify any positive changes made in the unit as a result of executive-level support.

Critical care

Are critical care services safe?

Requires improvement

We rated critical care at Princess Royal Hospital as 'Requires Improvement' for Safe:

- There was an inconsistent approach to reporting, investigating and classifying incidents. Learning from incidents was often vague or missing entirely and staff knowledge from incident investigations was variable, including from incidents relating to medication errors. There was little evidence staff understood or implanted the Duty of Candour consistently.
- Staff did not comply with national and European regulations on the safe storage and disposal of hazardous waste or on the safe storage of chemicals.
- The unit did not have a safer sharps policy and staff used needles against national and European best practice guidance.
- There was insufficient pharmacy cover on the unit and the stock rotation system was ineffective. We found 23 out of date medicine products and evidence staff were re-using single-use items.
- Five incident reports had been submitted in the previous 12 months, in which staff reported a low level or inadequately skilled nurse team had compromised patient safety. There was a significant lack of evidence the senior team had acted on this.
- A robust business continuity and emergency evacuation plan was in place and was based on previous major incidents. However, the executive team had failed to act on recommendations made by the unit team that could improve staff response in the event of another evacuation.

However we also found:

- The unit consistently met minimum staffing levels for nurse to patient ratio established by the Intensive Care Society and the Royal College of Nursing. A supernumerary nurse coordinator was always on the unit but occasionally had to take low-acuity patients to cover staff breaks and shortages.
- The unit had a consistent track record in providing harm-free care, with no unit-acquired infections, falls or pressure ulcers in the 12 months prior to our inspection.
- Staff embedded the principles of safeguarding in their practice and there were numerous examples of how their proactive actions had ensured people were protected from harm and had access to the help they needed.
- A team of 16 consultant intensivists led medical care on the unit on a 24 hours, seven day basis. This meant the unit met the requirements of the Faculty of Intensive Care Medicine. All patients had a treatment plan established by a consultant within 12 hours of admission.
- Mandatory training was monitored and kept up to date by two professional development nurses, who also provided additional specialist and ad-hoc training for staff. Mandatory training compliance was 82%.
- Cleanliness and hygiene standards were maintained by a dedicated housekeeping team and infection control lead nurse conducted regular audits to monitor and improve standards.
- Staff adhered to trust guidance on the care of deteriorating patients and used appropriate tools to assess this. Escalation strategies relating to deteriorating patients were in place and we observed staff use them appropriately. The critical care outreach team provided rapid reviews of deteriorating patients and support to ward staff.
- **Incidents**
- From February 2015 to January 2016, staff reported 34 incidents in the unit. Eight of the incidents were medication errors and five were related to shortages in nurse staffing. Documented outcomes to the incidents lacked detail or evidence of resolution and in seven cases there was no documented action taken. This meant it was not clear how senior staff improved working practices as a result of incident reports.
- Staff described an open reporting culture in which they felt confident and empowered to submit incidents using the electronic reporting system. However, the number of incidents submitted in relation to the number of patients treated was exceptionally low, which did not reflect an open incident reporting culture.
- The clinical lead and matron received each incident report. If they considered the report to be urgent or serious, they sent the report to the senior clinical team using a rapid response process by e-mail for action. However, it was not always clear incident investigators adequately communicated the severity of incidents. For example, an incident occurred where an enteral feed

entered a patient's lungs and they aspirated. This could have been avoided if staff had ordered x-rays of the patient as part of the feeding line placement process. Staff told us no new policies had been implemented after this incident because it had been well-documented and so a reminder to staff to get x-rays was sufficient.

- Senior staff communicated the outcomes of incident investigations and changes in policy using a monthly 'Risky Business' magazine and through quarterly safety review meetings. The clinical lead had sight of each incident report submitted but staff did not always receive individual feedback. The clinical lead told us this was due to the volume of incident reports submitted. Some staff we spoke with said they felt feedback from incident investigations was adequate. For example, after a medication error, a pharmacist would visit the unit and arrange one-to-one training for the member of staff concerned. Following an incident in which an airway pressure machine failed, a new policy was implemented whereby staff had to check each item of equipment at the patient bedside before they used it.
- Senior staff could demonstrate they discussed mistakes with patients and relatives under Duty of Candour requirements. However, this was inconsistent and only consultants and the nurse practice manager were adequately aware of trust policies on this.
- A consultant led monthly morbidity and mortality (M&M) meetings to discuss patient outcomes and deaths on the unit. The meetings were used to identify areas of good practice and where processes and care pathways could be improved. For example, one meeting led to a review of how patient records were handled following a transfer from another unit.
- Staff reported an infection control incident out of prudence due to the unit having only one side room available. For example, staff moved a patient with a reportable infectious condition out of the side room so they could provide care for a patient with greater clinical need. Staff identified this resulted in an unsafe clinical environment due to the risk of cross-infection. However, staff had taken appropriate mitigating action such as the implementation of a barrier nursing method and a bowel management system. This showed us clinical staff were able to respond quickly to manage risks associated with the challenges placed on the environment by patients with complex needs.
- Outcomes and learning from incident reports and investigations were not always clear or adequate. For example, in one incident report staff stated they had assisted with the transfer of a patient with a tracheostomy from the unit to another ward. On arrival the staff in the receiving ward said they had been told the patient did not have a tracheostomy and so were short of the safe number of staff needed to safely provide care. Although the accompanying member of staff remained with the patient and ensured the receiving ward was safe for them, the only documented outcome from the incident was "advice given to staff" and that discharge communication procedures needed to be reviewed. This meant it was not evident this incident had been investigated using a robust process or that changes had been made to discharge communication processes to prevent future risks.
- In another example, staff submitted an incident report regarding the unsecure return of confidential patient documents from another hospital. They stated the packaging was ripped, some patient details were visible and one section of the notes were missing. In addition, the notes had been sent by standard post with no tracking available. Although the incident was recorded, there was no evidence staff had tried to trace the documents to the sender or established policies for the safe transport of confidential documentation.
- Nurses demonstrated awareness of previous incidents involving medication errors and acted accordingly to ensure risks were reduced. For example, during a handover we observed nurses visually checked cannulas and infusion lines together and confirmed fittings and dosages were correct. This checking process had been implemented after a previous medication error involving an infusion.
- The matron and a practice nurse educator completed a research project to identify best practice in managing risk through incident reporting, investigation and learning discussions. The results of the project were embedded into the unit's incident reporting practices and the project poster was displayed in the unit.
- Some staff had undertaken human factors simulation training, which senior clinicians used to prevent errors by intercepting practice that could lead to errors.
- **Safety thermometer**

Critical care

- Staff in the unit contributed to the NHS Safety Thermometer programme. Information was collected on a monthly basis and clear, easy-to-read information was displayed for staff, patients and visitors.
- A clinician assessed each patient for their risk of venous thromboembolism (VTE), falls and malnutrition on admission and reviewed this at regular intervals.
- Between January 2015 and February 2016, the unit reported nine months of harm free care, with six instances of harm recorded for the whole period. All six instances were pressure ulcers acquired outside the unit. There were no instances of new pressure ulcers, falls with harm, and unit-acquired infections from catheters or venous thromboembolism.
- **Cleanliness, infection control and hygiene**
- Staff used 'I'm clean' stickers to identify when an item of equipment was clean and disinfected. Some equipment was stored in the main access corridor, which meant it was susceptible to dust contamination.
- There had been no cases of unit-acquired MRSA or clostridium difficile (C.Diff) in the 12 months prior to our inspection.
- An infection control team worked between hospital sites and was made up of the clinical lead and three nurses including a senior nurse based at Princess Royal Hospital. An infection control lead nurse was responsible for monitoring cleanliness and conducting monthly audits. They ensured the unit's track record was improved through robust monitoring of staff practices and ensuring audit results were used for future learning. Staff told us the lead nurse regularly conducted spot checks on their practices and the bed spaces they worked in; including quizzes they had to pass.
- The infection control team met on a six-weekly basis to discuss audit results and issues. The team also met with the microbiology department bi-monthly to develop best practice working protocols.
- In March 2016 hand hygiene compliance in the unit was 100% and in February 2016 it was 97%. Staff we spoke with were not able to tell us about any changes in practice as a result of the change.
- Staff observed good hand hygiene and infection control practices during ward rounds, handovers and when moving between patients. For example, staff used alcohol gel to wash their hands and used appropriate disposable personal protective equipment during patient examinations. Staff also decontaminated equipment, such as their stethoscope, between patient examinations.
- Alcohol hand gel was available in each bed space and at each exit and entry point to the unit. Not all handwashing sinks had a poster to demonstrate the World Health Organisation five moments for hand hygiene. This meant it was not immediately clear how staff benchmarked their handwashing practice.
- Doctors used a ward round safety checklist to prompt visual checks of the insertion site of central venous catheters. This formed part of the care bundle for this type of treatment and included adherence to hand hygiene guidance.
- Housekeeping staff and nurses adhered to separate cleaning schedules, which meant cleaning was structured and responsive to need. For example, staff performed a deep clean of a bed space or side room after a patient who was infectious was discharged or after a patient deceased.
- Cleaning standards on the unit were checked weekly by the housekeeping team supervisor and a nurse in charge. If they identified shortfalls, the housekeeping supervisor prepared an action plan, which the unit's housekeeper completed within 24 hours.
- The unit did not comply with the Health Safety Executive (HSE) classification regulations for infectious substances and clinical waste. This was because staff used yellow clinical bags for waste identified by the HSE as UN3291 instead of the required orange hazardous bags. Although all full bags were locked in an area outside the unit awaiting collection, not all bins were labelled as required by the HSE Carriage of Dangerous Goods Manual.
- The unit scored 97% in the national cleanliness score for intensive care.
- **Environment and equipment**
- A team of nurses had trained to be specialists in specific items of critical care equipment. In this role they maintained up to date knowledge of equipment guidelines from manufacturers. They also delivered training and bedside support to other staff in the safe and correct use of the equipment. Equipment link nurses specialised in equipment such as portable ventilators, beside monitors, enteral feeding pumps and haemofiltration devices.

Critical care

- The side room in the unit could be used for isolating patients whose condition presented an infection control risk. Staff could control the pressure in this room but there was not a separate anteroom between it and a dirty utility room directly next door. This meant when staff opened the door between the side room and the dirty utility room, bacteria and airborne spores were sucked into the side room. This presented a heightened infection control risk that was not mitigated.
- The unit was not compliant with the Health and Safety Executive Sharp Instruments in Healthcare Regulations 2013 or the EU Council Directive 2010/32/EU with regards to a safer sharps policy. This was because needles were not covered with a protective sheaf.
- Flooring in the unit was compliant with the Department of Health Building Notes (HBN) 00-10 but was damaged in parts, with temporary tape in place as a repair. Welding at the joints of the vinyl flooring was in a poor state of repair, which reduced its effectiveness in meeting HBN requirements. This also meant there was an elevated risk of bacteria building up in the areas of damaged flooring.
- There was a plumbed water cooler available in the pantry with hard taps and an overflow tray that was not compliant with the Department of Health HBN 00-09 regarding infection control in the built environment. A fridge used to store milk and yoghurts and a freezer for ice lollies and ice chips was also stored in the pantry but staff did not document daily temperature checks. This meant the use of the equipment did not guarantee the requirements of national 'cold chain' guidance.
- A dirty utility room on the unit was unlocked and contained chemicals applicable to the control of substances hazardous to health (COSHH) regulations. The unit was not compliant with COSHH requirements because the cupboard used to store the chemicals was unlocked and access to the room was unrestricted.
- Staff documented daily checks on the resuscitation trolley and automatic defibrillator, an ordinary intubation trolley and a difficult intubation trolley. Where they found a problem, staff documented the corrective action taken.
- Senior nurses delivered practical training when new nurses started working in the unit on the correct techniques for washing-down and decontaminating equipment.
- **Medicines**
- The unit did not have permanent dedicated cover from a pharmacist. A pharmacist visited the unit daily Monday to Friday and the lead pharmacist at the Royal Sussex County Hospital (RSCH) provided advice and guidance for staff on drug errors. The lead pharmacists for critical care at RSCH had submitted two business cases to the executive team to demonstrate the need for additional pharmacy staff. These had not been acted on at the time of our inspection.
- There was not a robust system in place for the ordering and stock rotation of medicines and antibiotics. For example, pharmacy technicians checked medicine stocks and ordered them;, porters delivered new medicines and nurses put them away and completed stock rotation. There was no oversight of this process. We checked stocks of medicines and found 23 to be out of date and stored in the clean utility room. This included two pre-filled syringes of ephedrine, five doses of dobutamine and a box of clexane syringes. We spoke with the clinical nurse manager who said they would dispose of the expired items immediately.
- We found evidence staff in the unit were re-using single-use items. For example, a bag of glucose fluid and a 500ml bag of saline fluid were both hanging up in the clean utility room, marked with open dates in the previous two days and with a delivery tube attached. Such items should only be used once, for one patient, before being destroyed. The unit's practice did not adhere to safe or legal manufacturer guidelines and was in breach of the Nursing and Midwifery Council practice guidance on nurse accountability.
- Staff stored controlled drugs on the unit in accordance with national guidance and recorded daily stock checks. One incident was reported in the previous 12 months in which the stock of a controlled drug was found to be incorrect. Reporting staff indicated the discrepancy could mean a patient had previously received incorrect medicine. There was no action taken documented in the incident information supplied by the trust and staff we spoke with.
- Staff reported seven instances of medication errors in the previous 12 months. Five of the incident reports indicated support and advice had been given to staff but only one report indicated pharmacist advice had been given. For example, a member of staff submitted one incident report after an incorrect medication was administered to a patient. The only action documented by the trust was to remind nurses to be vigilant. Another

incident report indicated a patient had been administered morphine at ten times the prescribed dose. There was no documented action taken or learning from the incident report.

- There was no antimicrobial pharmacist available on site and hospital policy did not require codes for ordering antibiotics although the pharmacy did mandate microbiology approval for antibiotics. Staff told us this system was not subject to management review and at times registrars order antibiotics without approval from microbiology.
- **Records**

- Patient records were in paper format, which was not consistent the trust's other critical care units. This presented a problem to staff if patients were transferred from the trust's other units.
- In four patient notes we looked at, staff had completed risk assessments for VTE, falls, peripheral cannula care bundles, patient handling, malnutrition and waterlow scores. Staff used a daily assessment document to review and update each risk assessment. A pharmacist had documented a daily review in each case.
- All records we looked at included evidence a consultant made the decision to admit and the time of this was recorded.
- Medical staff did not always record their role or grade when completing patient records. This meant other doctors and nurses relied on knowing the name of each doctor who might complete patient notes to trace them if they had a query.
- **Safeguarding**

- Staff demonstrated knowledge of safeguarding protocols and action to take when they had concerns. This worked in the best interests of patients and ensured they were protected from the risks associated with abuse or neglect. For example, one patient had been admitted from temporary accommodation and staff had liaised with local police to trace and contact their next of kin. As part of this process, staff worked with staff from the accommodation as well as the police to ensure family who were contacted were appropriate to invite into the unit and did not pose a threat to the person.
- Link nurses were in post for safeguarding adults at risk. The link nurses worked with the hospital safeguarding team and ensured they were up to date with the latest national guidance to support colleagues in caring for people who had needs relating to safeguarding. For example, nurses sought advice when they were concerned about a carer who came to visit a patient as they wanted to make sure the carer had the support they needed at home.
- The unit had an established bruising protocol that staff used as part of their attention to the principles of safeguarding. Staff used this protocol to assess the likely cause of a patient who was admitted with bruising to their body and prompted staff to complete a body map, contact the person's family or carer and complete an incident report. The protocol required staff to establish if the patient could explain the bruising themselves and to consider if the explanation was reasonable.
- The critical care safeguarding and Deprivation of Liberty Safeguards (DoLS) policies and decision flow charts were available to staff on the unit. The policies included guidance for staff on when to contact the safeguarding liaison team for both adult and child concerns as well as links to the hand mitten policy and nasal bridle policy.
- The clinical nurse manager had worked with the safeguarding team to develop a new communication protocol to ensure safeguarding processes were documented when a patient was acutely unwell. This process had been adapted for use with patients who were subject to DoLS and helped doctors and nurses standardise their approach to providing individualised care to these patients that respected their rights.
- Information had been provided in the quiet room used by relatives and visitors that signposted people to a local safeguarding protection organisation. This information guided people to recognise the signs of abuse and what they could do about it.
- **Mandatory training**

- Trust mandatory training was provided in 14 areas, including infection prevention and control, fire safety, safeguarding, moving and handling and conflict resolution. Refresher training was provided annually or every two years depending on the nature of the subject.
- The unit had an overall mandatory training compliance rate of 82%. This included 100% compliance with mental capacity act training and 99% compliance with adult basic life support training.

Critical care

- Staff were allocated to one of seven clinical management days on an annual basis that were used for completing mandatory training updates. Sessions were limited to 11 staff to ensure the opportunities for learning were maximised.
- **Assessing and responding to patient risk**
- The trust recognised the detection and management of deteriorating patients could be improved following a number of concerns raised by a coroner. To address this, a deteriorating patient steering group was established in March 2016. The critical care nurse consultant was part of this team and was actively involved in improving the identification and care of sick patients across all hospital wards. This included debriefs and learning sessions following emergency and cardiac arrest calls and a pilot project to determine the effectiveness of treatment escalation plans as a method to improve the rapid assessment of patient safety.
- Staff from the speech and language therapy (SaLT) team reviewed patients as needed and provided clear guidance for critical care staff. For example, SaLT staff displayed the results of dysphagia assessments on a yellow sign at the back of each patient's bed to identify their swallowing needs, such as if they needed thickened fluids.
- Evening ward rounds included a checklist to ensure doctors ordered targeted blood tests and to embed best practice in weaning and delirium prevention.
- Staff used the national early warning scores (NEWS) system to identify sick patients who were deteriorating. The critical care outreach team (CCOT) monitored this system and responded to patients across the hospital who may need to be admitted to critical care. The guidance and protocol used by ward staff for contacting CCOT and used by nurses to prioritise patients for review was well established and robust.
- **Nursing staffing**
- Senior staff had established a need for 59 nurses to fully comply with staffing requirements and patient care if all 12 beds were open. A team of 46 nurses staffed the critical care unit, including band seven team leaders and senior band six nurses. This represented a full staffing team for the eight beds open, which would need to increase by 31% for the unit to safely open the additional four beds that were ready pending recruitment. Of the nursing team, 72% were mentors.
- A critical care outreach team of 12 nurses, led by a senior band eight nurse, provided critical care support to patients on wards and in the emergency department. All nurses were qualified as mentors.
- Nurses were recruited through a process of practical simulation, formal interview and group work. This ensured the skills of new nurses met the complex needs of the patients the unit regularly provided care for.
- A senior band six or band seven nurse was in charge of each shift but was not always supernumerary in accordance with Royal College of Nursing and Intensive Care Society guidance. Senior nurses we spoke with said they sometimes had to take responsibility for a patient due to unplanned short-staffing. They said this was rare and when it happened they would ensure they took a patient who was ready for discharge or who had low acuity.
- Two handovers took place daily between nursing teams, led by the shift leader. We observed one morning handover and saw it was well organised, comprehensive and enabled nurses to identify patients at risk of deterioration as well as those with needs relating to infection control. Nurses were allocated to patients based on their skills competency and ability to meet the needs of the person. For example, the senior shift nurse checked each individual's skills competency progression before allocating them to a patient, as well as taking into consideration if they had previously cared for a patient still on the unit. For example, one nurse had not yet completed training in end of life care and so was not allocated to a patient with palliative care needs.
- Three nurses formed a roster management link team to monitor rostering processes and ensure the skill mix of the unit met the needs of people based on their acuity.
- The skill mix of CCOT included intermediate life support as a minimum and most nurses in this team had advanced life support training.
- The clinical nurse manager occasionally used agency nurses to fill shortfalls in staffing. Only nurses from agencies who followed the national clinical framework were able to work in the unit. Although senior nurses could respond quickly to a shortfall in staffing by requesting agency nurses, they told us finding the right person to authorise this at the directorate level often delayed the process significantly.
- A practice nurse educator managed and delivered a local induction programme for new nurses, including a shortened version for agency nurses. The programme

included a four week supernumerary period for new nurses with five study days. They were also formally supervised for one year post-appointment on their practice using the Critical Care National Network Nurse Leads Forum (CC3N) competency programme. All new nurses were assigned a mentor for at least one year.

- Nurse shift leaders had a minimum training and skill set before they were able to lead shifts, including leadership training, safeguarding training and the ability to make referrals for the Deprivation of Liberty Safeguards (DoLS).
- A team of four healthcare assistants (HCAs) supported the nurse team, with one HCA allocated per shift, including night shifts. HCAs undertook a four day trust induction followed by two supernumerary shifts before they were able to work unsupervised. All new staff received training from a tissue donation nurse as part of their induction.
- Nurses described staffing levels as "generally manageable" but said the nurse in charge often had to take patients to be able to give nurses a break.
- The unit had met the requirements of the Intensive Care Society (ICS) that no more than 20% of nursing staff per shift be sourced from an agency for the previous 12 months.
- Staff had used the incident reporting system to document five instances where a shortage of nurse staffing had impacted patient safety. For example, in one incident report staff documented a nurse without critical care training or experience had been supplied to the unit to replace a qualified critical care nurse who had been redeployed to a medical ward staffed entirely by agency nurses. Three patients had been admitted to critical care overnight, which was insufficiently staffed. Another incident report noted one nurse had been left to care for five patients due to other staff being involved with patient intubation or behind the curtains used to provide privacy for sick patients. The details of the incident reports relating to short staffing indicated the number of nurses on each shift was not always safe.
- **Medical staffing**

- A team of 16 consultant intensivists led medical care, with one consultant available on the unit daily between 8am and 6pm.
- Daytime medical cover was provided by a consultant, a specialist registrar with airway training and a junior doctor. Overnight, a consultant intensivist was available on call and available to attend the unit within 30 minutes and a specialist registrar was based in the unit. This met the requirements of the Intensive Care Society and the Faculty of Intensive Care Medicine. A registrar with airway training, an obstetrics junior doctor and an anaesthetist trainee provided support to the unit overnight.
- Two daily medical handovers took place. The handovers included the consultant and junior doctors. We observed a handover and saw junior doctors were confident in presenting patients and included patients who were waiting for referrals and a discussion of sick patients on the wards who were managed by CCOT.
- During a ward round a consultant took time to ensure a new registrar was included in the patient discussed and commenced bedside teaching with them. This was consistent with the practice we observed throughout our inspection.
- The decision to admit was made by a critical care consultant in 100% of admission cases in the 12 months prior to our inspection. In addition, all patients had a consultant-led treatment plan and were reviewed by a consultant within 12 hours of admission. This met the requirements of the Intensive Care Society.
- A consultant led a ward round daily. This included ad-hoc or on-demand input from the wider multi-disciplinary team but was not attended by a range of multi-disciplinary staff.
- Each consultant acted as a research lead for a specific clinical area, such as renal failure, trauma and emergency links and rehabilitation. Consultant leads were also in post for quality improvement, clinical information systems and junior staff and teaching.
- Doctors were given protected time weekly to attend teaching sessions on a six monthly rolling basis mapped to the Faculty of Intensive Care Medicine curriculum. This included simulations and practical exercises. A faculty tutor coordinated the rotas and educational need of junior doctors, who were allocated an educational and clinical supervisor.
- Junior doctors spent at least 50% of their working time on shifts with a consultant present. They also spent at least 12.5% of their training time during the night. This met the Guidelines for the Provision of Intensive Care Services guidelines for junior doctors in critical care.
- A doctor with advanced airway and resuscitation skills
- was available 24-hours, seven days a week.

Critical care

Major incident awareness and training

- Access to the unit was restricted and staff only authorised this when they had identified the person using a remote video camera system.
- Staff had not had recent fire evacuation training and the practice nurse educator was working with the fire risk department to provide a simulated evacuation exercise. In place of this, senior staff who were trained as fire wardens conducted a fire escape walk through and staff had to pass a fire awareness quiz.
- All shift leaders were trained as fire wardens and were responsible for prioritising patients for evacuation in the event of an emergency.
- Staff had taken conflict resolution training and were skilled in strategies for protecting themselves from aggressive patients. For instance, an HCA said they could often help an agitated patient to calm down just by sitting with them and giving them time to talk.
- A business continuity plan was in place, which would be led by the clinical nurse manager in the first instance during a major emergency. The unit's response to this had been tested during an aircraft emergency at a nearby airport, whereby the emergency plan was to admit trauma patients to the unit. As a result of this incident, the staff cascade call out process had been tested and updated and action cards were in place to guide staff. Another previous incident had occurred resulting in a full unit evacuation. Learning from this had been identified and shared amongst the whole trust critical care team. Senior staff had asked for high-visibility jackets to be provided for the nurse in charge and consultant, so they could be easily identified during an emergency. The trust had not yet provided these. This meant it was not clear how unit-level investigations and learning were acted upon by the senior directorate team.

Are critical care services effective?

Requires improvement

We rated critical care at Princess Royal Hospital as Requires Improvement for Effective. This was because:

- Although local audits were evident, there was a lack of robust, embedded learning and practice change based on audits. This included the lack of a sepsis audit programme.
- Multi-disciplinary input into patient care was sporadic, inconsistent and did not occur reliably. Occupational therapy cover was significantly restricted.
- Training in pain management was below requirements for the unit although an action plan to improve this was in place.
- The unit did not have a full time, dedicated dietician and out of hours support was limited. This meant the unit was not compliant with the British Dietetic Association's guidance.
- Staff had access to specialist training offered proactively by a dedicated nurse practice educator. However, this individual was funded in an education role on a part time basis, which restricted the time they could spend on teaching and learning.
- The unit did not meet the requirements of the National Institute of Health and Care Excellence (NICE) clinical guidance 83: rehabilitation after critical illness in adults. This was because there was no formal follow up clinic in place.

