# Western Sussex Hospitals NHS Foundation Trust

## Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

## Facts and data about this trust

### Acute hospital sites at the trust

A list of the acute hospitals at Western Sussex Hospitals NHS Foundation Trust is below.

| Name of acute hospital site | Address | Details of services provided at the site | Geographical area served |
|---|---|---|---|
| Southlands Hospital | Upper Shoreham Road, Shoreham By Sea, BN43 6TQ | Assessment or medical treatment for persons detained under the 1983 Act, Diagnostic and screening procedures, Family planning services, Services for everyone, Surgical procedures, Termination of pregnancies, Treatment of disease, disorder or injury | West Sussex |
| St Richard's Hospital | St Richards Hospital, Spitalfield Lane, Chichester, PO19 6SE | Assessment or medical treatment for persons detained under the 1983 Act, Diagnostic and screening procedures, Family planning services, Maternity and midwifery services, Services for everyone, Surgical procedures, Termination of pregnancies, Treatment of disease, disorder or injury | West Sussex |
| Worthing Hospital | Lyndhurst Road, Worthing, BN11 2DH | Assessment or medical treatment for persons detained under the 1983 Act, Diagnostic and screening procedures, | West Sussex |

| | | | |
|---|---|---|---|
| | | Family planning services, Maternity and midwifery services, Services for everyone, Surgical procedures, Termination of pregnancies, Treatment of disease, disorder or injury | |

*(Source: Routine Provider Information Request (RPIR) – Sites tab)*

# Is this organisation well-led?

## Leadership

The trust had a very well qualified and very experienced board that worked well together. Challenge from the non-executives was evidenced and robust with clear demarcation of roles and responsibilities. At all levels, the leadership was entirely positive about their teams and the quality of care they provided. There was a buzz of enthusiasm for learning and high performance. All leaders were proud of the work their teams were doing and could give specific examples of where each team had 'gone the extra mile'. Staff that we spoke to were entirely positive about their leaders and talked of support, approachability, pride, a visible executive and trust in each other.

The executive team provided exceptional leadership and had a very good understanding of how the hospital was working in both the longer term (through a sound assurance framework) and on a day to day basis (through a regular ward and department presence and open-door sessions). There was clear team work amongst the executive team and their positive leadership style filtered down through middle managers to local managers.

The trust had leads for child and adolescent mental health, learning disability and autism.

### Board Members

Western Sussex Hospitals NHS Foundation Trust was managed by a Board of Directors comprising a Chairman, Executive Directors and Non-Executive Directors.

The Chairman and non-executive directors were appointed by the trust's Council of Governors

The Chief Executive was appointed by the Chairman and non-executive directors

The other Executive Directors were appointed by the Chairman, Non-Executive Directors and the Chief Executive.

The trust board met regularly throughout the year at both St Richard's Hospital and Worthing Hospital.

### Board Members

Chair; Alan McCarthy

The Chair joined in October 2018, as the chair of both Western Sussex Hospitals NHS Foundation Trust and Brighton and Sussex University Hospitals NHS Trust. He is a chartered civil engineer with 40 years' experience in the public sector, including five years as chief executive of Brighton and Hove City Council. Alan retired from full-time employment in 2009 and embarked on a mixed portfolio of non-executive positions including being chair of Surrey and Sussex Healthcare NHS Trust for eight years and a year chairing Brighton and Hove PCT.

Chief Executive Officer; Dame Marianne Griffiths DBE

Dame Marianne has served 11 years as chief executive of Western Sussex Hospitals NHS Foundation Trust. She led the trust from its creation from a merger in 2009 and within four years the organisation was awarded foundation status.

In 2016, Western Sussex Hospitals NHS Foundation Trust became the first multi-site trust to be rated outstanding by the Care Quality Commission (CQC) and that same year Dame Marianne was named Chief Executive of the Year at the HSJ awards. In December 2018, she was made a Dame Commander of the Order of the British Empire (DBE) in the New Year Honours List for services to the NHS.

In April 2017, Dame