However:

- The unit performed well in national audit data in the unplanned readmission or non-clinical transfer of patients. Out of hours transfers were typically low but there was evidence of rapid and significant increases in the previous 12 months.
- The unit mortality ratio was better than the national average.
- **Evidence-based care and treatment**
- Ventilator care bundles were in use and staff recorded daily checks on the electronic clinical information system.
- Staff used a custom-made selective decontamination of the digestive tract (SDD) gel on all intubated patients and those with a tracheostomy. The use of SDD can reduce the occurrence of ventilator-associated pneumonia.
- The trust did not routinely audit compliance with the ventilator care bundles. However, audits of incidences of catheter related blood stream and ventilator-acquired pneumonia were used to measure patient outcomes. Catheter related blood stream

infection rates were consistently below the Matching Michigan project at 0.25 infections per 1,000 catheter days. This was better than the national standard of 1.4 infections per 1,000 catheter days.
- Staff monitored the use of central venous catheter against national NHS guidelines for preventing healthcare-associated infections.
- A physiotherapist attended the unit daily and contributed to the rehabilitation care plans of patients in line with the requirements of the National Institute of Health and Care Excellence (NICE) clinical guidance 83: rehabilitation after critical illness in adults. A physiotherapist attended the critical care multidisciplinary meeting every Wednesday.
- Staff assessed patients on admission and then at regular intervals for delirium using the confusion assessment method for intensive care units (CAM-ICU) and the Richmond Agitation and Sedation Scale (RASS).
- We saw evidence of local audits undertaken by critical care nurses and posters with results and recommendations presented at various training sessions. There was a critical care audit programme in place for 2016/2017, which included engagement from clinical staff at all levels.
- Although a sepsis team had been formed in 2009, no sepsis audit programme had been established. The team had updated the severe sepsis protocol based on the Society of Critical Care Medicine Surviving Sepsis Campaign. This protocol had been developed by a critical care doctor and critical care outreach nurse and was displayed at each bedside as part of a sepsis resuscitation care bundle and a sepsis management bundle. Staff completed the sepsis resuscitation bundle within six hours of admission and the sepsis management bundle within 24 hours of admission.
- **Pain relief**

- An acute pain management link nurse was in post, who worked closely with the hospital's acute pain team and supported colleagues on the unit to ensure people had their pain managed appropriately.
- Clinical staff had updated the management of pain, agitation and delirium policy to ensure delirium screening was more consistently managed.
- Trust protocols and guidance on pain management was in line with national guidance. This included the management of pain, agitation and delirium guidance.
- Staff used a pain-scoring tool to assess levels of pain and recorded these clearly in patient notes. This was documented within four hours of admission and reviewed at intervals appropriate to the needs of the patient.
- Pain management training for nurses was provided on analgesics, such as patient-controlled analgesia (PCA) pumps and epidural and local anaesthetic wound infusion. Nurses were required to complete a patient-administration competency assessment and competency checks on their use of equipment. At the time of our inspection, 93% of nurses had up to date competency checks on the use of pain management equipment, 28% had an up to date patient competency check in epidural and local anaesthetic wound infusion and 56% up to date patient competency checks in PCA. A plan was in place to focus training on patient competency checks in 2016.
- The matron had implemented an action plan to improve pain management, including the documentation of pain scores. At this site, the action plan aimed to train four acute pain assessors who would be responsible for staff competency assessments and training. This had been allocated to the practice educator team but did not take into account the shortage of capacity in this team.
- **Nutrition and hydration**

- Two nurses formed a nutrition link team and monitored the provision of nutrition and hydration to critical care patients. They worked closely with a dietician and a consultant with nutrition training and provided support to colleagues to ensure people with complex needs had their nutritional needs met. The link nurses had recently reviewed the unit's nasogastric feeding policy to ensure it followed best practice guidance.
- The unit did not have a full time dedicated dietician. Staff told us a dietician visited most days and they could make online referrals for patients. All nurses on the unit had nutrition and hydration management including fluid management and completed an hourly fluid chart and daily nutrition review for each patient.
- Enteral feeding began within 12 hours of admission for each patient.
- Staff used national guidelines on texture modification from the British Dietetic Association and Royal College of Speech and Language Therapy to ensure fluids were thickened appropriately and safely.

- The unit did not have dedicated dietician cover. This did not comply with the recommendations of the British Dietetic Association based on the number of beds.
- Patients who were able to eat and drink had a choice of food from a menu. Staff asked patients to choose their meal from a menu and explained the choice of food and options. There were checks in place to ensure that food was served at an appropriate temperature and we observed this during our inspection.
- Staff provided patients with jugs of water and hot drinks as well as snacks throughout the day. Easy to hold cups, straws and cups with drinking sprouts were available to patients who had difficulty drinking out of cups.
- Staff monitored nutrition and hydration using fluid balance and nutrition intake sheets and reviewed this at appropriate intervals.

- **Patient outcomes**

- The unit contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide.
- The unit was part of the Surrey and Sussex Local Clinical Research Network organised through regional National Institute of Healthcare Research (NIHR) Critical Care research network.
- In 2014/2015, the critical care team supervised several research projects with Brighton and Sussex Medical School including a project looking at the outcomes of 400 patients admitted to the ICU after a cardiac arrest between 2010 and 2012. The results were presented at European Society of Intensive Care Medicine in 2015.
- The numbers of unplanned readmissions and non-clinical transfers were comparable to the national average. Out of hours transfers fluctuated and were dependent on wider capacity and flow issues in the department and had increased from 0% of discharges in September 2015 to 14% of discharges in December 2015.
- The critical care mortality ratio was 0.6, which was better than the national average for similar units. The mean length of stay on the unit was 4.3 days, this was comparable to similar units.
- Clinical staff used care bundles to plan and deliver treatment. The care bundles included sepsis, ventilator, central venous catheter, sepsis and peripheral cannula. An audit nurse worked with doctors to conduct local regular audits on the effectiveness of the care bundles.

- **Competent staff**
- Eighty-nine percent of unit nurses and 92% of the CCOT team had a post registration award in critical care nursing. This was significantly better than national target guidance of 50% set by the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units.
- At the end of January 2016, 75% of unit nurses and 93% of CCOT nurses had received an annual appraisal.
- Nurses were organised into six teams, each led by a band seven team leader. The team leader was responsible for appraisals, sickness management, ensuring education and development needs were met and for organising team meetings. A nurse consultant led the CCOT team.
- Each nurse team shared responsibility for 12 areas of professional interest, in which nurses developed and updated policies and protocols and contributed to audits. Learning from such exercises was disseminated through team meetings, research posters, and briefing papers in the staff room. The 12 areas included ventilation, rehabilitation, management policies, renal replacement therapy and education. One team was dedicated to audit and research.
- Shift leaders demonstrated a good awareness of nurse competency during a nurse handover we observed. For example, they told nurses if people were being cared for using specific equipment and checked they were competent in its use.
- The critical care outreach team provided ad-hoc instruction and support as well as formal teaching sessions to staff in non-invasive ventilation (NIV), patient transfers and use of ventilation equipment. They provided training to 180 ward nurses per year on acute medicine training courses and also delivered tracheostomy and NIV study days. CCOT nurses were appropriately trained to provide this function but the study days were not attended by respiratory nurse specialists. This meant the level of specialist training provided could be improved.
- Staff were able to choose specialist training courses according to their professional development goals and the needs of patients. This included ventilation, weaning, rehabilitation and epidural infusions. Training was offered by multidisciplinary staff across the hospital.
- Senior staff ensured the skills competencies of nurses were increased to meet the complex needs of patients

when they noticed new trends in treatment needs. For example, an increase in the number of patients who needed therapeutic plasma exchange meant staff needed additional training to safely care for people.

- The unit did not have a full time practice nurse educator in post. A senior nurse filled the practice nurse educator post on a 0.5 whole time equivalent basis and provided training and learning support to staff. They were supported by a nurse educator from the Royal Sussex County site. The nurse educator team was involved in the strategic planning of nurse education across the trust's critical care units, including an increase in the education provision for band seven nurses and the delivery of intensive care modules with a local university.
- The workload for a part time nurse practice educator was significant and had increased following the closure of a neurology intensive care unit (ICU) nearby when some nurses were redeployed. There was a vacancy for another full time nurse educator. Some staff told us this meant it was difficult to secure time with the educator and formal training was sporadic. However, one nurse said they had been supported to complete an ambulance transfer course, which was delivered practically using an ambulance and crew. They said this was reflective of "really good, up to date training whenever we ask for it."
- There was a simulation suite on site used by staff when preparing for their objective structured clinical exams as part of the post-registration critical care course. The practice nurse education team had a simulation lead who supported staff in using the simulation suite effectively.
- Healthcare assistants (HCAs) undertook a generic HCA training workbook followed by a critical care specific workbook to enable them to work effectively in the unit. A senior band seven nurse supervised this time and managed their training needs, supervisions and appraisals. Nurses provided ad-hoc training to HCAs, such as in completing electrocardiograms and taking blood gases.
- The infection control team led education in the aseptic non-touch technique (ANTT) for infection control and delivered regular training sessions to colleagues with support from nurse practice educators.
- Trainee doctors were offered the 'BASIC' ICU course, which was funded by the deanery and ran twice each year. Senior trainee doctors were offered an advanced mechanical ventilation course.
- The consultant team had developed a programme of cardiac echo teaching, with some achieving accreditation in Focused Intensive Care Echo. One consultant achieved accreditation from the British Society of Echocardiography and supported a cardiac echo training fellow who was seeking their accreditation. This meant the consultant team had been able to offer a biannual echocardiography training course for trust staff.
- Nurses were trained in life support at a level appropriate to their grade. For example band six and band seven nurses were typically trained in intermediate and advanced life support and band five nurses were trained in basic life support.
- **Multidisciplinary working**

- Three nurses formed a rehabilitation after critical illness link group and another nurse acted as a lead for the ICU Steps programme. This programme is operated nationally by a charity and supports patients and their relatives after discharge. However, the unit did not have a formal follow-up clinic and in four patient records we looked at, there was no input from an occupational therapist. This meant the unit did not meet the requirements of National Institute of Health and Care Excellence (NICE) clinical guidance 83: rehabilitation after critical illness in adults. A critical care outreach nurse said they had previously trialled a follow-up clinic but suspended it following poor attendance. A CCOT nurse was leading a project to trial a new follow-up clinic.
- The unit did not have a dedicated occupational therapist but staff could contact the team when needed, including for support with cognitive assessments.
- A physiotherapist visited the unit seven days a week and we saw evidence of their input from looking at four patient notes.
- The CCOT team was available 24 hours, seven days a week. This nurse-led team provided support to ward staff in the care of deteriorating patients and those with tracheostomies and NIV. The CCOT duty nurse worked

as part of the hospital cardiac arrest team alongside a medical registrar, a senior house officer, junior doctor and a porter. The team met daily at 9am to define each individual's role in the team.

- The CCOT team worked closely with nurses who provided end of life and palliative care and the ICU Steps support group, which supported patients and their relatives after discharge. This team also accompanied critically ill patients during transfer with the ambulance service.
- Daily ward rounds were not attended by a multidisciplinary team due to short staffing in pharmacy, occupational therapy and dietetics. The ward round was also not attended by a physiotherapist. A single multidisciplinary meeting took place once each week and was attended by the clinical lead, a dietician, physiotherapist and the speech and language therapy team.
- Two nurses and a band eight nurse manager led a speech and language therapy (SaLT) team at the hospital and provided support and assessments for critical care patients Monday to Friday between 8am and 4pm. This team were able to support patients with complex needs, including those with a tracheostomy and patients who would benefit from a videofluoroscopy to investigate problems with swallowing. This team was involved with the Global Tracheostomy Collaborative, which meant their work was guided by international best practice and patients received care that was subject to continuous scrutiny and quality improvement.
- The unit was visited by a pharmacist on a daily basis Monday to Friday and staff could use an on-call system for pharmacy support out of hours.
- There was a positive working relationship between critical care staff, transplant coordinators and the end of life care team. There was a system in place to flag critical care patients to the Specialist Nurses Organ Donation (SNOD) when there was potential for someone to donate their organs.
- **Seven-day services**

- Out of hours, a critical care consultant was available on call and a clinical fellow anaesthetist and senior obstetric doctor also provided support. Specialist support from cardiology, endoscopy and surgery was not routinely available out of hours.
- Endoscopy, radiology services, echocardiography and general surgery were not available 24-hours, seven days a week. Out of hours, pharmacy and physiotherapy services were available on-call. Transfusion services, biochemistry and essential haematology services were available 24-hours, seven days a week.
- A range of independent services were available 24-hours, seven days a week through agreements with other trust hospitals. The services included interventional vascular and non-vascular radiology, neurosurgery, vascular surgery, general surgery, nephrology, coronary angiography, cardiothoracic surgery and trauma and orthopaedic surgery and 15 additional specialty services.
- Physiotherapy cover on weekday evenings and all weekend was provided by senior physiotherapists. Band five physiotherapists worked to a respiratory rota but had completed a rotation in the critical care unit and could provide support once their competency had been assessed.
- Occupational therapy services were available 9am-5pm Monday to Friday. There was no regular occupational therapy service outside of these hours. The manager responsible for this team had escalated the risk this presented by submitting a business case to the trust executive team for the recruitment of more staff.
- **Access to information**

- The unit did not use an electronic patient records system, which meant patient history notes had to be ordered through the hospital's records department or by contacting other service providers. This system was time-consuming and some staff we spoke with said it meant they did not have timely access to information that would help them provide appropriate care.
- A dedicated ward clerk worked Monday to Friday and facilitated the timely dispatch of discharge letters to GPs and community services
- **Consent and Mental Capacity Act**

- The clinical nurse manager was the unit's specialist link for issues and assessments relating to mental capacity, best interests assessments and the Deprivation of Liberty Safeguards (DoLS). They were also the departmental lead for the Mental Capacity Act (MCA) (2005).

Critical care

- Nurses were aware of patient capacity and mental health status during a handover we observed, including if a patient had a do not resuscitate (DNAR) authorisation in place and who had authorised this.
- Nurses received training on the MCA and DoLS but this was not always specific enough for them to apply to the critical care environment. Doctors and senior nurses conducted mental capacity assessments and these were documented appropriately and followed up with specialist mental health teams when needed.
- We spoke with two transplant coordinators from the specialist nurse in organ donation team. This team adhered to NICE clinical guidance 135 in organ donation for transplantation with regards to consent from relatives. For example, in a situation whereby family members had a difference of opinion regarding giving authority for an organ transplant, they would follow the
- decision of the patient's legal next of kin.

Are critical care services caring?

Good

We rated critical care at Princess Royal Hospital as 'Good' for 'Caring'. This was because:

- Staff at all levels demonstrated dignity, kindness and compassionate when speaking with patients, their relatives and visitors.
- Families we spoke to told us staff were courteous and respectful and they felt involved in the treatment decision making process.
- Emotional support and counselling services were available to patients and their relatives, including on-site Chaplaincy.
- Care for patients was evidence through the team's multidisciplinary approach, such as working closely with specialist nurses to speak with family about the organ donation process.
- **Compassionate care**
- Patients, families and friends reported they felt involved in their care and were given explanations about their treatment. One family member told us staff had "communicated at every stage". It was easy for patients to identify staff and we observed staff introducing and identifying themselves before talking to patients.
- Throughout our inspection the privacy and dignity of patients were maintained. We saw the use of 'This is me' documentation for patients living with dementia, which staff used to help them understand the person's social needs.
- The latest friends and family test (FFT) results showed 100% of family and friends felt welcomed by staff on unit when they first visited. Fifty per cent said that almost all the staff on the unit introduced themselves when they first visited and 83% said that they were able to talk to a doctor if they needed to. Sixty seven percent said that they were kept informed of their relative's progress.
- Nurses demonstrated consistent compassionate care to patients. For example, we saw one nurse talked to a patient who was sedated about their family and told them they had a nice chat with their brother earlier in the day. Nurses also told patients what was happening during a staff handover and the nurse taking over introduced themselves by name.
- A nurse acted as a compassion awareness champion and worked with colleagues to ensure people, their relatives and friends were treated with the most appropriate level of compassion possible in an environment that could be challenging and stressful for them.
- There were numerous thank you cards on display in the unit, which patients and relatives had sent to staff. They included comments such as, "Thank you all very much for the tender loving care" and, "Thank you again to all you lovely people for everything."
- Staff demonstrated a substantial dedication to protecting patients and their relatives from unnecessary anxiety and stress. For example, during an emergency that required the evacuation of the unit, a member of staff had contacted the next of kin of each patient to explain the situation as a protective measure in case they found out from social media or news reports. This ensured relatives had accurate and up to date information.
- **Understanding and involvement of patients and those close to them**
- Nurses began a patient diary when a person had been in the unit for longer than 72 hours or when they were ventilated. Nurses, doctors and family members had contributed to diary entries with positive messages of improvement and information on daily events. An

outreach team nurse gave each patient their diary on discharge and they were encouraged to use them as part of their rehabilitation process if they took part in the ICU Steps programme. A patient diary link nurse was in post who supported staff in their use and ensured they were used in the most appropriate way possible.

- Nurses discussed the involvement of patients' relatives during a handover we observed. This included whether relatives had been contacted and if they had visited as well as if family had requested a meeting with senior staff. We spoke with a nurse about this who had cared for the same patient for a number of consecutive days. They told us they had taken the time to get to know the patient's family over the course of a few days so they could understand the family dynamic. This enabled them to find out who should be involved in the person's care. This meant staff had an acute awareness of how to appropriately involve family whilst ensuring the patient's privacy and confidentiality was maintained.
- Staff demonstrated an unfailing and genuine sensitivity to the children of a patient in the unit. They planned their visit with an awareness of the impact the critical care environment could have on children and made sure support processes were in place for them. They also introduced the children to a specialist nurse in organ donation to discuss their relative's treatment plan.
- Doctors fully established the prognosis for a patient who was identified as a potential organ donor to be able to discuss this with their next of kin, before asking for a specialist nurse in organ donation to visit. This meant they could discuss the facts of the patient's condition with their relatives and explain the role of the specialist nurse before introducing them. This approach meant the family were given time and support to consider their decision.
- The hospital provided weekly or monthly parking permits for the relatives and visitors of long-term patients.
- Relatives we spoke with told us that they felt well informed by staff about the care and treatment being given to their family member. FFT results showed 83% of people felt that they were able to talk to a member of staff when they needed to.
- **Emotional support**
- Nurses demonstrated a good awareness of patient anxieties and potential for stress in the unit. For example, one patient was worried about telling their relatives they were being discharged to a ward. A nurse provided reassurance and told them, "Do not worry about that! That's for us to worry about and we'll sort it out for you."
- Three critical care nurses formed a bereavement support group, which provided emotional support for people, their relatives and staff. This team worked alongside two care of the dying link nurses, who provided targeted support for people receiving end of life care. A bereavement nurse sent out a condolence card and personalised handwritten letter to family members after a death. This included contact details for a local organisation that could help with grief and also offered relatives the opportunity to come back to the unit to meet staff.
- Information about how to contact the hospital Chaplaincy and a spiritual care organisation were posted in the relative's quiet room.

Are critical care services responsive?

Good

We rated critical care at Princess Royal Hospital as 'Good' for 'Responsive'. This was because:

- The unit had responded proactively to changes in the acuity of patients admitted, such as after the move of urology and fractured neck of femur services to the hospital.
- Facilities for patients and relatives in the unit included a kitchen area with snacks, two quiet rooms and toilets.
- There was a good working relationship between critical care staff and a transplant coordination team.
- Numerous link nurses were in post to support individual needs, such as people living with dementia and learning disabilities.
- Staff had access to on-site or local support teams for alcohol and substance misuse, community psychiatric needs and HIV positive patients.
- The unit performed positively compared to the national average for discharge delays and unplanned readmissions.

- There was a robust transfer protocol in place, which was used only by appropriately trained nurses with consultant oversight. The protocol was audited by the critical care network.

However:

- Performance for out of hour's discharges was variable and was connected to generally poor patient flow across the hospital.
- There was room for improvement in the consistency of discharge protocols and documentation for patients who needed rehabilitation
- **Service planning and delivery to meet the needs of local people**
- An information leaflet for relatives visiting the unit was available in six languages commonly spoken in the local area. The leaflet provided a clear and concise overview of critical care services and who people could approach for help. The trust's carer and patient information group had ratified this information for clarity and usefulness.
- Staff in the unit liaised with a hospital specialist nurse in organ donation to successfully complete a multi-organ donation process for local patients awaiting a transplant. We spoke with two transplant coordinators who were working with staff in the critical care unit. The coordinators provided support to staff to identify triggers that would indicate if a patient was a suitable candidate for organ donation. This service was part of an organ donation team that covered the south of England and adhered to NICE clinical guidance 135 in organ donation for transplantation.
- When successful organ donation took place, the transplant coordinator wrote to the patient's family to tell them how many people their donated organs helped. This team also contacted family members on the first anniversary of the donation to offer to chance to meet and discuss how this had helped the recipients. This service was part of a well-coordinated and established service to help critically ill people in the local area.
- There was limited paediatric medical cover available locally for critically ill children as some consultants were not trained in paediatric anaesthetics. Some cover was provided through non-anaesthetic consultants who were encouraged to undertake advanced paediatric life support training but this was not consistent and did not provide seamless cover.
- Urology services and fractured neck of femur services had moved to this site, which resulted in an increase in the number of patients with complex needs and significant comorbidities. Doctors had received additional training but there was not a robust framework in place to ensure 24-hours seven day cover was available from specialists in these areas.
- Two quiet rooms were available in the unit with hot drinks for relatives, who also had access to a kitchen where they could prepare snacks. Soup, cereals, yoghurts and rice pudding was kept on the unit to help people who spent long periods of time there.
- **Meeting people's individual needs**
- A number of link nurses were in place to support people and colleagues in specialist areas. In these roles nurses undertook additional training and learning opportunities and supported colleagues when caring for people with specific conditions. This meant the unit was able to provide targeted, individualised care for people with dementia, older people and those with diminished mental capacity or a Deprivation of Liberty Safeguards (DoLS) authorisation in place. Link nurses were also available for respiratory weaning, sepsis, haemofiltration, ventilation, nutrition, equality and diversity, tracheostomy care, delirium and bowel management and wound management.
- Nurses were able to take up link roles following completion of a mentorship course.
- Nurses demonstrated how they were responsive to meeting people's individual needs during a handover we observed. For example, one patient had not been able to tolerate a face mask for airway pressure and staff had been able to accommodate this by assessing other ways to provide care.
- Staff demonstrated an acute and compassionate understanding of a patient with mental health needs who had a history of self-harm. This included liaising with their family and other specialist services in the hospital.
- Staff used an individualised care plan to care for patients at the end of their life, including four-hourly observations. This practice met the policy guidance from the NHS Improving Quality priorities for the care of the dying person.
- The unit's safeguarding policy included guidance for staff on when to contact the learning disabilities team and how to obtain an independent mental capacity

advocate. We saw examples of referral documentation completed appropriately. Staff said they felt support from specialist teams in this area was very good and they were able to obtain rapid support at any time for patients with learning disabilities.

- Staff used the confusion assessment method (CAM) and the Richmond Agitation-Sedation Scale (RASS) to assess delirium and mental state. We saw a doctor completed the assessments for each patient on admission but the consultant was not able to tell us how often patients should be re-assessed. This meant it was not clear patients were re-assessed at appropriate intervals or what triggers staff used to complete this.
- Critical care staff established guidelines around visiting hours to meet the needs of relatives and to ensure patients had protected rest periods. Relatives of patients who were very sick could visit at any time.
- A relative's room and toilet and a patient toilet was available on the unit but did not have disabled access.
- Staff had access to a mental health liaison service and community psychiatric liaison nurses for support with caring for patients who demonstrated deliberate self-harm. Patients received a review from this team before they were discharged from critical care.
- An alcohol liaison team was available in the hospital and could also provide support to staff in caring for patients with substance addiction.
- An on-site HIV liaison team was available to provide support to HIV positive patients on admission and for patients who received a diagnosis whilst they were in the unit.
- The unit contributed to the Commissioning for Quality and Innovation (CQUIN) payment framework as a strategy to highlight and drive excellent service and outcomes. As part of this, the critical care network audited the unit for completion of rehabilitation pre-discharge assessments. Between April 2015 and December 2015, the service did not meet the CQUIN target of 95%. In November 2015 the unit achieved the audit result closest to this, when 80% of patients received a rehabilitation pre-discharge assessment. In the same period, the unit did not meet the CQUIN target of 95% for rehabilitation needs assessments of all patients. In December 2015, the unit achieved its highest audit result of 86%. The clinical lead had introduced plans to improve this performance.
- **Access and flow**
- The unit was a member of the South East Coast Critical Care Network (SECCCN) and participated in peer-led quality reports on a quarterly basis. The results were used to benchmark the unit's performance against other members of the SECCCN and to establish how well patient flow was managed in comparison to other member units.
- A consultant intensivist reviewed each patient admission within 12 hours.
- The unit reported a slightly higher rate of non-clinical transfers out and delayed discharges over 24 hours than the England average. From April 2015 to December 2015, an average of 19% of patients were delayed over 24 hours. This was under the 20% target established by NHS England under the Quality, Innovation, Productivity and Prevention strategy as an average. However, in four month delayed discharges the unit exceeded this target.
- Between April 2015 and December 2015, an average of 44% of patients experienced a discharge delay of between four and 24 hours. This was similar to the England average.
- Between January 2015 and November 2015, the unit reported no non-clinical transfers out, which was better than the SECCCN threshold of 0.4%. In December 2015, 2% of discharges were reported to be non-clinical transfers.
- In five months between January 2015 and December 2015, the unit met the SECCCN target of no patient admission delays of four hours or more after the decision to admit. In the remaining months, between 2% and 10% of patients were delayed by four hours or more.
- The number of unplanned readmissions within 48 hours was slightly lower than the England average. Between January 2015 and November 2015, the unit reported no readmissions and in December 2015 the unit reported 2% of patients discharged were readmitted.
- Between January 2015 and December 2015, the unit met the Intensive Care Society and SECCCN threshold for overnight discharges between 10pm and 7am of 6.3% in seven months. The unit had not met the target between October 2015 to December 2015, during which time they reported between 11% and 14% of discharges as having taken place overnight. Senior staff understood the risks associated with overnight transfers and only accepted these when the unit was full to capacity and a critically ill patient needed urgent intensive care.

Critical care

- Between June 2014 and January 2015 there had been a rapid and sustained increase in the numbers of patients transferred out of the unit for clinical reasons, to above 10%. This figure had decreased to less than 5% between January 2015 and June 2015.
- Critical care bed occupancy remained similar to the England average between January 2014 and January 2016.
- Two national audit data link nurses were in post who worked with the lead consultant to ensure the timely submission of audit data and scrutinised results to identify areas for improvement in unit processes.
- Patient flow across the hospital presented a challenge for critical care staff. For example, in the four months prior to our inspection, 40 elective operations had been cancelled due to a lack of critical care beds. Although 50% of the patients had undergone their operation the next day, this presented a significant problem. The unit had an additional four bed spaces equipped and funded for high dependency patients but it was not sufficiently staffed to open the beds safely.
- The patient transfer protocol was audited by the critical care network delivery group for safety compliance and outcomes.
- A critical care outreach nurse attended the daily bed meeting as a critical care liaison. This enabled them to communicate issues with bed pressures and delayed discharges to site managers.
- **Learning from complaints and concerns**
- Senior staff were proactive in encouraging patients and their relatives to talk about concerns, including through helping people to have the confidence to approach them if they needed to. For example, a poster in the relative's quiet room was prominently displayed stating, 'Please talk to us about your concerns – don't take them home!" Another poster advised people how they could talk to staff in confidence through the unit's complaints process or by speaking with staff from the Patient Advice and Liaison Service (PALS).
- The unit reported no formal complaints in the 12 months to our inspection.
- Nurses told us they were empowered to resolve issues with patients and relatives one-to-one if possible before they were escalated to the senior team.

Are critical care services well-led?

Requires improvement

We rated critical care at Princess Royal Hospital as Requires Improvement for Well led. This was because:

- There was evidence of a breakdown in communication between the executive team and the directorate team, which resulted in the inability of local senior staff to obtain approval for urgent issues, such as nurse recruitment.
- Staff were not able to obtain human resources support in a timely manner.
- There was no established relationship between the senior team responsible for nursing and the executive level staff who could approve this.
- Staff described "limited communication" from senior leaders and said they rarely got together or had the opportunity to meet.
- It was not clear how effective the management structure was above the clinical nurse manager as they took responsibility for the majority of the unit's leadership needs.

However:

- There was significant local evidence that the unit was well run by the clinical nurse manager and the senior team of nurses, with excellent relationships between nurses and consultants.
- Staff at all levels spoke positively about the support they received from the senior nurse team and manager.
- The unit was ready to open four additional beds pending recruitment of new nurses.
- The clinical governance structure was complex but robust and was focused on patient safety and outcomes through the monitoring of quality and driving improvements.
- Staff were encouraged to develop their innovative practice through research projects and piloting new projects. A critical care outreach nurse had won an award for their work in patient safety.
- **Vision and strategy for this service**
- The critical care unit had four fully equipped bed spaces that were not open for use. The clinical nurse manager and clinical lead told us increasing staffing levels to cover the beds and standardising patient notes into an

electronic system formed the main vision for the unit. Although this strategy was embedded in the unit locally, there was a significant lack of understanding of this from a senior executive level.

- The four bed spaces had been ready to open in January 2016 pending the recruitment of new staff. This recruitment had been delayed whilst human resources managed staff redeployment and the recruitment of overseas nurses. This presented a significant challenge to the leadership team as there was a further delay of seven months in obtaining approval from the Nursing and Midwifery Council for the overseas nurses to commence work unsupervised.
- Senior staff acknowledged the challenges with regards to nurse recruitment and retention but there was not a robust strategy in place to mitigate this.
- **Governance, risk management and quality measurement**

- Critical care services were part of the acute floor directorate, which included intensive care medicine, acute medicine and emergency medicine. The directorate was a member of the South East Coast Critical Care Network (SECCCN).
- Clinical governance was overseen by an intensive care medicine (ICM) team that formed part of the acute floor management team. This team was formed of a matron, clinical director and a clinical lead consultant. The critical care outreach lead also contributed to the team. Oversight was provided primarily from the Royal Sussex County Hospital site, with weekly attendance by the clinical lead and bi-weekly attendance from the matron. As part of the governance structure, consultants met on a monthly basis and band seven nurse team leaders also met monthly. The governance structure indicated the matron met with staff nurses on a weekly basis but nurses we spoke with said this rarely happened in practice.
- The ICM management team met weekly to discuss local operational issues and attended a monthly performance meeting with human resources, finance and a business manager. The outcomes of the meetings were used to provide feedback to staff through the band seven nurse meetings, consultant meetings and the monthly quality, safety and patient experience panel meeting.
- The unit had a Black and minority ethnic (BME) champion nurse in post, who worked to ensure management practices were fully inclusive for staff regardless of their ethnic background.
- The trust had a whistleblowing policy in place but staff knowledge of this was inconsistent. Two nurses we spoke with said they had not received any information on this and did not know where to find it.
- The unit completed a 'red, amber, green' risk analysis against the 249 national critical care standards of the General Provision of Intensive Care Services, which is endorsed by the Faculty of Intensive Care Medicine and the British Association of Critical Care Nurses. In the latest report at the time of our inspection, the trust met 207 of the standards and was rated amber or red for 42 of the standards. Significant risks included nurse staffing, pharmacy cover and rehabilitation.
- The service demonstrated proactivity in encouraging staff to contribute to an open culture of reporting incidents and safety concerns. However, there was a significant lack of evidence from the incident reporting log that senior staff acted on this. This included evidence of a critical impact on nurse performance and competence as a result of short staffing, such as fatigue, medication errors and other clinical mistakes.
- **Leadership of service**

- A clinical nurse manager led the daily operation of the unit. All of the staff we spoke with were positive about the leadership from this member of staff. One individual said the manager had worked with them to change their shifts when they wanted to attend college. This promoted their learning as well as their motivation to work well in the unit. Another member of staff said the manager had been very supportive of them taking up a link role and securing protected training time for this.
- The critical care matron was responsible for the units at the Princess Royal Hospital and the Royal Sussex County Hospital. Senior staff told us the matron planned for one day every two weeks at the Princess Royal site. We were not able to verify this information. Staff told us the matron acted as a conduit for communication with them. For example, the matron would brief the band seven nurses on changes or important information, who would then pass this on to their teams. This was not a

formal process and three nurses we spoke with told us they were not aware of any communication processes with the matron or how they were involved in the leadership of the unit.

- Senior staff described a significant disconnect between directorate leadership teams as well as between the directorate and the executive team. For example, a senior clinician told us they felt there was no support from the executive team or medical director when dealing with daily problems and there was no clear line of communication or support from the site management team.
- Senior staff could not identify how the trust executive board led or strategized service improvements. This was evident in the on-going lack of dedicated specialist service support from dietetics, occupational therapy and pharmacy. For example, the lead pharmacist for critical care had submitted business cases to the executive team demonstrating the need for more pharmacy support, which had not been provided. Despite this, staff told us the chief nurse was visible and some staff said they appreciated the efforts of the new chief executive officer to communicate with them through her blog.
- **Culture within the service**
- Staff worked to an established philosophy of care, which focused on supporting patients to return to the quality of life important to them and respecting the diversity of their patients.
- There was limited evidence the trust was supporting staff to meet the requirements of the Duty of Candour. Three nurses we spoke with did not know about the Duty of Candour or where to find guidance. One nurse said, "That's not something nurses would be involved with."
- Bank and agency nurses sometimes supported substantive staff on the unit. During a ward round doctors communicated well with a bank nurse and took time to answer their questions, which was part of an overall culture of positive communication and respect.
- There was a significant lack of human resources guidance for senior staff at an executive level. This included a lack of targeted support for senior unit staff when handling staff complaints, such as a four year delay in resolving a grievance. The lack of a formal governance process or structured support framework for staff in such situations meant those that could be simply resolved instead had a long-term impact on the morale of staff.
- We asked all of the staff we spoke with how they felt about working in the unit and about morale. One member of staff said, "Staff are exhausted. The ethos here is 'work harder with fewer people'. It's relentless."
- All of the staff we spoke with told us they had good working relationships with each other at a local level, including between different grades of staff. For example, a healthcare assistant told us they felt the unit was "nicely run" and said, "There's no judgements on me for not being a nurse. Everyone always says 'thanks for what you've done today' at the end of a shift; it means I feel truly valued." A nurse said the removal of different coloured scrubs for different grades of nurses had, "removed the hierarchy attitudes we had before. It means we work really well together and mutual respect is very much part of working here."
- Senior staff encouraged nurses to conduct research and present posters as part of their post-registration intensive care course. There were several examples of these posted on the unit, such as the poster a nurse produced based on their research exploring the psychological needs of patients and their families in critical care. The posters were assessed as part of nurse achievement in the course.
- The practice nurse educator (PNE) and clinical nurse manager facilitated leadership succession training for nurses to ensure they progressed professionally with leadership skills. As part of this programme, nurses completed a reflective paper on the experience and used this to identify further areas for their development.
- The unit demonstrated an overall drive to embed learning and clinical development in the working culture. This included encouraging band five nurses to approach practice nurse educators for support and bedside learning. For example, band five nurses had undertaken a renal study day and a training day with an equipment technician. One nurse told us they had previously completed a student rotation on the unit and was then proactively contacted for a future post, which they felt demonstrated the positive working relationships with senior staff and the respect they facilitated in the unit.
- The PNE provided training to band five nurses in prioritising care plans and workload planning and

supporting the shift leader. An HCA told us they felt training support from the nurse team was very good. They said, "I could do blood gases but didn't completely understand what it meant so a nurse really took the time to show me. That's the sort of learning culture I enjoy here." A senior nurse told us support from the PNE to complete training was very good but the trust would not always agree to protected time for this, which meant only staff who could take this in their own unpaid time had access to it.

- The PNE was supportive of HCAs who wanted to take a progressive approach to their professional development. For example, one HCA was supported to find a suitable place to finish their GCSEs and then to complete a university Access course, as a precursor to their degree.
- **Public engagement**
- Staff offered relatives and visitors the chance to speak with a senior member of staff at any time through posters advising this in the quiet rooms. Staff said relatives often took them up on this and because they worked to have such a positive and inclusive environment, relatives offered approached them informally to chat and offer feedback.
- The unit contributed to the Friends and Family Test, which was advertised in relatives' areas by posters that explained the purpose of the survey.
- **Staff engagement**
- The ICM management team provided feedback to staff through band seven nurse meetings, a staff communication book and e-mail. The clinical nurse manager provided a monthly unit briefing to discuss changes in policies, incidents and to introduce new members of staff.
- A support network for BME staff was available in line with the broader trust policy on diversity and inclusion. This group advertised funded professional development workshops to staff. We spoke with senior staff about the trust's wider BME policy. One individual told us they were "very disappointed" with the lack of oversight from human resources in ensuring the policy worked to engage all staff. They said the department was very proud of the diversity of its staff team but the lack of guidance meant it was difficult to provide support and guidance to staff when they faced challenging situations.
- Senior nurses told us there was no forum such as an away day whereby they could have protected time together to discuss unit development and problem-solving. They said this meant communicated was limited and had resulted in a team with reduced cohesiveness.
- Staff told us engagement could be improved in the unit and said a band seven nurse was planning to trial a period of daily 1pm safety briefs to help improve communication during shifts.
- As a strategy to further improve the incident reporting culture, a staff safety meeting was planned for 2016/17 to identify areas for enhancing performance.
- **Innovation, improvement and sustainability**
- The critical care outreach team had a focus on improving the service and extending the scope of support they were able to provide. For example, the team had completed a scoping exercise to see if treatment escalation plans would benefit patient outcomes. They had submitted their work to the Resuscitation Council and were awaiting their feedback before deciding whether to implement them substantively. In addition, the team were conducting a data entry exercise with the electronic patient tracking system used by the wards to identify how they could increase the number of patient reviews they completed for those who needed a complex discharge plan. This team also had a band six developmental nurse post who was planning to introduce a rotational rota, whereby they would work between the outreach team and on the critical care unit to provide a substantive clinical liaison between the two teams.
- Nurses were encouraged to lead their own research projects, often as part of their study for post-registration in critical care. Nurses prepared posters of their projects and displayed them in the unit to share with colleagues. One nurse recommended daily care plans be adapted to include a subheading of 'psychological care' to encourage staff to commence a patient diary and to write in it daily. Another poster described the optimal process to use for referring staff to the specialist nurses in organ donation in accordance with critical care best practice. Staff implemented the recommendations from both projects in practice.

Critical care

- A critical care outreach nurse had won the Kent, Surrey and Sussex Academic Health Network Safety award 2015 for their work to embed a daily meeting and handover into the work of the medical emergency team.
- The critical care outreach lead nurse had led a project to implement a standard operating procedure (SOP) for the safe transfer of critical care patients. The project led to a seven-step transfer protocol based on published research from multi-disciplinary sectors as well as guidance from the Intensive Care Society and the World Health Organisation. The SOP was embedded in critical care practice and the nurse who completed the research presented the outcome at a British Association of Critical Care Nurses conference, demonstrating the unit's commitment to quality improvement and good patient outcomes through the development of research-led practice.

Maternity and gynaecology

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

Information about the service

Brighton and Sussex University Hospitals NHS Trust's maternity and gynaecology services are managed across two main sites: Princess Royal Hospital at Haywards Heath and The Royal Sussex County in Brighton. The two main sites are approximately 15 miles apart. In the 12 months between July 2014 and June 2015, 5,763 women delivered their babies across the trust, either in hospital units or at home. This was an average of approximately 480 deliveries each month.

The rate of births remained constant in the nine months between April and December 2015. On average there were 207 deliveries a month at the Princess Royal Hospital.

Princess Royal Hospital provides gynaecology services including outpatient clinics and an early pregnancy unit for women experiencing difficulties in the first few weeks of pregnancy. There is also a 12–bedded gynaecology ward (Horsted Keynes Ward) for women before and after surgery. This ward had a six bedded bay and six side rooms, mainly used for termination of pregnancy and miscarriages. There was no emergency gynaecology service at the Princess Royal Hospital

There are antenatal services including a range of clinics for pregnant women attending for a first booking appointment and for women considering the options available for the birth of their baby. There are also consultant-led clinics and clinics for conditions such as diabetes. Specialist midwifes in teenage pregnancy, homelessness and substance misuse run clinics in the community. Clinics had been moving out of GP practices and into other facilities in the hospital and community.

There is a day assessment unit in the antenatal clinic, a triage service and an eight-bedded labour ward, with mostly ensuite facilities. Bolney ward is a combined antenatal and postnatal ward with 25 beds.

There is a neonatal special care baby unit at Princess Royal Hospital. However, if a women was likely to deliver her baby before 34 weeks gestation, she would give birth at the Royal Sussex County Hospital in Brighton where there is a neonatal intensive care unit (the Trevor Mann Baby Unit).

Three teams provided community midwifery services, covering the whole of the Brighton and Sussex University Hospitals NHS Trust community area.

Because the service was busy, staff were not able to leave the wards and units, so we were not able to hold a discussion in a focus group. We spoke with approximately 30 members of staff at Princess Royal Hospital at all levels and from both gynaecology and maternity. We spoke with specialist midwives and managers working at ward level and across both sites. We spoke with ten patients from the gynaecology and maternity service. We also looked at ten sets of patient records.

Maternity and gynaecology

Summary of findings

Overall we found the maternity and gynaecology services at the Princess Royal Hospital to be requiring improvement. This was because:

- The interpersonal issues between some consultants undermined the performance of this service. While some staff identified improvements in working relationships, in the areas of governance and risk, the service experienced setbacks in 2014 from which it had only begun to recover and progress in 2015 and 2016. All consultants were yet to engage and participate fully in areas; including investigating serious incidents, reviewing and updating protocols and attending safety and quality meetings.
- Midwives reported on staff shortages and some staff expressed their concern about the potential risks to women and their babies. They told us staff routinely covered vacant shifts, could not always take breaks during 12-hour shifts and provided the scrub practitioner role in theatre. The service also identified risks from the shortage of medical staff, the high use of locum cover and the failure to achieve waiting time targets in gynaecology.
- The service had some of the best rates across England, for home birth and for breast feeding. In addition, the trust had appointed three new consultants and they were making a positive contribution to the service. Patient records were up-to-date and accurate and the areas we visited were clean. The service had responded to the local demand for variety of menus and alternative treatments in the form of aroma therapy. The service had introduced an advanced recovery programme in gynaecology. They ran one-stop clinics for women and their babies who were vulnerable as a result of their circumstances.
- The service had a committed team of midwives and nurses and an active Maternity Services Liaison Committee with participation from local parents and their families.

Are maternity and gynaecology services safe?

Requires improvement

We rated the maternity and gynaecology services at the Princess Royal Hospital as requires improvement for Safety. This was because:

- All areas of the service had staffing shortages. Staff worked across the service and units in antenatal, postnatal and the labour ward. This was worsened as midwives had to attend the obstetrics theatre to provide assistance for elective caesarean sections.
- Because of staff shortages, the gynaecology staff were not fully involved with the safety and quality processes.
- Some consultants did not engage with each other in the safety aspects of the service. There was a high use of locum doctors.
- Attendance at mandatory training was affected by the staff shortages and compliance from medical staff was particularly poor

However:

- The service had cleared a backlog of incidents in March 2015. At the time of our inspection incidents were being investigated and lessons learned shared.
- We found that the wards and units were clean and infection prevention controls in place. Medicines were stored safely and we saw a good standard of record keeping.
- **Incidents**
- We were informed that a backlog of incidents had been investigated by March 2015 and all serious investigations were conducted on time throughout 2015 and early 2016. This was also reflected in a newsletter listing “Key Project Achievements”.
- There were no never events reported in maternity and gynaecology at Royal Sussex County Hospital in the year from January 2015 until April 2016. A never event is a serious incident that is wholly avoidable if systems were working as they should.
- In the same period, staff in obstetrics and gynaecology reported 1,620 incidents. The maternity department accounted for 1,400 incidents and 220 incidents were

from gynaecology services. These incidents were all categorised as causing either no harm, or low to moderate harm. We saw the service had a trigger list for incidents that should be reported

- Staff told us they completed incident reports for issues involving the safety of patients, visitors or staff. Staff gave us examples of incidents and changes made as a result of reporting an incident
- Some staff we spoke with on labour and Bolney Wards told us they did not always complete an incident form to report staff shortages. They felt nothing changed as a result of reporting incidents.
- Managers analysed incidents so the service could identify any trends and take appropriately focused action. The recent trends identified from incidents in maternity included the transfer of babies requiring neonatal services, avoidable repeat new born blood spot screening and communication issues surrounding individual and multidisciplinary team working.
- We saw from the notes of the Women's Services safety and quality meeting in February 2015 that the service took appropriate action in relation to the trends identified. For example, we saw continuous audits recording the reason for a repeat new-born blood spot screening. There was a note from the antenatal screening coordinator about quality control changes that would affect spot samples. Two senior midwives had taken responsibility for on-going work designed to improve adherence to the protocol in order to reduce the number of repeat screening tests
- We saw reminders about the importance of effective communication and involving women in all aspects of their care in the monthly newsletter for staff in maternity and obstetrics. We also saw bulletins entitled 'lessons learned from good practice from incident themes'.
- In gynaecology, the main trends with incidents related to inadequate and missing documentation, medication errors and lack of consultant cover.
- There were no serious incidents reported in gynaecology from January to December 2015, but staff reported three incidents in maternity services in 2015. The service investigated all three incidents to establish the facts, to determine whether failings occurred in care or treatment and to identify lessons learnt for sharing.
- Staff told us all serious investigations had been completed on time in the last year. We saw a newsletter which indicated this had been achieved.
- In the monthly newsletter for staff in maternity and obstetrics, we saw reminders about the importance of effective communication and involving women in all aspects of their care. We also saw bulletins showing what lessons had been learnt. Staff told us the service had a process of highlighting, "Lessons for the Week" from the weekly incident review meetings. We saw the, "lesson of the week" on staff noticeboards. In addition, we heard discussions at handover meetings of the lesson for the week of our visit, which was about protecting a woman's confidentiality when discussing her clinical history if she is not alone during a consultation.
- Staff informed us that the process of learning lessons and improving practice from individual birth stories was being re-introduced within the service. We saw examples of the birth stories and the lessons for the service.
- **Safety thermometer**
- The NHS Safety Thermometer is a monthly point prevalent audit of avoidable harm including new pressure ulcers, catheter urinary tract infections and falls.
- The NHS Safety Thermometer information for measuring, monitoring and analysing harm to patients and harm free care is collected monthly.
- We saw a poster on the noticeboard on Horsted Keynes ward with details of infections on the ward and details supplied for the safety thermometer. The poster was for March 2016 and said that there had been no cases of Methicillin-resistant Staphylococcus Aureus (MRSA), one case of Clostridium Difficile (C diff), one fall and one occurrence of pressure damage.
- We saw data for the 12 months from April 2015 to March 2016 on the Horsted Keynes ward. It indicated, there had been three infections arising from the use of a catheter and three pressure ulcers.
- There were no incidents reported on the safety thermometer for Bolney Ward and the labour Ward for the same period.
- **Cleanliness, infection control and hygiene**
- The national specifications for cleanliness (NSC) requires all staff to have a work schedule, when we asked for this document we were told that the trust does not have these in place.
- The NSC states: 'Management of staff - All levels of the cleaning team should be clear about their roles and

responsibilities. Each member of staff should have a clear understanding of their specialised responsibility, in a form of a work schedule'. The risk of not having a work schedule is that staff do not know what another has done and areas could be missed

- The cleaner showed us the cleaning and infection control noticeboard on the Bolney Ward. We saw that the ward had a cleanliness score of 96%, which the cleaner told us was better than the 95% national average. The ward looked clean.
- We saw the service was using "I am clean" stickers and we saw plastic covers protected clean equipment.
- We saw sharps bins available in treatment areas where sharps may be used. This was in line with health and safety regulation 2013 (The sharps regulations), 5 (1) d. This requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw labels on sharps bins had signatures of staff, which indicated the date it was constructed, by whom and on what date.
- The ward manager told us there was an ensuite room on the Horsted Keynes Ward available for infectious patients. We saw that there was an isolation notice on the door, which was closed during our inspection. This was in line with the trusts infection control policy.
- Clinical staff were required to comply with the, '"five moments for hand hygiene" as set out by the World Health Organisation (2009) and with the Trust's own hand hygiene policy. We saw alcohol based hand sanitizer available on the wards and units in maternity and gynaecology at the hospital. We saw staff and patients' visitors use the hand sanitizer.
- We saw staff in clean uniform, bare skin below the elbows with long hair tied back. This was in line with the trusts uniform policy. One the midwives told us that it was practice on the labour ward not to leave a delivery room still wearing an apron and gloves .Staff should remove and dispose of these in the room. We saw midwives did not wear aprons and gloves in the corridors.
- We saw the results of hand hygiene audits. On Horsted Keynes ward from May 2015 to March 2016, the score was 100% compliance for five months, 95% or above compliance for four months and 93%, and worse than the trust target, for two months. From March 2015 to April 2016, Bolney Ward was 100% compliant for seven of the nine months, and 98% compliant for the remaining two months during this period. Hand hygiene audits on the central delivery suite showed 100% compliance over a six-month period.
- We saw a trust wide audit in line with the trust's MRSA screening policy. This policy required patients, admitted as emergencies, were screened within 24 hours. The policy required that elective admissions were screened at least two weeks before admission.
- During December 2015, the Infection Prevention Team visited and audited 14 patient areas across the trust. They asked 34 patients if they were screened for MRSA and all said they had. However, the documentation for six patients had not been completed fully.
- **Environment and equipment**
- Staff told us they were short of machines for recording foetal heartbeat and uterine contractions . There were five on the labour ward and just one on Bolney Ward. There was a process in place to sign in and out for a pack of equipment, a monitor to listen the baby's heartrate and a thermometer.
- We saw an asset and works log of equipment for preventive maintenance, servicing and repair at Princess Royal Hospital. The log included scales for weighing babies and monitoring equipment for listening the babies' heart rate. We saw stickers on equipment which indicated it had been serviced. We saw a glucose monitor present that had been calibrated.
- Community midwives had access to cars to use when in the community. Midwives checked equipment in the car at shift changeover.
- The labour ward had two pool rooms.
- There was one item on the Women's Services risk register which identified difficulties with the environment at Princess Royal Hospital. Doorways to side rooms were too narrow to allow a bed to pass through. The ward manager showed us the side rooms and we noticed that they were unoccupied, although the bays on the ward were full. The ward manager said that the side rooms were unoccupied because they were only suitable for women who were less likely to require bed evacuation in an emergency.
- We saw emergency equipment was available and ready to use. We saw the equipment was checked twice daily.
- **Medicines**

- On Horsted Keynes ward, we saw that intravenous fluids were stored in a secure area with keypad entry. We saw the drug fridge was locked and secure and the contents were in date. Staff checked the fridge temperature daily, and we saw that it was in the correct range from March 2016 to April 2016.
- We saw the medicines trolley on Horsted Keynes ward. We found 28 strips of various medications stored together without original packaging. There were no expiry dates on the strips, so it was not clear if they were in date. We told a nurse who agreed staff should return medications to their original packaging. This would reduce the risk of confusion with other medication and so they retained an expiry date.
- We checked the controlled drugs cupboard. It was locked, the stock was correct, and records indicated the appropriate checks had been done. However, staff did not record when a bottle of one liquid drug was opened which meant recording was incomplete. When we asked, staff confirmed that in the instance of an Oromorph spillage an incident form would be completed and the pharmacist informed.
- We saw that staff noted when there was a difference between controlled drug in stock and on record. However, staff did not record this as an incident. This meant they could not monitor trends in incidents involving drugs.
- Staff checked and recorded medicines required in an emergency on one record. We saw all drugs were stored and recorded appropriately. Staff told us the pharmacist visited daily to check also.
- We saw wall mounted lockable cupboards, were available on the Bolney and Horsted Keynes wards to keep personal pain relief medication securely by the bedside. Staff told us when women brought their own medicines in with them two nurses checked the medicines, in and out.
- **Records**
- Pregnant women had handheld records that they kept with them and they took to antenatal appointments and a "red book"' for their baby's medical records. We looked at four sets of patient records on the postnatal ward and a further four sets on the gynaecology ward.
- We found a high standard of record keeping. We found records contained reason for admission, an initial assessment of needs, short and long term goals and care plans.
- **Safeguarding**
- The service had a dedicated midwife for safeguarding, who worked 30 hours a week, covering maternity and the neonatal service. The lead was also a supervisor of midwives. The lead told us that if safeguarding issues arose, the community midwives would make an electronic referral.
- Staff completed a Common Assessment Framework and, where a woman had serious or complex needs, the safeguarding midwife would support the community midwife. Staff sent copies of the referral form to children's social services. The Safeguarding Midwife told us that that there were different pathways for East and West Sussex.
- The safeguarding midwife attended case conferences and core group meetings in the absence of the community midwife. Discharge planning meetings did not take place at the Royal Sussex County Hospital. Instead, comprehensive pre-birth plans were developed and these were in place from 36 weeks of pregnancy.
- Since September 2014, it has been mandatory for all acute trusts to provide a monthly report to the Department of Health on the number of patients who have had FGM or who have a family history of FGM. In addition, where FGM was identified in NHS patients, it was mandatory to record this in the patient's health record. We saw a clear process in place to facilitate this reporting requirement. We saw the protocol on Female Genital Mutilation (FGM). Staff received training on FGM as part of their mandatory training days.
- Staff gave us an example of identifying a baby at risk and raising a safeguarding alert. The case was discussed at the Safety and Quality meeting and we saw the minutes to confirm this. We saw safeguarding was a standing agenda item at these meetings.
- The safeguarding midwife told us community midwives received group supervision each month from the safeguarding midwife and 1:1 supervision from a community team leader. Midwives attended level 3 training as part of the mandatory training days.
- We saw attendance at level 3 safeguarding training was worse than the trust target of 100% for all staff groups. It was 86% for maternity management and specialist midwives and 84% for community midwives. Attendance was 36% for medical staff at Royal Sussex County Hospital. Nursing staff on gynaecology ward completed level 2 training and had a completion rate of

40%. This was not in line with in the Safeguarding Vulnerable Groups Act 2010 or the Royal College of Paediatrics' Child Health Guidance, 2010 which recommends staff interacting with children to attend level three safeguarding training.

- **Mandatory training**

- The hospital failed to meet mandatory training target of 95% for any staff group in women's services. Average completion rates for mandatory training overall for the 12 months from April 2014 to March 2015 were 49% for Bolney Ward, 35% for community midwives and 44% for Horsted Keynes. Obstetrics and gynaecology medical staff in Princes Royal Hospital only achieved a 29% completion rate, which was much worse than the trust target of 95%.
- Completion rates for individual modules on Bolney Ward were 54% for equality and diversity, 65% for fire safety, 100% for manual handling and 95% for safeguarding adults. Completion rates for training on sharps and splash injuries was 35% on Bolney Ward, which was much worse than the 100% trust target.
- Completion rates for individual modules on Bolney Ward were 25% for equality and diversity, 50% for fire safety, 44% for manual handling and 19% for safeguarding adults. Completion rates for training on sharps and splash injuries was 38% on Horsted Keynes Ward, which was much worse than the 100% trust target.
- We saw training attendance was a standing item on the Safety and Quality meeting agenda and managers monitored this. Areas of concern were overall completion rates, attendance by consultants, e-learning, equality and diversity and training on the mental capacity act.
- We spoke to midwives who told us it was to attend training when the service was so busy. Another midwife told us they had to attend study days in their own time because of staff shortages. This was not in line with the trusts mandatory training policy.

- **Assessing and responding to patient risk**

- Staff used obstetric early warning charts, knew what to look for and how to respond to concerns. We saw completed charts, with scores calculated, observations documented and escalated as required.
- We saw other systems were in place to assess and manage risk, including venous thromboembolism (VTE) assessments for the risk of a blood clot forming. However, we saw that compliance for VTE risks assessments completed across the trust in Women's service was 65%, which was below the target of 95%.
- We saw that the service used the Modified Early Warning Score (MEWS) to help identify a deteriorating patient. Where surgery had been involved, we saw staff completed the checklist for 5 steps to safer surgery and anaesthetic records.
- Staff used monitors to assess the foetal heart during pregnancy and labour for women with a pregnancy regarded as high risk. Such as those undergoing induction of labour or women with twin pregnancies.
- Staff told us the trust had conducted an audit of five steps for safer surgery at the hospital in March 2016. This audit included 14 theatre cases and found that the service was not compliant in any of the areas audited. For example, only 9 or the 14 women had a briefing before going to theatre and just 8 out of 14 had a debriefing in the recovery room. However, the audit did show that in all cases, the anaesthetist was present, the patient identity was confirmed in theatre and the procedure was discussed.
- We saw emergency evacuation equipment was available and ready to use in the birthing pool rooms.

- **Midwifery staffing**

- We looked at the trust's data for planned and actual staffing on the gynaecology ward and for maternity at from September to December 2015. This indicated the actual staff hours on the ward night and day, were less that the planned hours from September to December 2015. In gynaecology, the planned and actual hours were the same from September to December 2015.
- The Trust reported a midwife to birth ratio of 1:30 across the trust and at both of the main sites. This was equal to the trust target, but worse than the national average of 1:27. The Trust had a target of 100% 1:1 care in labour. The average rate for the hospital between April and December 2015 was 97%.
- The Women's Services performance scorecard for April to September 2015 demonstrated an average vacancy rate of 3.7%, which was below the target of 8%. In addition, staff told several members of staff were taking maternity leave with no cover provided. The sickness absence rate of just over 5% was worse than the trust target of 2.9% and the trust overall average of 4%.

Maternity and gynaecology

- Data from August 2015 showed Bolney Ward had the highest sickness absence rate of 10.4%. Community midwives had the biggest improvement in absence rates from 5.4% in July 2015 to 2.4% in August 2015.
- The staff turnover rate of 14.2% was worse than the trust target of 11.5%. Bolney Ward had a turnover rate of 18.6%.
- The service did not use agency staff often but employed its existing staff undertaking additional shifts as part of the trust 'bank'. The highest use of bank and agency staff was on Horsted Keynes ward with 18%, compared to 8% on Bolney Ward. Both wards were better than the trust average rate of 21%.
- Midwives, maternity care workers and managers all told us staffing levels were a problem across the service, including at Princess Royal Hospital. We were aware during our inspection staff were unable to leave the busy wards and units to attend a focus group and instead they came to see us individually. They all said that staffing levels were a 'struggle' at Princess Royal Hospital.
- Managers told us there was a work force planning tool in use at the hospital to monitor 1:1 care of women in labour, but that an overall staffing audit had not been completed for some time. The Head of Midwifery told us she was planning to conduct a review of staffing using acuity work force planning tool at the end of the summer.
- Staff told us the maternity service, across the wards and units at Princess Royal Hospital, should have nine registered midwives on duty every shift. On the day we visited there were six midwives on duty and just five midwives were expected for the night shift. There was also a maternity care worker and a nursery nurse.
- We looked at the trust's data for planned and actual staffing on Bolney Ward for September to December 2015. This demonstrated that the actual midwives and care staff hours on the ward, night and day, were less that the planned hours for September, October and December 2015. In November, the planned and actual hours of care staff in the day night matched, but during the day and night shifts, actual midwives' hours were fewer than planned and there were fewer actual care staff night time hours than planned. The difference between planned and actual midwife hours for night time shifts in September was 644 hours.
- Staff told us they were sometimes unable to spend enough time supporting women with breastfeeding. Staff told us management moved midwives rostered to work on Bolney Ward to the Central Delivery Suite almost daily. This was to maintain the staffing levels needed to provide one to one care for women in established labour when the planned number of midwives were not on shift. The unit's incident log showed that on eight occasions between February 2015 and January 2016, staff had felt unable to provide adequate care to postnatal women due to lack of staffing. On one of these occasions, it was stated, 'some basic care may not have been given, or given later than ideal'.
- We looked at the rotas on Bolney Ward for the week beginning 31 March 2016. During that week there were 21 shifts: early, late and night time shifts. Only one of the 21 shifts had the full quota of nine midwives on duty. Five shifts had eight midwives, eight shifts had seven midwives and seven had six midwives.
- Staff told us this level of understaffing was not unusual and that, in recent months, the service had rarely been fully staffed. They told us in these circumstances they would prioritise the labour ward, as the most high risk area. If it became busy they would take midwives off Bolney Ward and close the triage unit.
- The triage unit was closed on the morning of our inspection and all calls were transferred to the labour ward. In addition, staff told us the Royal Sussex County Hospital was busy and had invoked the escalation procedure and sent all women in labour from the Royal Sussex County Hospital that day. The service delayed induction of labour and elective caesarean operations as a result. The triage unit opened again in the afternoon.
- We asked the midwives on the ward if they completed incident forms for the shifts that had been below the intended staffing level. They told us that these levels had become "the norm" and they did not fill incident forms in every day. The directorate manager was aware of this.
- Staff told us they had to attend the obstetrics theatre to provide assistance to the doctor during the day time shifts. This was not in line with the consensus statement on staffing obstetric theatres agreed by the College of Operating Department Practitioners, The Royal College of Midwives and Association for Perioperative Practice, published in May 2009 which agreed that 'the midwife's primary responsibility in the theatre setting is to the mother and her baby' .

- Staff felt the staffing levels compromised care, they told us work like breastfeeding support and routine observations are delayed when it was busy. They also told us that sometimes they did not have time to take their breaks and, one midwife told us, "A pregnant midwife was working 13½ hours shifts without a break recently because of the low staffing levels". Sometimes a midwife was asked to cover the triage and the day assessment unit simultaneously, which meant that the telephones could not be answered promptly.
- In addition to the hospital based midwives, there were also 52, whole time equivalent, community based midwives divided into three geographical teams. The full-time community midwives each had a caseload of approximately 110 women and full-time staff also held two clinics a week. There was also a home birth team made up of a midwife from each team completing a 12½ hour shift. The home birth midwife could also work on Bolney Ward at night time until they received a call to attend a home birth.
- We were informed that the whole service had only closed once in the last 18 months, but that the closure of one site and diversion to the other was a frequent occurrence. Midwives tended not to work across both sites.
- We saw data for planned staffing levels for Horsted Keynes ward from September to December 2015. We found that, in most cases the planned and actual hours were similar. The ward manager said that there were two nursing vacancies and plans were in place to fill the posts shortly. In the meantime extra shifts were being covered by existing staff.
- **Medical staffing**
- Overall, there were 58 doctors, which included 14 consultants. The mix between consultant, middle grade, registrar and junior doctors was similar to the England average. Some doctors worked across both sites, others just at one site. Most of the consultants covered both obstetrics and gynaecology.
- Lack of obstetric staff was an item on the risk register that had been rated as a major risk and "was almost certain to happen. There was no action plan for the management of this risk.
- The Clinical Director told us, they had recently altered the rotas on both sites to introduce 24-hour consultant cover. This meant that the consultant on duty during the day time was also on-call for the rest of the 24-hour period. The Clinical Director said that this had improved patient management during the day and overnight. Not all consultants carried pagers; some had mobile phones and could not be contacted if in an area of poor phone reception. Not all consultants could be on-call and five consultants were contributing to an on-call rota designed for 7 to 8 consultants.
- We saw that, for the 12 month period from April 2014 to March 2015, obstetrics and gynaecology made the greatest use of locum medical staff across the trust with an average of 11%. This was much worse than the trust average of 5% for the same period.
- **Major incident awareness and training**
- We saw a copy of the trust wide emergency preparedness, resilience and response policy which included a business continuity plan. Staff we spoke with told us major incident planning information was available to all staff on the trust intranet and one of the managers showed us how to access it.
- Staff had not received any major incident training. They told us one of the maternity and gynaecology managers for Princess Royal Hospital had attended a major incident training day on behalf of the service. This manager was due to feedback to colleagues from both trust sites at the next departmental meeting.

Are maternity and gynaecology services effective?

Requires improvement

We rated the maternity and gynaecology services at the Princess Royal Hospital as requires improvement for effective. This was because:

- Seventy eight percent of the services clinical guidelines and protocols were due for review in February 2015. Staff told us doctors did not interpret protocols in the same way, which caused variation in patient management.
- Multi-disciplinary working within the service was effective in some areas, such as in the 'one-stop clinics'.
- Despite improvements, some challenging behaviours were still an obstacle to team working.

However:

Maternity and gynaecology

- The service was rated as one the top ten maternity services in the country for breastfeeding. In addition, the home birth rates were one of the best in the country and first bookings were occurring within 12 weeks and six days of pregnancy for 92% of women.
- **Evidence-based care and treatment**
- Women using the services of the trust were receiving care in line with the National Institute for Health and Care Excellence (NICE). For example, routine antenatal care was delivered in accordance with NICE standard 22, including screening tests for complications of pregnancy.
- We saw from the review documents, in February 2015, 78% of maternity and gynaecology clinical guidelines were out-of-date. This matter was entered on to the risk register and an action plan prepared to bring all clinical guidance up-to-date by December 2015. We saw a report dated March 2016 which reported that the majority of guidelines had been reviewed and updated, however 28 guidelines were still outstanding.
- We also saw patient leaflets were produced in line with national institute for health and Care Excellence (NICE) guidelines. For example, one we saw provided information on procedures, such as induction of labour and nausea and vomiting in pregnancy, which was in line with NICE guidance.
- The trust had an ongoing programme of local audits, which we saw. The audits demonstrated achieving outcomes in line with national standards. The trust also used audits to monitor the implementation of new programmes and ways of working.
- **Pain relief**
- A variety of pain relief was available to pregnant women. Nursing and medical staff could give a range of medicines, women could bring their own transcutaneous electrical nerve stimulation (TENS) machine and three birthing pools were available. Doctors were available to insert epidurals if required.
- Pregnant women had hand held notes which provided information on pain relief. There were also leaflets available in the clinics and on the trust website. The leaflets set out options such as using transcutaneous electrical nerve stimulation (TENS) or Entonox or pethidine.
- We spoke to patients on the gynaecology ward who told us they had received good pain control after surgery.
- **Nutrition and hydration**
- The service was in the top ten maternity services in the country for encouraging and supporting women to breastfeed their babies following birth. Figures released by NHS England showed the Trust had a breastfeeding initiation rate of 91%, which was the tenth best nationally and the best in the Kent, Surrey and Sussex area.
- At the time of our inspection, breastfeeding initiation rates at the hospital were on average 88%, which was better than the better than the trust target of 85%.
- We saw a drinks machine available on the Horsted Keynes ward all day to supply hot drinks for patients. Meals could be ordered from the kitchen outside normal meal times. Bread was available on the ward for toast. Women we spoke with on the ward said that they were happy with the food and that the nurses were attentive in providing drinks. Special diets could be catered for.
- The trust used the "malnutrition universal screening tool" to identify patients who are malnourished, at risk of malnutrition or obese. A dietician was available to support patients identified in those categories.
- There were midwives, maternity support workers and nursery nurses available to help mothers with feeding their babies. Women we spoke with on Bolney Ward were happy with the new-born feeding support they received.
- **Patient outcomes**
- There were no patient outcomes that fall considerably outside of the England averages for the trust as at January 2016.
- From April 2015 to December 2015 there was an average of 207 delivers a month at Princess Royal Hospital.
- Eight babies were transferred to the Special Care Baby Unit at Princess Royal Hospital in the year from April 2014 to March 2015. In the same period there were 18 stillbirths across the trust and two early neonatal deaths. Between April 2015 and December 2015 there were no early neonatal deaths at Princess Royal Hospital.
- Deliveries for the first quarter of 2015/16 across the trust were 1,378 compared to 1,391 for the first quarter of 2014/15. This indicated the birth rate has been relatively stable in the last two years.
- Home birth rates for the Princess Royal Hospital catchment area have been an average of 2.4% of births for the period April to December 2015. The average rate for the Trust overall for this period was 4.4%.

Maternity and gynaecology

- The rate of elective caesarean rate at Princess Royal Hospital was 17.1% of births at the hospital, which is higher than the Trust target of 10%.The emergency caesarean section rate was an average of 13.4% at Princess Royal from April to December 2015 which was worse than the Trust target of 13%. The rate peaked for the period in December 2015 when it was 18.2%.
- Between April 2014 and March 2015 there were 39 medical abortions at the Princess Royal Hospital and 122 surgical abortions.
- The hospital had a 50% success rate for women opting for normal deliver following a caesarean at the hospital between April and December 2015 which was worse than the target target success rate of 75%.
- From April 2015 to December 2015, the third or fourth degree tear rate was 5% for all patients.
- The trust recorded postpartum haemorrhage above 2.5 litres on the dashboard from April 2015 to December 2015. The hospital had 12 such haemorrhages which equated to 1% of patients at the hospital.
- **Competent staff**

- The service employed a clinical skills facilitator to support staff and the Maternity, Obstetrics and Gynaecology Newsletter provided updates on learning opportunities on antenatal screening for example and on developments within the service. The Lesson of the Week, circulated in bulletins and repeated at the daily handover meetings, reinforced areas for attention such as the mental capacity Act. Introducing opportunities for learning in the daily routine helped the staff remain up-to-date in a busy service.
- There were quarterly 'away days' for staff working in gynaecology and we saw from meeting minutes that these were well attended. Staff told us that they were able to attend every other session as they needed to provide cover on the ward and the gynaecology assessment unit. Staff told us previous themes at away days had included mental capacity, audits, completion of patient records and preparation for this inspection. This contributed to maintaining their registration with the nursing and midwifery council (NMC).
- Staff told us they felt a mentorship programme for students was effective. The clinical skills facilitators monitored a student's progress.
- Staff told us they were encouraged to work towards promotion. They were also encouraged to learn new skills to assist women with aromatherapy for example and they had introduced the advanced recovery pathway in gynaecology and more recently in obstetrics.
- There was no education lead for doctors across the trust.
- The rate of completion of appraisals across Women's services in November 2015 was 78.8%, which was better than the Trust target of 75%.
- **Multidisciplinary working**

- Staff told us multidisciplinary working was poor between some consultants and the rest of the team. We spoke with several consultants who confirmed that these problems were ongoing and team working was still difficult.
- However, managers and staff told us there had been improvements following the intervention of an external facilitator at directorate meetings. They told us a multi-disciplinary review of incidents took place every Tuesday and covered maternity and gynaecology. We saw minutes of these meetings.
- We saw shared working within the midwifery team and between clinicians and midwives on the labour ward at Princess Royal Hospital. We spoke with staff providing support with new-born hearing, maternity support, and breastfeeding.
- **Seven-day services**

- Consultant cover 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 and seven days a week.
- The gynaecology assessment unit provided a service 24-hour a day and seven days a week.
- A 24-hour, seven days a week telephone triage service was not always available, due to low staffing levels.
- **Access to information**

- Guidelines and protocols were available to staff on the Trust intranet. The same guidance was used across both sites. Community midwives had remote access to the trusts information systems.
- **Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- We saw the trust's policy on the Mental Capacity Act, 2005 and we saw that a session on the Act was included in the midwives induction training.

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- Staff told us the community midwife completed the consent paperwork for antenatal screening at the woman's first booking appointment. We saw copies of signed consent forms in records we looked at.
- We saw the results of an audit of a procedure used to examine the inside of the womb, which was carried out in September 2015. The audit found not all women gave written consent to the procedure.
- We saw completed consent paperwork in medical records we looked at. Staff could describe the process of completing a separate consent form for termination of pregnancy and showed us we where they were kept.
- We saw a variety of information for women which provided options for care and treatment so they could fully consent to treatment. Patients told us they received clear explanation's and options for their care. For example, there was a detailed leaflet about hysteroscopy explaining the procedure, the risks of the procedure and any alternatives.

Are maternity and gynaecology services caring?

Good

We rated the maternity and gynaecology services at the Princess Royal Hospital as good for caring. This was because:

- We saw feedback from women and their families which was positive.
- Midwives, nurses and doctors were described as 'kind', 'attentive' and 'caring'.
- We observed staff dealing with patients in a kind and considerate matter.
- **Compassionate care**
- We saw feedback from patients on the Horsted Keynes ward collected via the 'Patient voice for Gynaecology' in November 2015. The feedback was positive. One patient said, 'I have been treated with the utmost kindness and care in every way', another woman said 'the ward manager and her team treated me with care and compassion and made my stay as comfortable as possible'.
- The Mid Sussex Maternity Services Liaison Committee provided positive feedback on the care provided on the labour ward and theatres.
- We spoke with women on Bolney Ward, all were positive about the care they received at the Princess Royal Hospital. They told us the care was very good and they had received clear explanations.
- The friends and family test has varied across the period from December 2014 and December 2015 for the postnatal wards and for postnatal community provision. It has been below the England average for five of the 12 months. However, antenatal, birth and postnatal scores were better than the England average for the majority of the time period.
- The Care Quality Commission (CQC) Maternity Survey results for 2015 demonstrated t the trust performed as well as other Trusts in response to all the areas of questioning . In two questions, it performed better than other trusts. The questions where the Trust performed better than the England average were both in relation to labour and birth and one was about mothers having early skin to skin contact with their babies.
- We saw a written complaint from another patient, who felt concerned that the nursing staff were under pressure due to the needs of the other patients on the ward and this had a negative impact on the care she received.
- **Understanding and involvement of patients and those close to them**
- The second question in the CQC maternity survey where the Trust performed better than the England average was for the question, 'If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted? The Trust scored 9.8 out of 10 for this question.
- Patients told us, "The nurses have been outstanding, always ensuring I'm comfortable, answering questions fully and honestly. They've all been approachable and made the process less daunting through their friendliness and humour', They told us all the explanations were clear, the nursing staff all introduced themselves and answered call bells promptly.
- **Emotional support**
- There was a specialist bereavement midwife at the hospital working one day a week to cover the maternity and the gynaecology wards. The bereavement midwife offered support to women with subsequent pregnancies after a pregnancy loss. In addition to this, staff could refer women and their families to local charitable organisations offering bereavement counselling.

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- We spoke with a woman who had transferred from the Royal Sussex County for care for her baby, born at 34 weeks, in the Special Care Baby Unit. She told us that she was grateful to the nurses for the care and emotional support.

Are maternity and gynaecology services responsive?

Requires improvement

We rated the maternity and gynaecology services at the Princess Royal Hospital as requires improvement for responsive. This was because:

- Some people were unable to access services for treatment when they need to. The hospital did not take the needs of some patients into account when planning services.
- The trust failed to meet national referral to treatment (RTT) waiting time targets for gynaecology.
- Low midwifery staffing numbers meant the unit was unable to maintain a 24-hour maternity triage service. Insufficient staff numbers on the wards meant staff were unable to respond to women's needs.

However:

- The service provided specialist antenatal services for women who were vulnerable as a result of their circumstances. This included homeless people and those with recreational drug or alcohol addiction. Translation services for women who spoke limited English were widely accessible. The service used complaints as an opportunity to learn.
- **Service planning and delivery to meet the needs of local people**
- For women who chose to give birth at home, the trust's community midwives ran a homebirth service that won the Royal College of Midwives Award for Better Births in 2016.
- Brighton and Sussex University Hospitals NHS Trust is one of the few remaining trusts in England that does not have a midwifery-led birth centre. This restricts choice over place of birth for low-risk women planning a normal birth in their local area.
- A manager told us that the trust was no longer able to deliver antenatal clinics from GP premises. The service had set up satellite clinics in Hove and was looking new locations for antenatal clinics. Clinics were running from Tuesday to Friday from three rooms. The next phase of this work was to open up a fourth room and offer clinics Monday to Friday.
- The trust offered aromatherapy, including aromatherapy massage, in labour for low-risk women who met criteria. The trust trained approximately 130 midwives to deliver this service, and it was available for women giving birth at home as well as those birthing in the trust's hospitals. We saw lots of positive feedback from women who used aromatherapy in labour. Women said they found aromatherapy "relaxing", that it provided an "immediate relief/distraction" and that it was "very calming". We saw clear patient information sheets describing the benefits, risks and availability of aromatherapy in labour.
- Experienced midwives ran a "birth options" clinic for pregnant women who had previously experienced a traumatic birth. Women saw a midwife at 22 weeks of pregnancy to discuss the options available to them and to make a plan for their forthcoming birth. Women then saw a consultant or registrar for review at 34 weeks of pregnancy.
- The Mid-Sussex Maternity Services Liaison Committee (MSLC) met once every two months. MSLCs provide a forum for women who have used maternity services and their representatives to meet with hospital staff and work together to drive improvements in services. We saw recent MSLC meeting minutes, which showed a representation from community groups, service users and hospital staff.
- Staff told us Bolney ward allowed partners to stay overnight following the birth of their child if they wanted to.
- **Access and flow**

- The trust failed to meet its waiting times for referral to treatment (RTT) for the majority of the last year.
- In gynaecology, the trust failed to meet the standard of 92%. In March 2016, 89.3% of patients were waiting within 18 weeks. At that time, 1,564 patients were waiting to start treatment.
- The most recent data for suspected gynaecological cancers indicated 96% of patients were seen in two weeks. This was better than the England average of 95% and the standard of 93%.

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- Trust data indicated from January to September 2015, 33.3% of patients waited six weeks or longer for diagnostic tests. This was considerably worse than the trust target of 1%.
- During the same period, 3.1% of patients had their operation cancelled at the last minute, worse than the target of 1%.
- Between July 2014 and June 2015, 5,763 women gave birth within the trust. This was higher than most other NHS trusts in England. The labour ward at Royal Sussex County Hospital (RSCH) saw women with 'high-risk' pregnancies within the trust as they had a level three neonatal intensive care unit. High-risk pregnancies include women with underlying medical conditions, such as gestational diabetes or pre-eclampsia, as well as women with multiple pregnancies.
- The target for patients receiving outpatient treatment within 18 weeks of referral was 95% and the trust achieved this in 92.8% of cases.
- The maternity unit sometimes sent women in labour to the Royal Sussex County Hospital (RSCH) when the central delivery suite was full. Moving to a different hospital during labour prevents women from receiving care at the setting of their choice and may cause anxiety for some women.
- Data indicated the central delivery suite was sent women to RSCH on 15 occasions from April to December 2015. On average, this was two women a month.
- Some women chose to use the enhanced recovery programme following surgery on Bolney and gynaecology wards. Research suggests if a patient gets out of bed, eats and drinks as soon as possible, their recovery from surgery is quicker and complications are less likely to develop. The ward was usually able to discharge women on the enhanced recovery programme one day after elective caesarean section if they were well enough. A short hospital stay following surgery may reduce the risk of complications associated with a longer stay, as well as improving patient flow on the ward. The postnatal ward worked with women to support them in this approach and we saw written information was available.
- On the gynaecology ward, Horsted Keynes, medical patients frequently occupied beds.. patients. We saw a policy stating clear acceptance criteria for medial outlier admission to the ward. However, staff told us the bed management team sometimes put pressure on them to ignore this policy and accept patients who did not meet criteria. Staff sometimes telephoned the ward manager for out of hours support when these situations occurred, although this was an informal arrangement between the ward manager and nursing staff on the ward.
- Staff told us they cared for eight medical patients on Horsted Keynes gynaecology ward two days before our visit. The ward had 12 beds in total.
- We saw nine incidents reported from January 2015 to December 2015 regarding lack of bed availability for gynaecology patients caused by medical outliers occupying beds. Staff confirmed that the hospital sometimes cancelled elective surgery for gynaecology patients when there was no bed available on Horsted Keynes for the patient to stay in after their surgery.
- Staff told us sometimes women were admitted to the spinal injury ward, before their operation when no bed was available on Horsted Keynes. Patients were transferred to Horsted Keynes after their surgery. Patients sometimes found this confusing as they were in an unfamiliar ward after their operation with staff they had not met before.
- **Meeting people's individual needs**

- The trust provided a multi-disciplinary, "One Stop" clinic on the second and fourth Thursdays of every month at the hospital for maternity patients with recreational drug or alcohol addiction in pregnancy. Patients who attended this clinic benefitted from additional time for antenatal appointments if they needed it. They were able to meet with other professionals involved in their care, such as mental health nurses and social workers, at the same times as their antenatal appointments. This reduced the number of separate appointments for patients and made it easier to access all the care they needed. Patients using the "one stop" saw the same midwife on each visit, and one of the two midwives coordinating the service told us she even visited patients on the postnatal wards after their babies were born.
- The midwives coordinating the "One Stop" clinic also provided specialist antenatal care for travellers and homeless women living in hostels or other temporary accommodation. A midwife told us they sometimes visited traveller's homes for routine antenatal appointments at a patient's request. A community midwife was the designated lead for teenage pregnancy.

Teenage girls also had antenatal home visits. Staff told us any woman who was vulnerable as a result of her circumstances was able to request antenatal appointments at home.

- The Lead Obstetrician ran a weekly multidisciplinary mental health clinic at the hospital, along with a psychiatrist, mental health nurse and administrator. Community midwives referred women with complex issues, such as phobias.
- Interpreters of many different languages were available throughout the trust from Sussex Interpreting Services. Staff told us the hospital used them to translate for patients who spoke limited English. We saw a patient attend a gynaecology clinic with an interpreter provided by the hospital.
- We saw some written information in different languages, including a patient booking form and an information sheet about vitamin K for new born babies. Trust maternity services provided lots of information for their patients on their website and advised patients who spoke other languages to copy and paste information from this website into an on line translating service. This enabled patients to access all the information they needed in their first language. The Community Midwifery Manager told us the trust plans to update the website with direct links to information leaflets in different languages.
- The Trust had lead midwives for teenage pregnancy, travellers alcohol and substance misuse. There was also an independent domestic violence advisor in the trust. They accepted referrals directly from women.
- Staff occasionally cared for patients living with dementia on Horsted Keynes gynaecology ward. Two dementia link nurses and one dementia link health care assistant (HCA) worked in this area. Not all, staff received dementia training. The ward manager gave an example of staff responding to a dementia patient's individual needs. The team on Horsted Keynes discovered that staff at the patients home wore pink uniforms. The staff member caring for the patient wore a pink top, which relaxed the patient.
- **Learning from complaints and concerns**
- Trust data showed that maternity and gynaecology services at RSCH received 51 complaints between February 2015 and February 2016. Of these, 25 related to maternity and obstetrics. The remaining 26 complaints concerned gynaecology. Some complaints concerned long waiting times for planned surgery. We saw that the hospital responded to complaints in line with the trust's complaints policy. We also saw that staff learnt from complaints. For example, we saw that the unit planned additional staff training following one complaint, and a change in procedure following lessons learnt from another.
- The trust website provided clear information on how to complain, as well as details of local advocacy services available to support patients and carers who wish to pursue a complaint. The trust website also gave information and contact details for patient advice and liaison service (PALS). This information was also available on the units we visited.
- Brighton and Hove MSLC met regularly. MSLCs provide a forum for women who have used maternity services and their representatives to meet with hospital staff and work together to drive improvements in services. We saw recent MSLC meeting minutes, which showed representation from community groups, service users and hospital staff. We saw an MSLC poster displayed outside the labour ward on level 13. This gave information and contact details for women who wanted to join.
- On the gynaecology ward, we saw a 'You Said, We Did' poster. This indicated the ward valued patient feedback, and used it to improve service. For example, the poster stated that patients wanted detachable showerheads, and the service installed them. It also said some patients felt that catering services did not adequately cater for special dietary needs. The Catering Manager subsequently visited the ward at a mealtime, and was using patient feedback to update menus.

Are maternity and gynaecology services well-led?

Requires improvement

We rated the maternity and gynaecology services at the Princess Royal Hospital as requires improvement for well led. This was because:

- A vision and strategy for the service had been developed, but the senior leadership team staff within the directorate had not been involved.

- The strategy did not address the immediate issues of staff shortages and there were no timescales for any of the strategic initiatives.
- Governance in gynaecology had no clear structure and staff from gynaecology rarely attended the safety and quality meetings for Women's Services.

However;

- Processes for incident reporting and investigations had been put in place and some guidelines brought up to date.
- **Vision and strategy for this service**
- We saw a copy of the document entitled 'developing a clinical strategy' produced in January 2016 by the management team of the Women's Directorate. This document included an analysis of current strengths, such as, the home birth rate, links with the University of Brighton midwifery school and the out-patient hysteroscopy service. Examples of weaknesses included the lack of a midwifery-led birthing unit, a constant caesarean section rate and the lack of a separate gynaecology and obstetrics on-call rota. The document also set out a vision for the service and some plans for the development of the service, particularly in foetal medicine and combining the day assessment units and triage at both sites.
- We asked the clinical director and head of midwifery how staff within the service had been involved in developing the strategy. The Head of Midwifery said that the Directorate was set up in its current form in May 2015, and that engagement with staff had been limited.
- **Governance, risk management and quality measurement**
- We saw a copy of the maternity risk management strategy. It was out of date for review. This strategy required the service to undertake prompt reporting and investigation of serious incidents and escalation to the Safety and Quality meeting. The strategy also required the service to identify trends within incident reporting in general and to conduct an annual review of safety and quality minutes to ensure trends were reported. These processes were now in place.
- The governance lead reported that there was no clear governance structure for gynaecology. We saw from the minutes of the safety and quality meetings that attendance from gynaecology staff was poor.
- The governance lead reported that lessons learnt were highlighted and a special edition newsletter was produced to share the lessons with the service. We saw copies of these newsletters and they contained lessons around continuous foetal monitoring, repairing faulty equipment and the impact of good multi-disciplinary team working.
- We saw from the Women's Services safety and quality meeting in November 2015 that incidents were closed within the required period of 45 days, monthly statics and trends were reported and lessons shared in a timely manner.
- In addition, the service had established a weekly multidisciplinary incident review meetings with clear terms of reference to act as a quality assurance, educational and development forum. The January 2016 update for staff reported, 'excellent nursing and midwifery attendance' and that the meeting time had just been changed to 'enhance and enrich attendance from medical colleagues'.
- We asked about attendance of medical staff at these meetings and were told, "progress was slow" but some staff were participating fully. Assurance could not be given that all staff were engaged with the governance systems.
- The governance lead had introduced a new process for panel investigations that was intended to be seen as 'just' and 'fair' because it has a clear protocol, made full use of accepted national guidelines. Panel members were selected on the basis of the clinical expertise required for the investigation.
- There were monthly safety and quality meetings, weekly incident review meetings and regular meetings on audit and morbidity. We saw minutes of these meeting.
- Staff told us perinatal mortality and morbidity meetings were held monthly with women's services and neonatology. We saw minutes of these meetings. Foetal loss was reported to, "Each Baby Counts". This is the Royal College of Obstetricians and Gynaecologists (RCOG's) national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour. Foetal and maternal loss was also reported to, "Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK". This is a national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths.

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- **Leadership of service**
- The trust had a manager based at each site and in the community. They reported to a directorate lead nurse along with the governance lead. Patient access managers reported to a directorate manager. The directorate lead nurse, directorate manager and principal lead consultants reported to the clinical director of the service.
- Staff felt a strong, committed and effective leadership was needed to tackle a legacy of challenging behaviours from some members of staff in the service. Overall, it was felt that, in recent months, there had been some progress but more was required. We found that, following three external reviews, a culture of mistrust amongst some members of staff persisted, which was an obstacle to team working, learning and development.
- The staff we spoke with in maternity and gynaecology felt that, at the time of our inspection, there was a lack of strong, visible leadership from both the clinical director and the head of midwifery.
- Staff told us, "Our manager is very visible and supportive" they are "highly visible and approachable." A senior nurse told us that training opportunities were available and she had recently attended the trust's two day course on leadership skills called 'leading the way'.
- Staff felt directors were occupied with other areas of the trust and were not able to give much attention to maternity and gynaecology.
- **Culture within the service**
- The midwives we spoke with said that the conduct and attendance at meetings was better than it had been. A mediator had been engaged to attend the meetings, but had now left. Several members of staff referred to the continuation of bullying behaviours. One senior midwife said, "We carry on in spite of the behaviour of the doctors".
- We asked several doctors, midwives and managers about the professional relationships between consultants. The majority view was that there had been some improvement, but there was further work to do. One consultant said, "I feel I am being treated with contempt", another said, "the same people are doing the same things since the last CQC inspection and they are still driving staff to go off sick with stress".
- Some staff told us the reluctance to participate in serious investigations was due to a "mistrust" amongst consultants. Staff told us, consultants were fearful of appearing to be critical of colleagues as this had led to a climate of "grievance and counter grievance". A letter, we saw from an external agency which confirmed this view and said, "The culture is more about defensiveness and self-protection than about individual and collective learning."
- Managers told us there had been problems arising out of cultural issues and the lack of engagement and teamwork amongst a group of consultants in obstetrics and gynaecology
- We also saw an action plan written in response to these issues and we saw that the recommendations to involve an external mediator and develop a leadership training programme, 'leading the way', had been implemented.
- Some midwives felt they formed an effective team at each site and worked well with the community midwives. However, some staff told us that there were tensions between the teams on each site and they struggled with staff shortages within the service. This happened when the service was busy and one site sent women to the other.
- **Public engagement**
- The service supported an active Maternity Services Liaison Committee (MSLC) at both sites. Patient representatives were able to support the service and contribute ideas and feedback. We saw minutes of these meetings.
- We saw some evidence of the NHS friends and family survey on the wards and units during our visit.
- **Staff engagement**
- We saw little evidence of staff engagement with the developing the clinical vision and strategy for the service.
- Staff told us that they completed the NHS staff survey. We saw an analysis of the report for the Women's Services Directorate which compared the responses with those from other Directorates. The Women's Directorate scored significantly better than the Trust average on eight questions including questions around support from immediate manager and recommending the organisation as a place to work.
- The service was worse than the average across the trust on two questions. The first was about 'not having

enough staff to do the job properly' and the second, 'putting myself under pressure to come to work despite not feeling well enough'. We did not see the response to this staff survey from the service.

- The manager informed us that, in order to integrate the hospital and community based midwives, an arrangement for buddying had been introduced. There were currently six pairs where hospital and community based midwives swapped roles every month to experience the role of their buddy.

- **Innovation, improvement and sustainability**
- The buddy scheme for the hospital-based and community midwives was an innovative way of reducing any feelings of 'them and us' between these groups of staff. The arrangement had six pairs of buddys there were plans to recruit more.

End of life care

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

Information about the service

Brighton and Sussex University Hospitals NHS Trust (BSUH) end of life care service was trust wide and led by two members of the executive team, the director of nursing and the medical director. Teams across a variety of directorates were involved in the provision of the service. These included the specialist palliative care team, ward staff, a non-clinical end of life care facilitator, bereavement office, mortuary, porters, chaplaincy, discharge team, critical care outreach team, resuscitation team, medical examiner and organ donation team.

The specialist palliative care team was made up of a multi professional team of health care professionals, supported by patient pathway coordinators and administrative staff. They operated a service Monday to Friday 9am to 5pm. Out of hours consultant telephone advice was available from the local hospice. The specialist palliative care team delivered palliative services to all clinical areas across the hospital and worked cohesively with all areas of the hospital involved in the care of patients who were on the end of life care plan.

During out visit to the Princess Royal Hospital, Haywards Heath, we spoke with the palliative care team, including palliative care consultants, and lead nurse, end of life care facilitator, porters, mortuary staff, and front line staff on the wards.

We visited a variety of wards across the hospital including wards: intensive care unit (ICU), Pyecombe, Ardingly, Ansty, Hurstpeirpoint, Balcombe, Clayton and the emergency department. We also visited the Patient Advice and Liaison (PALS) office, bereavement office and mortuary, and hospital chapel and prayer room. We reviewed the medical records and drug charts of five patients at the end of life and ten 'do not attempt cardio pulmonary resuscitation' (DNACPR) records.

We observed care provided by nursing staff on the wards. We reviewed information received from members of the public who contacted us separately to tell us about their experiences. We evaluated results of patient surveys and other performance information about the hospital and trust.

End of life care

Summary of findings

Overall we rated the end of life care service at the Princess Royal Hospital 'Good'. This was because:

- The hospital provided end of life care training for staff on induction and an ongoing education programme which was attended by staff. A current end of life care policy was evident and a steering group met regularly to ensure that a multidisciplinary approach was maintained.
- The specialist palliative care team were a dedicated team who worked with ward staff and other departments in the hospital to provide holistic care for patients with palliative and end of life care needs in line with national guidance.
- The Princess Royal Hospital and its staff recognised that provision of high quality, compassionate end of life care to its patients was the responsibility of all clinical staff that looked after patients at the end of life. They were supported by the palliative care team, end of life care guidelines and an education programme.
- The specialist palliative care team was highly thought of throughout the hospital and provided support to clinical staff. The team worked closely with the end of life care facilitator to provide education to nurses and health care assistants. Medical education was led by the medical consultants and all team members contributed to the education of the allied healthcare professionals.
- The majority of end of life care was provided by clinical staff on the wards. The palliative care service worked as an advisory service seeing patients with specialist palliative care needs, including those at the end of life.
- Staff at the hospital provided focused care for dying and deceased patients and their relatives. Most of the clinical areas in the hospital had an end of life care link person. Facilities were provided for relatives and the patient's cultural, religious and spiritual needs were respected.
- Staff in the mortuary, bereavement office, PALS and chaplaincy supported the palliative care teams and ward staff to provide dignified and compassionate care to end of life care patients and their relatives.
- Medical records and care plans were completed and contained individualised end of life care plans. Most contained discussions with families and recorded cultural assessments. The DNACPR forms were all completed as per national guidance.
- There was evidence that systems were in place for the referral of patients to the palliative care team for assessment and review to ensure patients received appropriate care and support. These referrals were seen and acted upon promptly.
- The trust had an advance care plan which supported a patient to develop their wishes and preferences. The plan could be located in the patient's health record on admission and was accessible to the out of hour's community service.
- The trust had a Rapid Discharge Pathway (RDP) and the documentation for this process was available on the end of life care intranet site which staff could access. The discharge team worked closely with the specialist palliative care team and coordinated the discharge of end of life care patients trust wide. The response time for discharge depended on the patients preferred place of care and what area the patient lived in.
- The trust had a multi professional end of life steering group that oversaw the improvement plans that were in place to support the work towards meeting the five priorities of care for end of life, and also meeting the National Institute of Health and Care Excellence's (NICE) end of life guidance.
- The end of life care service had board representation and was well led locally. This had resulted in a well led trust wide service that had a clear vision and strategy to provide a streamlined service for end of life care patients.

However we also found:

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- The trust was not meeting the requirements of three key performance indicators of the National Care of the Dying Audit 2014. In their response to the audit in the End of Life Audit- Dying in Hospital 2016 the trust was worse than the national average for two areas.
- There were inconsistencies in the documentation in the recording of spiritual assessments, Mental Capacity Act assessments and recording of ceilings of care (best practice to guide staff, who do not know the patient, to know the patients previously expressed wishes and/or limitations to their treatment) for patients with a DNACPR.
- Patients did not have access to a specialist palliative support, for care in the last days of life, as they did not have a service seven days a week.

Are end of life care services safe?

Good

We rated the end of life care service at the Princess Royal Hospital good for Safe. This was because:

- The service provided safe care for patients who were recognised to be in the last 12 months of their life.
- The trust used an electronic incident reporting system, and provided us with evidence of learning achieved and the resulting changes in practice that took place. Staff were encouraged to report incidents, and gave us examples of how they reported and the feedback they received. Incidents relevant to end of life care were not addressed at the end of life care steering group.
- There were robust systems and processes in place to ensure that a high standard of infection prevention and control were maintained on the wards. The wards and mortuary area were visibly clean and cleaning rotas were displayed. Staff in all departments could show appropriate hand hygiene. Personal Protective Equipment (PPE) was available for use by staff handling deceased patients in the mortuary. Mortuary training was available for porters on induction and on an annual basis
- Syringe drivers (a device which helps reduce symptoms by delivering a steady flow of injected medication continuously under the skin) were readily available across the trust to support end of life care patients. Staff reported they did not have any problems with obtaining them when required.
- We also saw documentation used in the mortuary for recording patients details and the bereavement officer explained the systems in place to process death, burial and cremation certificates.
- We reviewed five medical records and care plans of end of life care patients. We observed the appropriate prescribing of medication for patients who were end of life. The specialist palliative care team documented changes in patient care needs and the management of their medications in the records. We saw all records contained evidence of discussion with the family. However only one recorded contained evidence of the patient being assessed for their spiritual care.

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- The trust had a programme of end of life care training at induction for all staff in line with recommendations by the National Care of the Dying Audit 2014.
- **Incidents**
- The trust had an incident report writing policy and used an electronic incident reporting system. Permanent nursing and medical staff, porters, mortuary and administrative staff gave us examples of how they reported incidents and they received feedback. There is an area on the trust website for lessons learnt which staff can access individually or for discussion at team meetings. Staff told us the trust encouraged them to report incidents to help the whole organisation learn.
- There were no 'never events' reported by the trust about end of life care patients from December 2014 to January 2016. 'Never events' are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.
- Trust wide, 38 incidents had been reported related to end of life care patients from February 2015 to January 2016. Fifteen incidents were recorded as 'low impact' and 23 incidents 'no harm, impact not prevented'. Sixteen incidents recorded action taken and nine incidents recorded 'lessons learnt'.
- Twenty incidents were reported by the mortuary. Nineteen were about incorrect or missing patient information on the body when transferred to the mortuary.
- Thirteen incidents were reported by the wards. Five were medication errors and four were about staffing levels for end of life care patients.
- Minutes seen of the end of life care steering group did not show that clinical incidents were discussed and actions identified.
- Staff told us monthly Trust Mortality Review Group meetings were in place. These were attended by members of the multidisciplinary team, including pharmacy, medical and nursing staff. Action points were recorded at the end of each meeting and learning points discussed.
- Staff were able to describe the rationale and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008. This relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Service users and their families were told when they were affected by an event where something unexpected or unintended had happened. The trust apologised and informed people of the actions they had taken.
- **Cleanliness, infection control and hygiene**
- We saw that all the areas in the mortuary, including the viewing area were visibly clean. The cleaning rotas were on display. We saw the mortuary was audited for cleanliness in March 2016 and had achieved 98%.
- We saw there was personal protective equipment (PPE) for use by staff handling deceased patients in the mortuary
- We saw staff were bare below the elbow, sanitised their hands between patient contacts and wore aprons and gloves when they delivered personal care to patients.
- The trust had a policy for the management of a patient's body following their death with a suspected or confirmed infection. This had clear guidelines about the potential risk from body fluids and specific advice for portering staff when transporting a body.
- **Environment and equipment**
- We saw and were provided with the up to date servicing and maintenance records for all the equipment used in the mortuary.
- We were told the trust had obtained 60 new appropriate syringe drivers. Syringe drivers were maintained and regulated by the equipment services and stored in the equipment library. Staff told us these were easily available.
- **Medicines**
- The trust had a policy for the safe and secure handling of medicines (March 2016). The policy ensured that medicines were prescribed, stored and administered and managed safely according to current best practice.
- There was trust wide guidance for the administration of medicine using the appropriate syringe driver which fulfilled the safety guidance by the National Patient Safety Agency Rapid Response Report (2010). The syringe driver is a portable battery operated device to help reduce symptoms by delivering a steady flow of injected medication continuously under the skin. It is useful way of delivering medication for an end of life care patient when they are unable to take medication orally.
- The trusts 'symptom observation chart for the dying patient' and 'care of the dying person' contained clear

escalation guidelines for symptom management for patients at the end of their life. The guidelines were clearly set out and presented in an easy to follow manner. Staff told us the 'symptom observation chart for the dying patient' was easy to follow and use. We spoke with nursing staff that were able to show us the guidance on the intranet in all ward areas.

- All registered nurses and medical staff received training about the safe use of medication for an end of life care patient and prescribing anticipatory medication. The prescribing of anticipatory medication is designed to enable prompt symptom relief at whatever time the patient develops distressing symptoms. A patient discharged with 'Just In Case' medication would allow qualified staff to attend and administer medication which may stabilise a patient or reduce pain and anxiety and prevent the need for an emergency admission to hospital. All patients on an end of life care plan were discharged from hospital with 'Just In Case' medication which ensured that streamlined care was maintained.
- Across the wards, we reviewed seven medication charts for patients who were receiving end of life care. The charts we observed showed that appropriate medications had been prescribed as stated by NICE Quality Standards guidelines for anticipatory medication. This ensured that end of life care patients received timely and appropriate care.
- **Records**
- The mortuary attendant told us that effective systems were in place to log patients into the mortuary. They explained the process and showed us the ledger record book that contained the required information. We observed that the book was appropriately completed.
- On visiting the bereavement office we saw there were systems to process death, burial and cremation certificates. An officer showed us the process and explained what the role involved.
- All palliative care records were hand written and managed in line with trust policy.
- Patients receiving care from the specialist palliative care team had their documentation updated when reviewed. This gave information around changes in patient care needs and medicines management. Staff on the wards then implemented the changes as required, such as applying a syringe driver or changing medication.
- We saw eleven 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms and these were all completed as per national guidance.
- Following the withdrawal of the Liverpool Care Pathway and the release of 'one chance to get it right' 2014 by the National Leadership Alliance for the Care of the Dying Person, the trust has generated the 'Priorities for Care for the Dying Person' in 2015. This ensured that patients who were identified as dying experienced transparent and open communication and compassionate care from all healthcare professionals.
- The 'Priorities for Care for the Dying Person' had recently been introduced by the trust and had not been widely initiated across the wards. Staff we spoke with had not yet used the 'Priorities for Care for the Dying Person', but had used the 'symptom observation chart for the dying patient'.
- Staff told us that the 'symptom observation chart for the dying patient' was user friendly with helpful prompts. The guidance and prompts were beneficial for all staff. The chart gave clear guidelines that nursing staff should assess the patient at least every four hours, and escalation prompts as required.
- Across the wards we visited we reviewed five medical records and nursing notes. All records contained evidence of discussion with the family. Only one record contained evidence of the patient being assessed for their spiritual care.
- **Safeguarding**
- Trust wide the chief nurse was executive lead for safeguarding. Adult safeguarding was managed by the deputy chief nurse and had 1.6 whole time equivalent (WTE) band seven nurses for safeguarding, learning disability and Mental Capacity Act and Deprivation of Liberty Safeguarding. Children's safeguarding had a consultant nurse and two band sevens.
- The trust had a safeguarding adult's policy. Safeguarding was part of mandatory training for all staff and this was monitored by managers. Trust wide data provided for safeguarding adults was 50% with a target of 100%.
- The specialist palliative care team was trust wide and their training rates for safeguarding adults were 100%. Safeguarding children level two was 85%.

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- Staff demonstrated a good knowledge and understanding of safeguarding vulnerable adults. The relevant local authority and social services numbers were available for staff.
- **Mandatory training**
- The trust had a programme of mandatory training for all staff and we saw evidence and records of this training. The National Care of the Dying Audit 2014 recommended that staff received mandatory training in the care of the dying. All staff who had direct contact with patients received training for caring for patients and their relatives at the end of life. This specifically identified the need for staff to communicate well and practice care in line with national and local best practice. This training was received at induction.
- The trust had a trust wide induction programme for permanent and temporary staff with the required mandatory and statutory training plan which involved classroom and E-learning. Education in end of life care was provided by the specialist palliative care team and the end of life care facilitator. Significant contributions were also made by the chaplaincy team about spirituality/religion/faith and the bereavement team taught about care after death.
- Trust wide mandatory training for all staff had achieved 49% with a target of 100%. Trust wide statutory training for all staff had achieved 52% with a target of 95%.
- The specialist palliative care team was trust wide and had achieved 58% statutory training with a target of 100%. Mandatory training for the team was 50% with a target of 95%. This figure applied to 7 members of staff. Subjects included infection control, information governance, fire safety, Mental Capacity Act and Deprivation of Liberty Safeguards.
- Training for the use of syringe drivers was mandatory for permanent nursing staff and was part of the intravenous study day. The trust provided us with lists of names of staff who had attended the course. However, the trust was unable to provide specific numbers of attendance and told us this would be collated on the central computer system in the future.
- The chaplaincy, patient affairs and bereavement officers provided evidence that they were up to date with their mandatory training.
- Guidance from Hospice United Kingdom for staff responsible for care after death clearly states education and training on all aspects of care after death should be included in induction and mandatory training programmes. For porters this should include safe handling and transfer and preparation for transferring of the body. Portering staff confirmed they received mortuary training on induction and had annual updates.
- **Assessing and responding to patient risk**
- Staff on the wards told us, once patients were deemed to be for end of life care the ward staff tried to move them to a side room on the ward where possible. They also told us where possible they were flexible with visiting hours.
- The clinical needs of patients were monitored through regular nursing, medical and therapy reviews.
- The officers in the bereavement office supported all bereaved families with the paperwork and processes for care after death.
- **End Of Life Care staffing**
- The trust wide specialist palliative care team was made up of 1.8 whole time equivalent (WTE) consultants. Five clinical nurse specialists (CNS) were employed which were equal to 4.6 WTE. The team had two (1.34 WTE) patient pathway coordinators/ administrators.
- A two week rota enabled one trust wide CNS to be based at Princess Royal Hospital. This was to ensure staff were not lone working on a regular basis.
- The trust wide chaplaincy team had 3.5 WTE Christian staff plus Roman Catholic representation. There was a paid on call Jewish Orthodox Rabbi and Sunni Muslim Imam. Three sessional on call chaplains provided cover for absences. There was a large team of ward based volunteers from a variety of faith traditions and on call representatives of a variety of faith and belief groups from the immediate area. The service had a vacancy for a two day a week Church of England chaplain and this was advertised.
- A trust wide full time end of life care facilitator, who was not part of the specialist palliative care team, provided information and education for end of life care. The facilitator worked with the specialist palliative care team to provide the end of life care education programme.
- The PALS office was staffed by one officer who did not work on a Wednesday. One PALS officer from Royal Sussex County Hospital also worked at Princess Royal

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Hospital on a Wednesday and also covered sickness and leave. The PALS team were an extension of the complaints team which had six WTE complaints managers.

- There were two WTE members of staff employed in the mortuary. There were no additional arrangements for covering annual leave or sickness. This was organised and covered by the mortuary staff.
- During out inspection we asked ward managers about their staffing levels and whether they felt they were adequate staff on the wards when caring for patients on an end of life care plan. Ward managers we spoke to did not raise concerns with the level of staffing and were able to provide adequate specific end of life care to patients.
- **Major incident awareness and training**
- There was a trust wide "major incident plan" (2015) which set out a framework for ensuring that the trust had appropriate emergency arrangements which were in line with the Civil Contingencies Act 2004 statutory duties.
- Major incident training was undertaken at the trust, and staff told us there was a major incident exercise planned for July 2016.
- Mortuary staff were aware of major incident plan. The Mortuary has two overflow fridges that contained 10 spaces in the event of a major incident.
- The chaplain confirmed they had attended major incident training. The chaplain gave an example of during a major incident they had attended the emergency department to give emotional support to
- patients and relatives.

Are end of life care services effective?

Requires improvement

We rated end of life care service at the Princess Royal Hospital Requires Improvement for Effective. This was because:

- The trust did not meet the requirements of the key performance indicators of the National Care of the Dying Audit 2014. They did not have access to specialist palliative support, for care in last days and hours of life, as they did not have a service seven days a week. They did not have a non-executive director for end of life care services. Also they did not have a formal feedback process regarding capturing bereaved relative's views of delivery of care.
- The trust was worse than the national average in End of Life Audit- Dying in Hospital 2016 for multidisciplinary recognition of a patient dying and documented evidence in the last 24 hours of life of a holistic assessment.
- The service did not have a programme of regular audits for end of life care.
- There were inconsistencies in the documentation in the recording of Mental Capacity Act (MCA) assessments and recording ceilings of care for DNACPR.
- Trust wide only 68% of staff had received an annual appraisal. Staff we spoke with confirmed that some had and others had not received an appraisal in the last year.

However:

- The trust was in the process of correcting the organisational and clinical indicators highlighted in the National Care of the Dying Audit 2014. The trust had an action plan with defined implementation dates.
- The hospital had implemented standards as set by the National End of Life Care Strategy 2008 published by the Department of Health, NICE End of Life Quality Standard for Adults (QS13) and 'One chance to Get it Right' 2014 by the National Leadership Alliance for the Care of the Dying Person.
- Alternative end of life care guidance had been developed in response to the national withdrawal of the Liverpool Care Pathway. The 'Priorities for Care of the Dying Person' and 'symptom observation chart for the dying patient' had been generated. Patients on the care plan were prescribed appropriate medication by medical staff.
- Patients' pain, nutrition and hydration needs were monitored in accordance with national guidelines. The palliative care team supported and provided evidence-based advice to health and social care professionals from other wards and departments.
- End of life care education consisted of study days, induction programme, and workshops for clinical staff,

sessions and lectures for medical staff. Most clinical areas had an end of life care champion who was key to disseminating end of life care education and support to their local multidisciplinary team.

- The chapel and prayer room were accessible 24 hours 365 days of the year. The chaplaincy team provided a 24 hour on call service for all faiths via the switchboard. The specialist palliative care team were available Monday to Friday between 9am and 5pm, with out of hours telephone support for palliative medicine provided by a consultant.
- The 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms were completed for appropriate patients.
- **Evidence-based care and treatment**
- The National End of Life Care Strategy 2008 published by the Department of Health, sets out the key stages for end of life care, applicable to adults diagnosed with a life limiting condition. NICE End of Life Care Quality Standard for Adults (QS13) sets out what end of life care should look like for adults diagnosed with a life limiting condition. The 16 quality standards define best practice within this topic area.
- Two of the standards had been achieved with the provision of a specialist palliative care team and had an operational policy. The trust was working towards being compliant with the remaining standards and had an action plan with defined implementation dates. The action plan was in draft form and started in March 2016. The specific actions compared Brighton and Sussex University Hospitals NHS Trust with national results.
- The trust had responded to the withdrawal of the Liverpool Care Pathway (LCP) and the publication of 'One Chance to Get it Right'. The specialist palliative care team worked with the end of life care facilitator to introduce the 'Priorities for care of the Dying Person' and 'symptom observation chart for the dying patient'. Training sessions were provided trust wide in 2015 for staff or for individual groups of staff and were attended by approximately 380 members. The sessions were completed over a two week period and lasted one hour each. The care plan was available on the intranet. However the trust did not record the number of patients within the hospital who were on the care plan. It had recently been introduced and had not been widely initiated across the wards.
- The trust told us that they were committed to continuing to embed best practice in care of the dying patient. This was to be achieved with a comprehensive education programme, modelling of a gold standard of care by senior clinicians, monitoring performance with an internal audit programme and benchmarking themselves against national standards by participating in the bi-annual National Care of the Dying Audit for Hospitals (NCDAH).
- The results of the NCDAH (2015) were published March 2016 and the trust had incorporated the findings into a draft action plan to ensure the lessons from the audit process were shared. The overarching actions were allocated to teams with specified timescales. The hospital told us they would disseminate the findings of the audit within the trust end of life care newsletter and local governance meetings.
- We did not see a programme of regular audits for end of life care. However we saw that some audits were being performed.
- We saw DNACPR records were audited March 2016. The result of the audit showed that generally the standard of completion of the forms was high and there were no concerning patterns or trends. The audit was suspended until after the inspection. We were not provided with a reason for this.
- We saw evidence across the wards we visited that the specialist palliative care team supported and provided evidence based advice when caring for patients reaching the end of life. Guidance and instruction was given regarding complex symptom control and individualised care of the patient.
- During our visits to the wards staff demonstrated how they were able to access end of life care information on the intranet and knew how to refer to the palliative care team.
- All wards we visited had at least one end of life care champion known as 'link persons'. These were mainly nurses and some health care assistants (HCA). The end of life care links were key to disseminating end of life care education and support to their local multidisciplinary team. We spoke with the link person on Hurstpeirpoint ward who was knowledgeable and proud of their role. They told us they received monthly updates and showed us the resource folders they had assembled.
- **Pain relief**

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- Effective pain management was an integral part of the delivery of end of life care and was supported by the specialist palliative care team and the acute pain team.
- The trust had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015). There were guidelines for prescribing using NICE guidance on opioids (a strong pain killer) for palliative care.
- The 'Priorities for Care for the Dying Person' and 'symptom observation chart for the dying patient' supported effective pain management of the dying patient. Guidelines included prescribing anticipatory pain relief alongside guidance for other common symptoms. Staff on Pyecombe ward were able to tell us what anticipatory medicine was available.
- We reviewed five patient's medical records and drug charts and saw that patients had regular assessments for pain and appropriate medicine was given as required.
- Pain levels were routinely collected together with vital signs and pain was promptly treated. We saw this recorded in the patient's records we looked at on Plumpton, Pyecombe, Hurstpeirpoint and Clayton wards.
- **Nutrition and hydration**

- Risk assessments were completed by a qualified nurse when patients were admitted to hospital. This included a nutritional screen assessment tool which identified patients who were at risk of poor nutrition, dehydration and or those who experienced swallowing difficulties. It included actions to be taken following the nutrition assessment scoring and weight recording. The five care plans we observed across the wards contained the nutritional screening assessment and showed where patients had been referred to the dietician.
- We observed that water jugs were full and accessible for patients. We spoke with staff on ICU, Pyecombe, Ardingly and Ansty, who told us end of life care patients would be encouraged to drink as and when they wanted while they were able. Staff could administer prescribed subcutaneous fluids (administered into the space under the skin which can be slowly absorbed into the blood and body) if required.
- The 'Priorities for Care of the Dying Person' and 'symptom observation chart for the dying patient' had clear guidelines for the assessment of mouth care, hydration and nutrition. The patient records we observed showed that these were being completed and updated by staff.
- The personalised care plan included prompts to ensure that the patient and their family's views and preferences around nutrition and hydration at the end of life were explored and addressed.
- **Patient outcomes**

- The Hospital Standardised Mortality Ratio (HSMR) for the trust was 97.3 for 2013/14 and 90.5 for 2014/15. HSMR is a calculation used to monitor death rates in a trust and is based on a subset of diagnoses which give rise to around 80% of in hospital deaths. The ratio is worked out by the total number of observed in hospital deaths compared to expected deaths (multiplied conventionally by 100). If mortality levels are higher than would be expected, the HSMR will be greater than 100. Therefore, the trust's ratio for HSMR was better than the national average.
- Trust wide there were 1642 deaths in 2013/14 and 1015 referrals to the palliative care team. Cancer referrals were 69% (700) and 31% (315) non cancer.
- Trust wide there were 1711 deaths in 2014/15 and 1085 referrals to the palliative care team. Cancer referrals were 65% and 35% (381) non cancer.
- The trust was unable to provide data for the number of patients who die who had been seen or referred to the specialist palliative care team for each hospital. The data was requested from the trust and at the time of writing the report this had not been provided.
- From March 2015 to February 2016 the specialist palliative care team had received 1302 new referrals and 286 were for Princess Royal Hospital.
- Results of the NCDAH 2014 showed the trust achieved four of the seven organisational indicators and was worse than the England average for three of the ten clinical indicators. The trust was worse than the England average for access to specialist support for care in the last hours and days of life, trust board representation for care of the dying, formal feedback processes regarding capturing bereaved relatives views of delivery of care, multidisciplinary recognition that the patient is dying, review of assessments in 24 hours of life and review of care after death.
- The trust had responded to the results of the NCDAH 2014. There was multidisciplinary recognition that the

patient was dying and documented evidence in the last 24 hours of life of a holistic assessment. Staff received end of life care education at induction and there was an ongoing education programme for all staff. End of life care champions known as 'link persons' were on most wards and information was easily accessible for all staff on the intranet.

- The trust did not meet the requirements for three key performance indicators of the NCDAH 2014. They did not have access to specialist support for care in the last hours and days of life as they did not have a service seven days a week. The trust had executive members representing end of life care but did not have a non-executive director. A formal feedback process was not in use. We were shown a draft of a bereavement survey which had been designed. However, at the time of inspection this had not been piloted.
- The End of Life Audit- Dying in Hospital 2016 national achievement against end of life care quality indicators showed the trust had not achieved and was worse than the national result for communication skills training for care in the last hours of life for all staff.
- The trust had responded to the withdrawal of the Liverpool Care Pathway (LCP) and the publication of 'One Chance to Get it Right'. The specialist palliative care team worked with the end of life care facilitator to introduce the 'Priorities for Care of the Dying Person' and 'symptom observation chart for the dying patient'.
- The trust had an advance care planning policy which explained staff's role and the importance of healthcare professionals involving patients and their families in decisions about care and respecting decisions that had been made and documented earlier. The policy related to the information leaflet given to patients who were recognised to be end of life and gave guidance on the reason and process of advance care planning.
- Data provided by the chaplaincy team showed that in 2014/15, 16599 visits were made to patients across the trust. Data was not recorded for each hospital. Approximately 1750 visits were to patients in other trusts which the chaplaincy team had a service level agreement. The department recorded visits made for Christian, Muslim and Jewish visits. However the trust does not record the number of visits specific to end of life care patients. They were unable to provide data of how many people known to the specialist palliative care team were referred to and seen by the chaplaincy team.
- **Competent staff**
- In line with the NICE end of life care quality standards (2011) and Ambitions for Palliative and End of Life Care (2015) the trust recognised the need for a workforce skilled to provide end of life care, care after death and for staff to have the ability to have honest and sensitive conversations with patients and their families.
- The end of life care facilitator was not a member of the specialist palliative care team. However they worked with the team to provide trust wide end of life care education.
- Training of end of life care was given to non-specialists in many aspects of palliative care on a one to one basis on prescribing and symptom management. Sessions were organised at ward level on a variety of topics including the RDP for the patient who wanted to die at home. The specialist palliative care team delivered sessions for medical students and doctors. The team contributed sessions on the end of life care education series.
- The specialist palliative care team organised a conference in 2015 which was attended by 60 members of staff. The conference celebrated five years of palliative service, its development and innovation. A range of experts in the field of hospital specialist palliative care were key speakers and topics included rapid discharge, advance care planning, revising the boundaries and the future of palliative care. The conference was well received and comments received in feedback included: "an excellent day so insightful and informative", "good variety of topics" and "pain control presentation gave a thorough update."
- End of life care education was provided for all staff and learning opportunities were contained on the end of life care intranet site and newsletters. We were given a demonstration by the end of life care facilitator of the intranet site, which can be accessed by all staff at any time. The site included information, such as trust policies and procedures relating to end of life care, referral to the specialist palliative care team, multi professional training days and online booking system for end of life care study days. Staff showed us they could access the education and training easily.
- End of life care education consisted of study days, induction programme, and workshops for clinical staff and sessions and lectures for medical staff. In 2015 there were three conferences held which were well attended by trust staff and the local health and social care services.

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- Trust wide the appraisal rate for all staff was 68% April 2015 to January 2016 with a target of 75%. The trust did not provide completion rates specific to end of life care. Staff we spoke with confirmed that some had and others had not received an appraisal in the last year.
- **Multidisciplinary working**
- The close working relationship between the specialist palliative care team, end of life care facilitator, link nurses, ward staff and chaplaincy ensured that end of life care was embedded in trust structures, for example induction. The specialist palliative care team had formed close and mutually helpful working relationships with other clinical teams in the hospital. For example, the acute pain team, trust lead cancer nurse, pharmacy, psychological therapies team, bereavement officers and the discharge team.
- The specialist palliative care team had a close working relationship with the Palliative Care Partnership and several local hospices. They also worked closely with hospital palliative care teams in the region and the Macmillan site specific cancer team.
- The specialist palliative care team had a six monthly 'Big Mac' meeting with the Macmillan community and hospital teams.
- The specialist palliative care team held weekly multidisciplinary meetings at the hospital on Tuesday afternoons with doctors, nurses and members of the extended team. There was video conferencing to link both hospital sites of the trust. The meeting covered all aspects of patient's medical and palliative care needs. The outcomes of the meeting were recorded and shared with the extended team. We saw that the team administrator coordinated the meetings ensuring an accurate list was kept of patients discussed and a record of attendance.
- The weekly multidisciplinary meeting had a dedicated time each week to discuss a 'case of the week'. This was for all clinical members of the team to attend and discuss a complex clinical situation and identify learning points from this. Written records of these meetings were shared amongst the team.
- Staff told us the hospital worked as an effective multidisciplinary team recognising an end of life care patient. Medical staff told us that the specialist palliative care team were very supportive in assisting medical staff to have sensitive conversations with patients and their families regarding end of life care. We saw there was good support provided for junior staff.
- Every morning, Monday to Friday, the specialist palliative care team had case-load discussions which were chaired by the triage nurse. Every Monday meeting was used to highlight any outstanding issues for patients who were discharged over the weekend. The Friday meeting included a review of deaths and discharges from the previous week.
- **Seven-day services**
- The specialist palliative care team was not staffed or funded to provide a seven day per week visiting service.
- The specialist palliative care team was available Monday to Friday 9am to 5pm, except bank holidays. Out of hours consultant telephone advice was available from the local hospice.
- The mortuary was staffed 8am to 4pm Monday to Friday. Within these hours collections were possible by appointment. Out of hours arrangements meant exceptional requests could be met for both collections and viewings outside of normal hours.
- The chapel and Muslim prayer room were accessible 24 hours a day every day of the year. The chaplaincy team provided 24 hour on call service and were contactable via the switchboard.
- The bereavement office was open Monday to Friday 9am to 5pm.
- The Patient Advice and Liaison (PALS) office was open Monday to Friday 10am to 5pm.
- **Access to information**
- The trust's clinical intranet site, 'info-net', was available for all staff. This intranet resource provided easily accessible and easy to read information for all aspects of end of life care. It contained information for care of the dying patient, guidelines and prescribing advice for palliative patients.
- The trust acknowledged that patients who were dying and those at the end of life may require rapid discharge home. A RDP was developed and the documentation for this process was available on the end of life care intranet site which staff could access. The guidelines were for use by all clinical staff. Part of the resources that supported this process was example prescription sheets for the junior doctors to refer to when prescribing anticipatory medications.

End of life care

- The trust had developed a Notification Form for Advance Care Planning which was completed to support a patient to develop their wishes and preferences as an advance care plan or if a patient already had one. Therefore the existence of an advance care plan, any advance decisions to refuse treatment or last power attorney for health and welfare was documented and could be located in the patient's health record on admission. The system used was 'ShareMyCare' which was developed by a service that provided the out of hour's service for general practitioners and nurses. Staff on Pyecombe ward told us they used the advance care plan and saw patients bring them in with them on admission.
- **Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- The trust had a consent policy which was based on the model developed by the Department of Health. The policy included the process for consent, documentation, responsibilities for the consent process and use of information leaflets to describe the risks and benefits. The policy also included consent for advanced decisions, guidance for lasting power of attorneys and mental capacity.
- We saw staff always introducing themselves and seek consent before treatment.
- The trust had a Mental Capacity policy which incorporated Deprivation of Liberty Safeguards (DoLS). The policy had clear guidance that included the Mental Capacity Act (MCA) 2005 legislation and set out procedures that staff should follow if a person lacks capacity.
- Staff on the wards told us they consider the MCA for all patients and described the process.
- Staff on Ardingly and Pyecombe wards told us the consultants were excellent at recognising end of life care patients and write DNACPR in a timely manner. They told us they wrote appropriate ceilings of care.
- Staff on all the wards we visited told us the resuscitation status of patients was discussed at handover, and was recorded on their hand over sheet. We saw handover sheets on all the wards visited and saw the resuscitation status recorded.
- We saw 11 DNACPR forms. We saw that all decisions were recorded on a standard form for ten out of the eleven DNACPR forms. All forms were signed by an appropriate senior clinician and were kept in the front of the patient notes. Nine of the records had evidence that there had been a discussion with relatives.
- Four of the DNACPR forms we saw had recorded that the patient did not have mental capacity. However we did not find documentation of the Mental Capacity assessment in the medical notes.
- The forms were inconsistent with recording the patients ceiling of care. This guide's staff, who do not know the patient, to know the patients previously expressed wishes and/or limitations to their treatment. This is best practice in hospitals to provide continuity of care and good communication.
- We were told that DNACPR remains a high priority in teaching. Focus remains on the documentation of the communication of the decisions with the patient and
- their relatives.

Are end of life care services caring?

Good

We rated the end of life care service at the Princess Royal Hospital good for Caring. This was because:

- Staff provided sensitive, caring and individualised personal care to patients who were at the end of their life. We were told about and shown evidence of collaborative working across the teams to provide exceptional care for end of life care patients.
- On the wards we visited we observed compassionate and caring staff that provided dignified care to patients who were at the end of their lives. On two of the wards visited they had decorated specific side rooms to be used for patients and relatives at the end of their lives.
- Patients and their relatives were involved in their care and were given adequate information about their diagnosis and treatment. Families were encouraged to participate in the personal care of their relatives with support and patience from staff.
- Emotional support was provided by the hospital. Staff knew who to signpost relatives to for bereavement care. There was an on call service with access to chaplaincy staff and other multi faith leaders who supported families in times of loss and grief.
- **Compassionate care**

End of life care

- Staff on all wards we visited said end of life care was a vital part of their role and they enjoyed the relationships they formed with patients and their relatives. During our inspection we observed end of life care that was sensitive and caring by all staff.
- We saw staff on Ardingly and Pyecombe wards were passionate and committed who cared deeply about their team and the standard of care that was given.
- Staff on Pyecombe Ward and ICU told us consultants were good at talking to end of life care patients and their relatives. All wards visited felt they were open and honest and work well with the ward team and they were also good at identifying when further active treatment was not benefitting the patient.
- Staff on Clayton, Ardingly and Pyecombe wards told us the specialist palliative care team were "brilliant" "supportive", "responsive" and "very helpful".
- The 2014/15 carer's survey by the specialist palliative care team had written feedback which included: "the team was very kind, supportive and helpful".
- The chaplaincy team gave us examples of compassionate care provided for end of life care patients. In the event that a patient wished to marry their partner the chaplaincy team contacted the local registrar to conduct ceremony and the chaplaincy team performed a blessing if required.
- **Understanding and involvement of patients and those close to them**

- We observed staff introducing themselves to patients and their relatives.
- Staff were able to explain the procedures that took place after the death of a patient. We were shown the pack, which contained all the necessary documentation, wrist bands, notification form and a flow diagram around tissue donation. Body bags for the deceased were available on the ward.
- On Balcombe and Hurstpierpoint ward we were shown side rooms which had been decorated by staff on the ward to provide a calming space for relatives and patients at the end of their life.
- We were told that relatives were encouraged to participate in the care of patients, for example mouth care or assisting with personal hygiene.
- **Emotional support**

- Staff provided emotional support for end of life care patients. We observed on the wards occasions when this occurred.
- Bereavement support was not specifically provided by the hospital. Relatives were signposted to the relevant agencies that could support them.
- All GPs were informed within one working day of a patient's death so they could provide appropriate community centred bereavement support if required.
- The chaplaincy service offered access to multi faith worship 24 hours a day. There was an on call service with access to chaplaincy staff and other multi faith leaders. The chapel was a space for patients and families to have a quiet time.
- The hospital ensured that the faith needs of the community were met. The chaplaincy team offered spiritual, religious or pastoral support to people of all faiths and beliefs, religious and non-religious. The chaplaincy team was assisted by a group of volunteer visitors. They were able to contact community faith leaders who represented the major world religions.
- The chaplaincy team were involved in supporting families in times of loss and grief. Relatives of end of life care patients told us that they had been offered chaplaincy support and a member of the team had visited them promptly.

Are end of life care services responsive?

Good

We rated end of life care service at the Princess Royal Hospital Requires Improvement for responsive. This was because:

- The specialist palliative care team was embedded in all clinical areas of the hospital. They were professional, responsive and supportive to patients, relatives and other members of the multidisciplinary team. This was demonstrated with their specialised advice and knowledge.
- The specialist palliative care team responded promptly to referrals to assess the patient and plan care. Online referrals to the team were triaged throughout the working day and they were contactable via bleeps. The team told us everyone received telephone advice on the same working day and most patients were seen within 24 hours.

End of life care

- The wards provided an information pack for bereaved relatives which advised them about collecting the death certificate from the bereavement office. The pack contained the contact details for contacting the mortuary for a viewing if required.
- The mortuary viewing area was visibly clean and welcoming for relatives.
- The chapel accommodated all faiths as well as no faith. Staff respected the cultural, religious and spiritual needs of patients.
- The trust had an advance care plan which supported a patient to develop their wishes and preferences. The plan could be located in the patient's health record on admission and was accessible to the out of hour's community service.
- The trust had a RDP and the documentation for this process was available on the end of life care intranet site which staff could access. The discharge team was involved with all discharges for end of life care patients. The response time for discharge depended on the patients preferred place of care and what area the patient lived in.
- The trust had processes in place to acknowledge and investigate complaints appropriately. Complaints were handled in a timely manner and lessons were learnt.
- **Service planning and delivery to meet the needs of local people**

- During the inspection we observed that the specialist palliative care team was embedded in all clinical areas of the hospital. Staff on the wards told us that the team was professional, responsive and supportive with specialised advice and knowledge. Where a patient was referred to the team they were prompt in responding, assessing the patient and planning care and other required referrals, for example, therapists. Staff on the wards confirmed that the referral criteria was clear and patients were seen within 24 hours if not sooner.
- We observed across the wards we visited that staff supported relatives to stay with end of life care patients. We were told and observed that when a patient was recognised as in the dying phase, all wards would offer patients and their families side rooms dependant on availability and suitability.
- The mortuary had a viewing suite where families could visit their relatives. They were escorted by the mortuary attendant who would stay with the relatives in the waiting area during the viewing for as long as they required.
- Guidance and support was offered after death from the bereavement office. Contact numbers were provided to relatives within a trust wide information wallet. The staff in the bereavement office told us they were aware of whom to signpost relatives to if they required additional support.
- The bereavement office advised relatives on the process around the death of a patient. The office issued death, burial and cremation certificates. The information leaflet provided for relatives by the wards advised that the certificate would not be available for five working days. Bereavement officers told us that the certificate was usually issued within two to three working days. However, they were unable to provide any data to confirm this.
- The PALS office was a spacious office located off the main corridor and contained a separate seating area to accommodate confidential and private conversations. The PALS officers told us they would visit patients on the wards if required.
- **Meeting people's individual needs**

- The hospital where possible ensured that dying patients were moved into side rooms, when they are available and not needed for infection control purposes. Staff on Ardingly and Pyecombe confirmed this was almost always possible.
- The staff on wards we visited told us that not all relatives wanted to use the side room. There was open visiting and relatives were encouraged to stay with their relatives overnight.
- The mortuary was able to facilitate the transportation and storage of bariatric (severely obese) patients.
- The mortuary had a viewing suite that was divided into a waiting area and viewing room. The suite was visibly clean and provided facilities for relatives such as seating and tissues. The suite was neutral and able to accommodate all faiths.
- We were shown that systems were in place to identify patients on the ward and in the mortuary that had the same surname, including discreet orange dots placed on the patient's medical records and on the ward board.

End of life care

- The hospital ensured that the faith needs of the community were met. The chaplaincy team offered spiritual, religious or pastoral support to people of all faiths and beliefs, religious and non-religious. The chaplaincy team was assisted by a group of volunteer visitors. They were able to contact community faith leaders who represented the major world religions.
- The hospital chapel was multi-faith. Holy Communion was provided in the chapel on Sundays.
- The hospital had a Muslim prayer room with separate washing facilities. Muslim services were held on Fridays.
- We observed in one of the five care records reviewed that staff had assessed the patient's spiritual, cultural or religious needs.
- The hospital had access to translation services. All information leaflets informed patients that an interpreter could translate the information, if required.
- Patients living with learning disabilities or dementia were supported by the hospital. A blue butterfly flagging system on the notes identified the patients who required extra assistance.
- The chaplaincy team provided leaflets which explained its services, contact details and special events. Details were advertised on the chaplaincy centre notice boards and available on the hospital's web page. The team provided specific leaflets and information for supporting different religions while an inpatient and advice for going into hospital.
- A patient information leaflet for continuous subcutaneous infusions using the syringe driver was available on the hospital's web page.
- Relatives of a person who had died were provided with a trust wide information wallet by the wards. This contained information on collecting the medical certificate of cause of death, Department for Work and Pensions: what to do after death and a funeral choice information leaflet.
- The trust's clinical intranet site, 'info-net', was available for all staff. This intranet resource provided easily accessible and easy to read information for all aspects of end of life care. It contained information for care of the dying patient, guidelines and prescribing advice for palliative patients.
- **Access and flow**
- Online referrals to the specialist palliative care team were triaged (the process of determining the priority of a patients treatment based on the severity of their condition) throughout the working day. The specialist palliative care team CNS carried bleeps and there was a triage bleep at the Royal Sussex County Hospital. Every morning the patient list was updated and referred patients were graded on level of care 1-4 (4 the highest). The team told us everyone received telephone advice on the same working day and most patients were seen within 24 hours. Data provided by the trust showed that in 2015 the team saw 70% of patients within 24 hours of referral and 88% by the next working day.
- Through a triage system, the specialist palliative care team aimed to see all urgent referrals within one working day and routine referrals within two working days. Outside office hours, medical advice was available via the consultant on-call at the local hospice.
- Inpatient referrals to the specialist palliative care team could be made via the webpage or face-to-face referrals could be made to a member of the team. Urgent advice was available from the clinical nurse specialist who could give telephone advice prior to reviewing the patient. Outpatient referrals could be made in writing or via email to the palliative care consultants.
- The trust did not record data specific to preferred place of death. Data was recorded specific to preferred place of care (PPC) and rapid discharge pathway (RDP). The information did not split into hospital site specific. The 2014/15 specialist palliative care team annual report showed for 83% of patients the PPC was achieved when known and 84% from March 2015 to February 2016.
- The 2014/15 annual report showed 75% of RDP was successful and from March 2015 to February 2016, 82% of patients achieved rapid discharge. The average length of time (including weekends) to arrange RDP, when successfully achieved, was two days. Failures to achieve rapid discharge were due to delays in arranging necessary equipment and/or care or family were unable to support an individual's expressed preference.
- The discharge team worked closely with the specialist palliative care team and coordinated the discharge of patients trust wide. The coordinators attended ward rounds and handovers to highlight them of end of life care patients who wished to be discharged home or to a nursing home. This enabled them to start the process of arranging funding and the availability of packages of care.
- Fast track continuing healthcare applications were completed by the discharge coordinators. They told us that a patient who lived in the Brighton area, a

discharge could usually be arranged within one working day. This took longer for patients who lived in east and west Sussex owing to the availability of nursing home places and packages of care.

- The trust told us they used the Supportive and Palliative Care Indicators Tool (SPICT) to identify patients in last year of life. The SPICT can support clinical judgement by multidisciplinary teams when identifying patients at risk of deteriorating and dying. It can help identify patients with multiple unmet needs who would benefit from earlier, holistic needs assessment, a review of care goals and anticipatory care planning. This was available to all but not widely used at present.
- The respiratory team told us they had audited the SPICT to determine the discharge time of end of life care patients pre and post use of the tool. They told us that the patient's length of stay in hospital had decreased after using the tool. We requested information about the audit but the hospital was unable to provide us with it.
- The trust's policy for the administration of medication using a syringe driver had clear guidelines for discharge planning for a patient being discharged home with a syringe driver. The patient and/or the carer were provided with a pre stamped and addressed padded envelope. This system ensured the safe return of the syringe driver once community services had replaced it with their own.
- **Learning from complaints and concerns**

- The chief nurse was the executive lead for patient experience and complaints. The chief of safety and quality and deputy chief nurse shared the responsibility for the line management of the head of patient experience, PALS and complaints who were responsible for the operational management of the services and line management of the complaints and PALS teams.
- The patient experience PALS and complaints team comprised of six complaint investigation managers, two complaints/PALS coordinators and three PALS advisors who worked closely with the complaints team.
- There was a monthly serious complaints and safeguarding meeting held by the head of patient experience, PALS and complaints, deputy chief nurse, patient experience, safeguarding lead nurse and chief of safety and quality.
- A patient experience report was produced quarterly for submission to the quality and risk committee and the board. An annual report was produced and shared at both meetings.
- The chief executive officer received copies of all complaints relating to clinical treatment and care. These were discussed at monthly meetings with the head of patient experience, PALS and complaints to discuss actions arising, themes and learning.
- Patient information that advised patients how to make a complaint or raise a concern with PALS was available on the trust website. There was an easy to read leaflet 'comments, concerns and complaints' which was available throughout the trust and was available in other languages upon request. A poster 'Have you got a concern or complaint and don't know where to turn' was displayed throughout the hospital.
- Trust wide February 2015 to January 2016 there were eight complaints relevant to end of life care and one was about the Princess Royal Hospital. The complaint referred to the failure in communication by staff. All complaints were formally logged and had either been resolved or action was ongoing.
- Formal complaints relevant to the specialist palliative care team were dealt with by the team leader and lead clinician in accordance with trust policy. Outcomes, learning and improvement were discussed at the monthly team meetings. The eight complaints received trust wide relevant to end of life care were not
- applicable to the specialist palliative care team.

Are end of life care services well-led?

Good

We rated the end of life care service at the Princess Royal Hospital good for Well-led. This was because:

- The specialist palliative care team working with the end of life care facilitator and ward staff had a vision to ensure that end of life care was consistent with a trust wide approach. This was to be delivered in a timely, sensitively, spiritually and culturally aware manner, with appropriate patient and relatives focused care of the dying and deceased patients. We saw that the trust wide

end of life care strategy was underpinned by a clear action plan. The vision, values and strategy were being developed in line with all who were involved in the end of life care steering group.

- The trust had two executive members representing end of life care but did not have a non-executive director. There was good leadership of the specialist palliative care team led by a consultant and a nurse team leader. All staff we spoke with thought their line managers and senior managers were approachable and supportive. However they did not feel supported by the trust board.
- The end of life care service had an action plan, governance meetings and a strategy and steering group. The hospital and trust were committed to delivering excellent end of life care for all patients. The end of life care leadership, team working within the palliative care team and ward staff delivered care of a high standard and were proud of the service they provided.
- The trust culture encouraged candour, openness and honesty. The specialist palliative care team had an annual carer's survey and had designed, but not yet instigated a bereavement survey.
- The end of life care service worked with other teams in the hospital and trust to provide innovative and award winning systems that were to the benefit of the end of life care patient and their relatives.
- **Vision and strategy for this service**
- The trust told us that it strived to promote a culture where end of life care was seen as 'everyone's business' both personally and professionally.
- The trust aimed to continue to build the specialist palliative care team which provided excellent clinical care as well as being a learning team that provided and encouraged training to non-palliative care colleagues. It contributed robustly to research and policy development and was innovative in palliative and end of life care.
- The specialist palliative care service was not funded to provide a seven day visiting service. National guidelines and recommendations from the Neuberger Report 'More care - less pathway' 2013 and public Health England 2013 request seven day availability of face to face assessments for end of life care patients in acute hospitals. This had been recognised by the Cancer Services Strategy but was not allocated urgent priority by the trust board. The specialist palliative care team continued to forward a business case as one of the three cancer service development priorities for the directorate. A decision was pending at the time of reporting.
- The trust wide specialist palliative care team and end of life care facilitator told us that they aimed to expand the education programme, particularly the training of senior clinical and education staff who would roll out training to other staff. They aimed to work with colleagues to embed training in palliative and end of life care throughout undergraduate and post graduate training as well as continuous professional development.
- The vision of the service was to streamline the discharge process by educating ward staff and ensuring adequate support services in the community. This would enable patients to return home in a timely manner.
- The leadership of the end of life care service recognised that they needed to identify the dying patient earlier and keep end of life care as the focus. The specialist palliative care team acknowledged in the 2014/15 annual report a high number of referrals were received for patients who were actively dying and had not been recognised as end of life earlier. Therefore they were unable to engage in conversations about the patient's wishes and preferences or have the opportunity to achieve these. Additionally these had not been previously explored by the referring team.
- **Governance, risk management and quality measurement**
- The specialist palliative care team had regular team meetings in which performance issues, concerns, complaints and general communication were discussed. The annual work programme was discussed quarterly, with the progress and outstanding projects updated.
- The specialist palliative care team and relevant members of the extended team met annually in April to discuss, review, agree and record operational policies. At the meeting the team also reviewed other relevant activities including a formal review of the team's clinical activities, audits and other projects. The teams work plan from the preceding business year was reviewed and a work plan for the current business year agreed.
- There was a trust wide specialist palliative care team Annual Report for 2014/15 that described the staffing, role and training provided by the team. The annual report wasapprovedby the specialist palliative care

team. The report was sent to the Chief Executive, end of life care executive leads (director of nursing and medical director), directorate lead team, Macmillan, and Clinical Commissioning Group. We were told the information for the 2015/16 report had not yet been collated.

- The specialist palliative care team had an operational policy that set out the aims and objectives of the team and was reviewed every year.
- The trust had an end of life steering group that met monthly and was chaired by the end of life care facilitator. The director of nursing attended these meetings as the board representative. This group was overseeing the various improvement plans that were in place to support the work towards meeting the five priorities of care for end of life, and also to the meeting of the NICE end of life guidance. This was a multi professional group and included members from chaplaincy, specialist palliative care team, bereavement, pharmacy and organ and tissue donation teams.
- We saw minutes of the steering group meetings, for January 2016 and February 2016 which were well attended by representatives across the hospital who were involved in the care of an end of life care patient. The previous five months were not available due to poor attendance. The notes from the steering group were shared with all members. However, following a governance review, the steering group were to report to the new clinical effectiveness committee in the future.
- A specialist palliative care team consultant attended the trust mortality review group. Action points were recorded at the end of each meeting and learning points discussed.
- **Leadership of service**

- The trust had two executive members representing the end of life care service: the director of nursing and the medical director. The trust did not have a non-executive director for end of life care. Teams across a variety of directorates were involved in the provision of end of life care and all reported to the executive leads.
- All staff we spoke with thought their line managers and senior managers were approachable and supportive. Staff on Ardingly told us the matron was approachable and supportive. Staff on Pyecombe told us there was not matron in post. However they felt supported by both the directorate lead nurse and the director of nursing.
- Ward staff told us the specialist palliative care team were visible and provided good levels of education and support.
- There was good leadership of the specialist palliative care team led by the palliative care consultant and the specialist palliative care nurse team leader.
- .**Culture within the service**

- We were told by staff and the senior team that the trust culture encouraged candour, openness and honesty.
- All staff we spoke with demonstrated a positive attitude toward caring for the dying person. They described how important end of life care was and how their work had an impact on the overall service.
- Nursing staff we spoke with demonstrated a commitment to the delivery of good quality end of life care; they felt proud of the care they were able to give and there was positive feedback from nursing and care staff as to the level of support they received from the specialist palliative care team.
- We found staff had a 'can do' attitude. Staff were patient-centred and wanted to deliver good care though good training and support.
- The end of life care facilitator had a proactive approach to developing the workforce and ensuring the training of staff fitted the changing needs of the patients. Staff on Hurstpierpoint ward described the facilitator as 'inspirational for teaching'.
- **Public engagement**

- The carer's survey by the specialist palliative care team obtained feedback from carers about the service in 2012/13 and received a 19% response. In 2014/15, 55 surveys were distributed trust wide and 23 completed surveys were returned giving a response rate of 42%. Overall responses were satisfied with the support they were provided with. Written feedback included: 'be available at the weekend' and 'more information i.e. booklets and financial support'. The survey was due to be repeated in 2016/17.
- The specialist palliative care team acknowledged that although overall the survey achieved some positive feedback it was too small a sample from which to draw conclusions. They told us that consideration needed to be given to future audits on the best way to capture patients' experiences of their service.
- At the time of inspection the trust did not have a working bereavement survey which would enable the

trust to capture feedback from bereaved relatives. We saw that this had been designed but not yet piloted. The results of this survey would be fed back to wards and services.

- **Staff engagement**

- Staff told us that they were actively encouraged to express their views which could help to develop services.
- The specialist palliative care team told us they were actively encouraged to report any concerns regarding wards that may affect the care of an end of life care patient. For example, staff shortages that could affect the care of end of life care patients and identified training issues.
- **Innovation, improvement and sustainability**

- The 'symptom observation chart for a dying person' won an award for a doctor involved in its development. The idea was taken to the innovation forum and developed with the support of the members of the end of life care work stream which measured effectiveness.
- The critical care outreach team was engaged with the end of life care service and were members of the end of life care work stream. The team ensured that inappropriate interventions were not undertaken by the team if it was agreed that it was not in the patient's best interest including recognising that the patient was dying.
- The pharmacy team had developed a system that anticipatory medications were packed in a specific way which was separate from other medicines when a patient was discharged home. The pack contained an explanatory leaflet.
- In 2014 an palliative consultant won Doctor of the Year for BSUH.
- The end of life care facilitator had developed a regular end of life care newsletter. In March 2016 newsletter subjects covered included ' Key messages from teams sup-porting the end of life care work'; 'The doctors involved with the End of Life Care Audit: Dying in Hospital' and 'Invitation to the 8th BSUH End of Life Care Conference'. These newsletters were used to cascade information around end of life care to all areas of the trust and staff.
- The end of life care computerised resource was an innovative system. This intranet resource provided easy to read information for all aspects of end of life care. It was easily accessible and was available for all staff.

Outpatients and diagnostic imaging

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

Information about the service

The Princess Royal Hospital offers outpatient appointments for all of its specialties where assessment, treatment, monitoring and follow up are required. The hospital has medical and surgical specialty clinics, as well as paediatric or obstetric clinics. There were 241,106 outpatient attendances at the hospital in the last calendar year.

The diagnostic imaging department carries out routine x-rays, magnetic-resonance imaging (MRI), computerised tomography (CT), mammography and ultrasound. In the last year 91,308 patients used this service.

During the inspection, we spoke with 51 members of staff, which included mangers, nurses, administrative staff and allied health professionals. We spoke with 10 patients and their relatives. We visited outpatient areas, the booking centre and all areas of diagnostic imaging.

Summary of findings

Overall we found outpatients & diagnostic imaging services at the Princess Royal Hospital required improvement. This was because:

- Incidents were not consistently being discussed at meetings or learning from incidents demonstrated.
- Assurance could not be given patients who had been their referral changed from routine to urgent on the referral management system were being seen in a timely manner. Some pathology samples for cancer diagnoses were not being fast tracked as there was no way of identifying them. There was no monitoring of turnaround time for these samples.
- The outpatients and diagnostic imaging departments had undertaken local audits to monitor the quality, safety and effectiveness of care. We saw that staff on the whole had a good awareness of National Institute for Health and Care Excellence (NICE), although some staff in outpatients were unaware of what a NICE guideline was. We saw competency documents, which indicated staff were competent to perform their roles.
- The trust had failed to meet the England standard for referral to treatment (RTT) times since September 2014. The trust had failed to meet cancer waiting and treatment times.
- The pathology department was not providing diagnostic results for suspected cancer in a timely way. It had met the target time for suspected breast cancer results, but not others.

Outpatients and diagnostic imaging

- Call centre data indicated almost half of all calls had been abandoned and unanswered over the last year.
- From April 2015 to March 2016 the hospital cancelled 14% of clinics. Of those cancelled, 67% were done with less than six weeks' notice. There was no monitoring of overrunning clinics by managers. Staff recorded clinic delays on occasion, nut not routinely.
- There was no formal strategy or vision in place in the outpatient department. Not all staff felt they could approach their managers for support. Senior managers and the executive team were not always visible to staff in the department.
- We found staff cared for patients in a kind and compassionate manner. Volunteers provided extra assistance to patients moving from one area to another.

Are outpatient and diagnostic imaging services safe?

Requires improvement

We found outpatients & diagnostic imaging services at the Princess Royal Hospital required improvement for Safety. This was because:

- Staff did not consistently report incidents and some staff were unsure of what they should report. Only 137 incidents were reported in OPD? across the whole trust in outpatients last year. There was no regular discussion about incidents at team meetings and learning from incidents could not be demonstrated.
- Staff were not consistently bare below the elbows when dealing with patients. We did not see any staff handwashing or using hand sanitizer.
- There was no process of alerting the booking team when a patient category had been changed from routine to urgent. Assurance could not be given they were receiving an appointment in a timely manner. There was no clinical oversight of patients waiting longer than 18 weeks. Patients waiting longer than 52 weeks were reviewed. This meant patients waiting longer than 18, but not longer than 51 weeks for an appointment had no review to establish whether any harm had come to them because of the delay.
- Not all cancer biopsies were fast tracked. The time it took for some cancer biopsies to be dealt with was not monitored and could cause a delay in diagnosis.
- Staff were not compliant in mandatory training.

However;

- The diagnostic imaging departments had systems and processes in place to keep patients from harm.
- **Incidents**
- Staff in the outpatient and diagnostic imaging departments used an electronic commercial software system (DATIX) that enabled incident reports to be submitted. In the last year 137 incidents were reported using this system across the trust.
- Some staff told us they felt confident in knowing what to report as an incident, others did not. They did not regularly receive feedback following incidents. Minutes of staff meetings indicated incidents were not a regular agenda item. Clinical governance meeting minutes did

not demonstrate incidents or lessons learned were discussed regularly. This indicated incidents, themes or learning from incidents was not discussed regularly amongst outpatient staff.

- In the last calendar year, the diagnostic imaging department reported two incidents to the Care Quality Commission in line with ionising radiation (medical exposure) regulations (IR (ME) R 2000). Staff dealt with the incidents in an appropriate manner and they were investigated. These incidents were also discussed at the trust radiation safety committee meetings, of which we saw minutes.
- **Cleanliness, infection control and hygiene**
- To maintain registration with the CQC, healthcare establishments must demonstrate compliance with Infection Prevention criterion as detailed in The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Department of Health 2015).
- Hand hygiene audit scores from April 2015 to Jan 2016 were on average 100% for the outpatient department at the hospital, which met the Trust's expectation. The scores were not recorded on one occasion over this period. In the fracture clinic at the hospital the hand hygiene audit scores were on average 99% over the same period and was not recorded on one occasion.
- Waste in clinic rooms was separated and in different coloured bags to identify the different categories of waste. This was in accordance with HTM 07-01, control of substance hazardous to health and Health and Safety at work regulations.
- We saw sharps bins available in treatment areas where sharps may be used. This was in line with health and safety regulation 2013 (The sharps regulations), 5 (1) d. This requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw labels on sharps bins had signatures of staff, which indicated the date it was constructed, by whom and on what date.
- We saw daily cleaning schedules were available and complete in clinic rooms we visited.
- The patient led assessment of the clinical environment (PLACE) score, for the hospital in August 2015 scored 99.5% for cleanliness.
- Outpatient waiting areas were clean and tidy. Seating in the waiting areas and in clinic rooms was made of wipe clean fabric.
- The waiting areas in diagnostic imaging looked clean. A patient satisfaction survey completed in November 2015 indicated 100% of patients thought the department was either clean or very clean.
- Some rooms were used as dual purpose with a screen to separate patients. We saw the screen was rusty and very dirty, which indicated it wasn't cleaned regularly.
- We saw hand hygiene posters that were neither near a sink nor hand sanitizer. Hand sanitizer was not consistently available in all areas. We saw staff go into and leave clinical areas without using hand sanitizer.
- Some staff wore cardigans and were not bare below the elbow when attending to patients.
- We were shown a schedule of when curtains were to be changed with varying frequencies according to the risk factor within the area. We saw documents that showed evidence that the curtains had been changed however this evidence could only be produced up to February 2016. None was available for March 2016 when there had been curtain changes according to the schedule. This indicated the curtains were not consistently changed in accordance with the schedule. If Trusts do not have a robust system in place for changing of curtains microorganisms could be passed from curtains to hands when staff open and close them.
- **Environment and equipment**
- We saw service records which indicated equipment was serviced regularly. We saw equipment had stickers on which indicated it had been serviced recently. Staff told us the medical electrical engineering department responded quickly to requests to deal with faulty equipment.
- All equipment was regularly serviced. We saw records of regular quality assurance tests of diagnostic imaging equipment. In addition to this, a radiation protection committee reported annually on the quality of radiology equipment. These mandatory checks were based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations IR (ME) R 2000).
- Lead aprons were available in all areas of radiology for children and adults. Regular checks occurred of the effectiveness of their protection. We saw spreadsheets which showed checks occurred regularly and equipment provided adequate protection.
- An environmental audit completed in March 2016 scored 98% in the diagnostic imaging department.

Outpatients and diagnostic imaging

- The resuscitation trolley in outpatient areas had equipment for adults and children. They were non-tamper proof and there was easy access to drawer contents. Medications were stored in sealed units, but were not secured to the trolley.
- **Medicines**

- Some medicines need to be stored within a limited temperature range. They should be stored in a dedicated fridge. Regular temperature checks should occur to ensure the limited temperature range is maintained. We saw records to indicate the temperatures were checked and recorded separately. Some areas had separate thermometers to provide extra assurance.
- Drug cupboards we saw in outpatients were locked. Only registered nursing staff held keys to the drug cupboards. This was in line with NICE guidelines MPG2.
- Records held by the Patient Group Directions (PGD) Group indicated PGDs were in use that were past their review dates. PGDs provide a legal framework that allows the supply and/or administration of a specified medicine, by a named, authorised, registered health professional. Provider data suggested PGDs were in use past their review dates in Ophthalmology, Radiology and Dermatology.
- **Records**

- On average, throughout 2015, 8% of patients attended the outpatient record without a full medical record available. Data indicated between Jan 2015 and 2016, on average 4,524 records were missing each month. On average 93% of these were found. Staff told us the tracking system was not taken seriously by all members of staff.
- Between January 2015 and 2016, on average 296 temporary records were made each month. The percentage number of temporary records being made each month had reduced from 14% to three percent of all records each month.
- We saw medical records left outside clinic rooms unattended. This indicated medical records were not always being stored securely.
- **Safeguarding**

- Nursing and diagnostic imaging staff demonstrated a good awareness of what to do if they had safeguarding concerns. They could explain what to do if they had concerns and who to contact. Staff told us once an alert had been raised they did not receive an outcome, which they would have liked. There was no record of the number of safeguarding alerts raised in the last year as the trust did not record this information.
- Data indicated 65% of all staff had attended Level 1 safeguarding training, which was lower than the trust target of 100%. Fifty percent had attended level 2 training, which was lower than the trust target of 100%. Fifty seven percent of all clinical staff who interacted with children had attended level 3 safeguarding training, which was lower than the trust target of 100%. This was not in line with in the Safeguarding Vulnerable Groups Act 2010 or the Royal College of Paediatrics' Child Health Guidance, 2010 which recommends staff interacting with children to attend level three safeguarding training.
- The most recent data available to this indicated 53% of all staff had attended safeguarding adults training.
- **Mandatory training**

- Data provided to us indicated that outpatient staff were 54% compliant in mandatory training which was below the trust target of 100%. Statutory training compliance was 61% which was below the trust target of 95%.
- Staff told us the new computer based training system was easy to access. Others told us it was not user friendly. They told us there were delays in the availability of training, so they missed their target date. Other staff told us they were out of date because of annual leave.
- **Assessing and responding to patient risk**

- Turnaround times for diagnostic biopsies for breast, prostate and bowel cancers were monitored regularly. There was no system in place to identify biopsies for other potential cancers, so they were not fast tracked or monitored. This indicated some patients may not have been receiving a cancer diagnosis in a timely manner.
- Booking centre processes on the whole ensured patients did not get lost in the system. On receipt, referrals were put onto a patient administration system, for booking appointments. In addition to this, they were put onto a referral management system. The staff that inputted this data made a decision based on clinical details, which specialist team the referral was sent to. These staff were not clinically trained. A serious incident occurred last year as a result of this. A two week wait referral resulted in an appointment with an inappropriate clinician.

Outpatients and diagnostic imaging

- Staff and managers told us the computer systems were not compatible. If a consultant re-graded a referral as urgent, this would appear on the referral management system, but not on the patient administration system. This indicated not all urgent patients' referrals would receive an urgent appointment.
- We received an email statement which read: There is no clinical review of patients that go over 18 weeks. We prioritise those triaged or expedited as clinically urgent. This indicated patients waiting greater than 18, but less than 52 weeks were not being reviewed for any potential harm.
- A clinical review group was established to review all clinical records of patients who had waited over 52 weeks and whether the patient has been harmed by the delay to their treatment. This review would take place once treatment had been given. Progress and outputs of the Clinical Review Panel and any patients where significant harm had resulted because of a delay were reported to the Quality Review Meeting.
- A tracking list was maintained which listed all patients treated over 52 weeks, date of review and actions. This was to be maintained and updated during the clinical review process. We saw this list. Of the 309 reviewed so far, 114 were patients under the digestive diseases specialties (37%).
- Patients on a two week pathway had a dedicated booking team in the booking centre. Most referrals were received electronically. A paper referral would be taken to the two week wait team on the same day. The booking team could escalate concerns about appointment s to service managers. Weekly cancer patient tracking list meetings provided clinical oversight of patients on two week pathways.
- Regular access meetings were carried out to ensure all patients were on a patient tracking list (PTL). We saw minutes of these meetings.
- Staff in outpatients told us they were unsure about what to do if a patient became unwell or collapsed. They told us they would call for an ambulance. Data indicated 45% of all staff had attended basic life support training.
- We observed good practice for reducing exposure to radiation in the diagnostic imaging departments. Local rules were available in areas we visited. Diagnostic imaging staff had a clear understanding of protocols and policies. Protocols and policies were stored on a shared computer file which staff had access to. Staff demonstrated their knowledge of where policies were kept.
- We observed good radiation compliance as per policy and guidelines during our visit. The department displayed clear warning notices, doors were shut during examination and warning lights were illuminated. There was key card entry to examination rooms and only authorised staff held a key card.
- A radiation protection supervisor was on site for each diagnostic test and a radiation protection adviser was contactable if required. This was in line with ionising regulations 1999 and regulations IR (ME) R 2000).
- Departmental staff also carried out regular Quality Assurance checks. This indicated equipment was working as it should. These mandatory checks are in line with ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR (ME) R 2000). We saw records of these checks.
- Lead aprons were available in all areas of diagnostic imaging where necessary for children and adults.
- Signs advising women who may be pregnant to inform staff were clearly displayed in the diagnostic imaging departments in line with best practice.
- **Staffing**
- The outpatient nursing team was fully staffed at the time of inspection. Staff told us they would often have to work late to provide cover for overrunning clinics or if transport was delayed.
- A radiologist was available through the day, every day to provide reports and assistance to radiographers and medical staff if required.
- **Major incident awareness and training**
- Staff had a poor understanding of what to do in the event of a major incident. The trust had an emergency preparedness, resilience & response policy which included a business continuity plan. This was available
- on the trusts computer system.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate effectiveness as we do not currently collect sufficient evidence to rate this.

- The outpatients and diagnostic imaging departments had undertaken local audits to monitor the quality, safety and effectiveness of care.
- We saw that staff on the whole had a good awareness of National Institute for health and Care Excellence (NICE) guidelines and this was demonstrated in their practice.
- The diagnostic imaging department had policies and procedures in place in line with national guidance.
- **Evidence-based care and treatment**
- Diagnostic imaging services participated in the Imaging Services Accreditation Scheme (ISAS). ISAS is a patient-focussed assessment and accreditation programme that is designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments. A requirement of the programme was to audit services regularly. We saw that a variety of audits were ongoing in the imaging departments which could evidence that best practice was being achieved. We noted that these audits were ongoing.
- The diagnostic imaging department were following a variety of National Institute for Health and Care Excellence (NICE) guidelines. They followed NICE clinical guideline (CG), 176 for early assessment and management of head injury. Local implementation of a suspected lung cancer pathway in March 2016 met NICE guideline (NG), 12 for suspected cancer: recognition and referral. They were also working in line with NG, 39 for major trauma: assessment and initial management, with the CT traumagram protocol for polytrauma.
- The imaging department had policies and procedures in place. They were in line with regulations under ionising radiation (medical exposure) regulations (IR (ME) R 2000) and in accordance with the Royal College of Radiologists standards.
- **Nutrition and Hydration**
- Staff told us that if a patient experienced a delay because of transport, they would be offered refreshment.
- **Pain relief**
- If pain relief was required in outpatients, a patient would be given a prescription which they could take to the pharmacy department within the hospital.
- In diagnostic imaging staff would contact the ward if an inpatient was in significant discomfort. This was in order to return them to the ward as soon as possible and inform ward staff pain relieving medication was required.
- A variety of supports were available in diagnostic examination rooms to make patients as comfortable as possible whilst undergoing an examination.
- **Patient outcomes**
- Patient outcomes recorded on the computer system indicated if a patient, had another appointment, or had been discharged. Staff could not close a clinic without inputting an outcome. This indicated all patients had an outcome.
- **Competent staff**
- Staff told us that additional staff were available during the induction process so that sufficient time was allocated to get to know the area they were working in. Staff were moved through different clinical areas regularly to maintain their competency in a variety of skills. There was a system for assessing the competency of staff in several skills. We saw copies of competency certificates.
- Nursing staff told us they had access to local and national training. This contributed to maintaining their registration with the nursing and midwifery council (NMC).
- We saw diagnostic imaging staff were registered with the Health Care Professions Council (HCPC). Managers checked the registration of their staff regularly. Radiology staff who administered medicines were required to be certified to do so and we saw certificates for those staff which were in date.
- Agency staff completed an induction prior to starting work in the diagnostic imaging departments. We saw copies of these checklists.
- 82% of all diagnostic imaging staff had an appraisal in the last year, which was above the trust target of 75%.
- **Multidisciplinary working**

Outpatients and diagnostic imaging

- One stop clinics involved several different staff groups working together and occurred in urology and head and neck specialities. A variety of staff from different staff groups and hospital attended.
- **Seven-day services**
- Radiology Consultants worked seven days a week. The radiology department provided a seven day, on call service
- **Access to information**
- The computerised radiology information system (CRIS) stored patient data and was used for booking appointments.
- A patient archiving computer system (PACS) was used for the storage of diagnostic imaging tests. Staff throughout the trust could access the results of diagnostic tests through PACS. They required a passcode to log in.
- Policies, procedures, service records and meetings of minutes were stored in a shared folder on the trust intranet. We saw staff could access this information with ease.
- **Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**
- We saw posters around the hospital which gave a brief description of the mental capacity act.
- Staff were able to describe the process of dealing with a patient who may not have the capacity to consent to treatment. They were aware of who to contact if they required further advice.

Are outpatient and diagnostic imaging services caring?

Good

We found outpatients & diagnostic imaging services at the Princess Royal Hospital was good improvement for caring. This was because:

- Staff treated patients with compassion and care.
- We observed staff helping patients when they appeared lost or required assistance.
- We saw staff had processes in place to respect patient's dignity.
- **Compassionate CAre**
- A friends and family test (FFT) completed in January 2016 indicated 96% of patients would recommend the outpatients department and 2% would not. This is greater than the average of 92% who would recommend and three percent who would not recommend a service. Four hundred and eighty four of an eligible 51,556 patients completed the survey which is less than 1% of all patients who attended the outpatient department.
- We saw patients being spoken to in a kind and compassionate way.
- We spoke with a volunteer who told us they felt part of the team. Her role was to help escort patients to their destination department and we observed her doing this.
- We saw staff approaching and assisting patients who appeared lost when looking for their department.
- One staff member described the patient to staff contact as 'brilliant' and had seen incidents where they felt inspired. They had witnessed a patient collapse outside of the main entrance. They felt attending staff were dedicated and selfless in ensuring the patient was well looked after.
- In the radiology department, the viewing rooms had doors, which meant confidentiality was maintained whilst patients had their investigation.
- The diagnostic imaging reception area was away from the waiting area so patients could not be overheard when booking in.
- We saw patients waiting for their diagnostic imaging procedures in hospital gowns in the waiting room which did meant patient dignity was not always maintained.
- Staff told us there was no separate waiting area for men and women waiting for scans. Patients waited in hospital gowns. We saw patients waited in gowns for short periods prior to their investigation.
- **Understanding and involvement of patients and those close to them**
- We saw there were a variety of health-education leaflets produced by national bodies. Some of this information was general in nature while some was specific to certain conditions. This literature was available in the majority of waiting areas of the outpatient departments.
- A patient experience panel met every other month. Staff and patient representatives attended. The patient representatives were encouraged to give feedback on

what went well and not so well. Action points were made as a result of this feedback. We saw minutes of these meetings and updates on actions which had arisen.

- **Emotional support**

- We saw Macmillan cancer support information was available for patients, carers and their families. Literature on bereavement services was available in waiting areas.
- A charity provided a buddy service to support patients living with cancer. The buddies were trained Macmillan volunteers who had undergone treatment for cancer themselves. They provided help and support to patients, their families and carers.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We found outpatients & diagnostic imaging services at the Princess Royal Hospital required improvement for responsive. This was because:

- The trust had failed to meet the England standard for referral to treatment (RTT) times since September 2014. An action plan to recover the RTT was being implemented, but was in the early stages and yet to impact on waiting times.
- The trust had failed to meet cancer waiting and treatment times.
- The pathology department was not providing diagnostic results for suspected cancer in a timely way. It had met the target time for suspected breast cancer results, but not others.
- Call centre data indicated almost half of all calls had been abandoned and unanswered.
- From April 2015 to March 2016, the hospital cancelled 14% of clinics. Of those, 67% clinics were cancelled with less than six weeks' notice. No reasons were given for the cancellation of clinics. Overrunning or delayed clinics were not monitored, so managers could not be aware if this was a problem or not.

However;

- We saw there were systems and processes in place to deal with patient's individual needs.
- Patients accessed examinations in the diagnostic imaging department in a timely manner.
- **Service planning and delivery to meet the needs of local people**
- There was no signage to direct patients from the main entrance to the x-ray department. We saw several visitors to the hospital ask for directions.
- We saw adequate numbers of chairs in waiting areas we visited. Staff displayed clinic delays and waiting times on white boards.
- There was a quiet room available in the outpatient department, which staff could access if bad news had to be broken.
- The diagnostic imaging department had a walk in service for patients referred from their GP. The service ran from 9:15am to 4:00pm five days a week and gave patients a choice of when to attend.
- The hospital ran 241 weekend clinics in the last year. This gave patients the option of attending at a time more convenient to them.
- A text reminder service was in place. In addition to this, managers told us there were plans in place to introduce a two-way text reminder, so patients could change their appointment if necessary.
- We saw diagnostic imaging appointment letters contained appropriate information for patients prior to attending their appointment. Any special instructions were highlighted in a different colour, which the instructions easier for patients to identify.
- **Access and flow**

- Since January 2009 every citizen of this country has the binding NHS constitutional right to be treated within 18 weeks. Where a hospital is unable to offer patients treatment within 18 weeks the patient has the right to be treated elsewhere. Operational standards are that 95 % of non-admitted pathways should start consultant-led treatment within 18 weeks of referral.
- The non-admitted referral to treatment times (RTT) for this hospital from September 2014 was consistently worse than the England average and the standard of 95%. At the end of February 2016 one out of 18 specialities had met the standard. Overall 85 % of patients were seen within 18 weeks which remains below the standard.

Outpatients and diagnostic imaging

- A referral to treatment time (RTT) action plan had been established to deal with the RTT's. We saw the action plan had 104 actions, of which three had been completed. One of the actions was to have a weekly access meeting. We saw minutes of these meetings.
- The percentage of cancer patients seen by specialist within 2 weeks of an urgent referral varied between from April 2015 to December 2015 and in four out of the seven quarters was below the national average. The most recent data indicated 92% of patients were seen in two weeks. This was below the England average of 95% and the standard of 93%.
- The last reported data indicated ten out of four specialities had met the standard. The percentage of patients within two weeks with suspected lower gastrointestinal cancer was 67%. The most recent cancer meeting minutes indicated this had reduced further to 38%. The percentage of patients seen within two weeks with suspected upper gastrointestinal cancer was 87%. The most recent cancer meeting minutes indicated this had reduced to 76%. This indicated the performance in these two areas was worsening.
- The percentage of patients waiting less than 31 days for treatment for cancer was below the England average from April to December 2015. The most recent data indicated 95% of patients were seen within 31 days which was below the England standard of 96% and England average of 98%.
- The percentage of patients waiting less than 62 days for their first treatment for cancer was below the England average from April to December 2015. The most recent data indicated 82% waited less than 62 days which was below the standard of 85% and England average of 84%.
- The pathology department tested specimens where a piece of tissue had been removed to provide a diagnosis. Turnaround time (TAT) is a measure of how quickly a diagnosis can be provided. The most recent TAT for suspected breast cancer was 90% of results were available in seven days, this was better than the target of 80%. One hundred percent of results were available 14 days which was better than the target of 90%. For suspected prostate cancer the TAT was 15% of results available in seven days, which was below the target. Seventy percent of results were available in 14 days, which was below the target score. The TAT's for suspected bowel cancer were; 55% of results available in seven days, which was below the target of 80%. Eighty five percent of results were available within the 14 days, which was below the target of 90%. Any suspected cancer samples which did not fit into the above category were labelled as 'other'. TAT for these samples was 30% of results available in seven days and 60% of results were available in 14 days. This indicated only samples for patients with suspected breast cancer were receiving a result within the target time.
- Data indicated the hospital cancelled 49,322 patient appointments between April 2015 and March 2016, which equated to 14%. Sixty seven percent of appointment cancellations were done with less than 6 weeks' notice. This was not in line with the patient access policy which states; 'A minimum of 6 weeks' notice is required if a Consultant or Clinician needs an outpatient clinic or inpatient theatre list cancelled or reduced'. We requested the reasons for short notice cancellations but did not receive this information. This was not in line with the outpatient service delivery and improvement plan which planned to monitor reasons for cancellations in order to set targets. We saw booking centre staff cancelling appointments with less than 24 hours' notice during the inspection.
- Paper referrals were received into the outpatient appointment centre. Staff scanned them onto a computer system. Consultants accessed this system to triage referrals. The target time for this process was 48 hours. We requested data to indicate how long it took to triage referrals. We received data about referral to appointment booking time. This suggested the time taken from referral to appointment booking indicated the length of time taken to triage the referral. The data provided indicated 68% of referrals had an appointment booked within 5 days, 15% had an appointment booked between 6 and 10 days and 17% waited more than 11 days to have an appointment booked. It was not clear what percentage of patients were triaged within the target time. Patients we spoke with told us they had been 'fobbed off' by the hospital and had waited more than a year to receive an appointment. We spoke with a patient who had waited four and a half months for a cardiology appointment. They had then waited another month and a half to have a monitor fitted.
- Staff told us patients often attend for an appointment, but the appointment had been changed or cancelled without the patient being informed. We saw a patient

attend an appointment with a letter indicating the date and time of his appointment. Staff saw the appointment had been cancelled, but the patient had not been informed. The patient returned home.

- The number of calls received at the call centre had increased from 18,097 to 26,916 from July 2015 to January 2016. During this period the number of calls abandoned had increased from 8% to 41%. During our inspection we saw 48% of calls were abandoned. Staff told us patients come to the outpatient department with queries about appointments as they cannot get through on the phone.
- The trust did not record or monitor waiting times in clinic. There was no policy or protocol in place for overrunning clinics. This indicated the trust was unaware if and how many clinics ran late. Staff made note of double bookings and finish times in clinic. Data received indicated 68% of those recorded were overbooked. Thirty two percent of those recorded ran late. On four occasions a clinic had to be moved to another location because a clinic was running late. Staff noted they had to stay to 7pm in order to wait with a patient for transport to arrive.
- We saw data which indicated in March 2015, 15% of clinic letters were completed within 2 days. Thirty percent of all clinic letters were completed in 14 days. This meant 39% took more than two weeks, which equated to 12,129 patient letters. Performance was variable between specialities. This was not in line with the target of all clinic letters to be sent in five working days. The number sent in five days was not measured.
- The most recently published data indicated that overall 98% of patients received a diagnostic test within six weeks. Ninety nine percent of patients had an MRI in six weeks, 99.5% of patients had a CT in six weeks. Ninety nine percent of patients had an ultrasound scan in six weeks.
- Patients requiring a diagnostic test on a two week pathway were booked an appointment straight away. This was in line with the patient access policy. There were designated slots for diagnostic tests. If they were full staff would be able to create another available appointment. Staff told us they never had issues finding appointments for patients on a two week pathway.
- A troubleshooting radiologist was available through the day to provide urgent reports on diagnostic tests. They also provided staff with advice.
- The phlebotomy service had a ticketing system, so patients were seen in order of arrival.
- **Meeting people's individual needs**
- Staff told us patients living with dementia were fast tracked when attending outpatient appointments. They told us patients would attend with a carer and carry a hospital passport. Passports outline a patients care needs, preferences and any other information the staff would find useful to assist with their care.
- Staff gave patients with learning disabilities longer appointments. The learning disability team would be invited to attend appointments and patients would be seen at the next available appointment on attending the department.
- Staff could indicate on the electronic patient information system if a patient had an individual need. We saw how this could be done.
- We saw wheelchair accessible reception desks in some areas. They had been installed following a disability access audit in 2008.
- We saw waiting areas had seats of varying height, bariatric seating and space available for wheelchair or push chairs.
- Hearing loops were not consistently available in outpatient waiting areas. Staff told us they could book a sign language interpreter if required.
- We saw posters advertising a telephone interpretation service. Staff told us if a referral indicated an interpreter was required, they could book one at the time of booking an appointment.
- Health information literature was not available in other languages.
- In the areas we visited, we did not see any toys or books were available for children who may attend an appointment with their parent.
- **Learning from complaints and concerns**
- Leaflets informing patients how to make complaints were available in waiting areas. Staff felt able to handle complaints and preferred to do so at a local level to diffuse the situation.
- There was no regular feedback documented regarding complaints at team meetings.
- We received information which indicated 30% of all complaints to the trust were about outpatients last year. The three most common cause for complaint across the trust were; administrative error/failings, communication and wait for an outpatient appointment.

Outpatients and diagnostic imaging

- We did not see suggestion boxes in any areas we visited.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

We found outpatients & diagnostic imaging services at the Princess Royal Hospital required improvement for well led. This was because:

- There was no formal strategy or vision in place in the outpatient department.
- Senior managers and the executive team had variable levels of visibility across the department.
- There were variable levels of access to training across specialities.

However;

- The culture in the outpatient department was to provide good quality care to patients.
- The diagnostic imaging department management had a clear structure in place, managers were visible. Managers monitored the department's performance and staff took pride in their work.
- **Vision and strategy for this service**
- Staff told us there was no agreed vision or strategy for the outpatient department. When we asked managers about their vision, they told us about the vision for departments they were moving to.
- An interim manager told us about the referral to treatment (RTT) recovery plan and we saw this. The plan was extensive and had timescales which were Red, Amber, and Green (RAG) rated. A number of actions on the plan had passed their due date and some actions did not have a due date allocated.
- A manager told us that the trust had requested a pause in patient referrals for digestive diseases speciality from the Clinical Commissioning Group (CCG). This was because waiting times had increased for this speciality. The COO explained waiting times for patients on an 18 week pathway had increased. This was because appointments had been given to patients on a two week pathway, which enabled the two week targets to be met in some specialities.
- The outpatient department had a values and behaviours champion. Senior staff told us the majority of staff complied with the trust values.
- **Governance, risk management and quality measurement**
- The Lead Directorate Nurse for the outpatients department told us that monthly outpatient manager meetings were held and was a good forum for sharing ideas across the directorate. We saw minutes of these meetings, however, quality issues such as complaints, incidents, risks and audits, were not regular agenda items.
- The outpatient department carried out a variety of local audits. We did not see any improvement or action plan as a result of these audits. For example, over a ten month period, the hand hygiene audit scores for the outpatient department across the trust varied for 90% to 100%. The scores varied from month to month. This indicated standards were not consistently met and improvement was not occurring as a result of these audits.
- Minutes of outpatient staff meetings indicated incidents were not a regular agenda item. Clinical governance meeting minutes did not demonstrate incidents or lessons learned were discussed regularly. Staff were not always confident in reporting incidents. When they did report incidents they did not always receive feedback.
- Access meetings occurred monthly for cancer, diagnostic and referral to treatments times. We saw the minutes of these meetings. Regular agenda items were outcomes, learning from specific queries and reviewing the departmental dashboard. These meetings reported to the planned care programme board, which in turn reported to the finance, performance and people committee. This committee reported to the trust board.
- The diagnostic imaging department had a dashboard which provided managers with monthly performance data. It included waiting times, reporting times and friends and family test results, which we saw. They provide feedback to the board on their performance via the access meetings.
- The diagnostic imaging department took part in a number of audits which were on-going. They demonstrated NICE guidelines were being followed in a number of areas.
- **Leadership of service**

Outpatients and diagnostic imaging

- Nurse Managers reported to the directorate lead nurse. The directorate lead nurse with the directorate manager and lead clinicians for head and neck specialities all reported to the clinical director, who was on leave at the time of our inspection. The directorate lead and lead nurse were due to move to different roles the month in May 2016.
- Not all outpatient staff were in the same directorate. This was dependent on which speciality team they were in. We asked for the structure of outpatient nursing staff and received a list of the numbers of staff at different pay bands.
- The majority of the staff we spoke with felt well supported by their immediate line managers.
- Some senior members of staff felt that the Chief Nurse was approachable and accessible.
- One member of staff told us there was no ownership of issues higher up in the trust. They gave the example of patient transport issues that have been recurring and the knock on effect this has on patients and staff. The issue had been raised with managers on several occasions, but had never been acted upon.
- A member of staff who had worked at the trust for many years said that the communication "from above" was poor. They described how their job had been displaced with the arrival of the booking hub and although was well supported by their line manager, found this time very difficult.
- When asked about visibility of the executive team in the outpatient department, staff felt they visited wards more than the outpatient department.
- In the diagnostic imaging service, staff told us their managers were visible and approachable. They felt well supported by local and more senior managers. Managers formed a well organised team.
- **Culture within the service**

- A member of staff that had recently joined the trust that the induction process was comprehensive and lasted two days told us.
- Staff in outpatients wanted to provide good quality care to patients.
- Staff told us that the medical model that the trust had adopted could be a barrier to further development. An example was given where a job role was advertised but was only available to nursing staff and not to other healthcare professionals.
- Staff felt happy in their individual teams. There was no overall outpatient team.
- The diagnostic imaging departments clearly took pride in their work and worked well together as a team. They supported on another and told us there was an open and honest culture.
- **Public engagement**

- A manager told us that the trust published waiting times to the website per speciality. The trust had included on their website a 'guide to waiting times'. The page on the website showed a high level overview of the 18 week pathway and the areas or departments where patients may experience delays. We were not able to see specific waiting times data for specialities on the trust website.
- **Staff engagement**

- A manager told us that staff from the booking hubs attended the weekly directorate patient tracking list meetings (PTL) meetings. This inclusion of the booking staff helped to identify issues early on in the patient pathway, and allowed booking staff to escalate concerns and feel part of the wider team.
- We were told that the executive team were taking an interest in the management and development of the booking hub centre. The Board had approved the purchase of an additional module of the booking system which should allow more efficient working.
- **Innovation, improvement and sustainability**

- Some staff said they were able to access funding for external training and that this was positively supported. However, one member of staff was told at interview that there was no budget available for formal training.
- Staff told us that internal training had recently moved online and was easy to access.
- Staff told us about an innovation forum that was available for staff to attend. However, some staff were not aware of or could access the innovation forum.
- One member of staff had additional duties on their main role as a health and safety representative. Training for this extra role has been self-funded. There was no time
- within main job role to carry out these additional duties.

Outstanding practice and areas for improvement

Outstanding practice

Brighton and Sussex University Hospitals NHS Trust was amongst Britain's most dementia friendly trusts. The trust was one of five in the National Dementia Care Awards. The trust's dementia team provided direct support to patients living with dementia in both the specialist dementia wards and in the trust in general.

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure that there are sufficient numbers of staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of patients using the service at all times. This includes ensuring that newly appointed overseas staff have the support and training to ensure their basic competencies before they care for and treat patients.
- The provider must ensure that medicines are always supplied, stored and disposed of securely and appropriately. This includes ensuring that medicine cabinets and trollies are kept locked and only used for the purpose of storing medicines.
- The provider must ensure its governance systems are embedded in practice to provide a robust and systematic approach to improving the quality of services. This includes improving learning from incidents, safeguarding and complaints across the directorates.
- Facilitate and establish a line of communication between the clinical leadership team and the trust executive board.
- Urgently review staff skill mix in the mixed/neuro ICU unit. This must include an analysis of competencies against patient acuity.
- Implement an action plan to reduce further nurse sickness absence and attrition through a transparent, sustainable programme of engagement that must include a significant and urgent improvement in staff training.
- Review funding for multidisciplinary specialties and ensure business cases submitted by specialists are considered appropriately. This specifically refers to pharmacy, occupational therapy and dietetics.
- Adhere to RCN guidelines that the nurse coordinator remains supernumerary at all times.
- Review and improve medical and nursing cover to meet relevant CEM and RCPCH standards and reflect/review activity rates relating to paediatric for the unit.
- Review clinical training records for medical and nursing staff and rectify gaps in role specific resuscitation training such as ALS and PILS.
- Complete mandatory training and performance appraisals for all staff.
- Review the actual risk of the Alert computer system.
- Ensure that resuscitation/emergency equipment is always checked according to the trust policy.
- Ensure staff are working under appropriately approved Patient Group Directions (PGDs). Ensure PGDs are reviewed regularly and up to date.
- Continue to ensure lessons learnt and actions taken from never events, incidents are shared across all staff groups.
- Ensure the 18 week Referral to Treatment (RTT) is addressed so patients are treated in a timely manner and improve outcomes for patients.
- Ensure safe and secure storage of medical records.
- Monitor the turnaround time for biopsies for suspected cancer of all tumour sites.

Outstanding practice and areas for improvement

- Ensure that all staff complete mandatory training in line with trust targets, including conflict resolution training.
- Ensure that all relevant staff have the necessary level of safeguarding training.

Action the hospital SHOULD take to improve

- The provider should ensure there is a cohesive vision and strategic plan for the directorates which engages staff and provides an effective guide in the development of services.
- The provider should continue to prioritise patient flow through the hospital as this impacted on length of stay, timely discharge and capacity.
- The provider should ensure there is documentary evidence available to support recording that staff mandatory training is in line with trust targets.
- The provider should ensure that there are sufficient staff available to offer a full seven-day service across all directorates and support services.
- The provider should review the HR policies and ensure they are fit for purpose.
- The provider should ensure that effective HR resources are available that support staff. In particular the provider should continue to address the culture of bullying and intimidation found in some areas of the service.
- Ensure all staff are included in communications relating to the outcomes of incident investigations.
- Implement a sepsis audit programme.
- Review the workload of the nurse practice educators and assess the impact on their availability for bedside learning and teaching.
- Make adjustments to the rehabilitation pathway to ensure it is fully compliant with NICE CG83.
- Harmonize computerised patient information and management software between trust sites.
- Review and improve major incident storage facilities and replenish stock.
- Review analgesia authorisation for Band 5 nursing staff (PGD).
- Ensure equipment and medicines required in an emergency are stored in tamper evident containers.
- Review the provision of pharmacy services across the seven day week and improve pharmacy. support.
- Review the nurse staffing levels to ensure all areas are adequately staffed.
- Ensure all staff have had an annual appraisal.
- Review the consent policy and process to ensure confirmation of consent is sought and clearly documented.
- Review the provision of the pain service in order to provide a seven day service including the provision of the management of chronic pain services.
- Continue in embedding its governance systems to ensure a more consistent approach to governance processes.
- Have a defined regular audit programme for the end of life care service.
- Provide a seven day service from the palliative care team as per national guidelines.
- Record evidence of discussion of an end of life care patient's spiritual needs.
- Ensure all DNACPR, ceilings of care and Mental Capacity assessments are completed and documented appropriately as per guidelines.
- Ensure that all staff receive annual appraisals.
- Have a non-executive director for end of life care services.
- Implement a formal feedback process to capture bereaved relatives views of delivery of care.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...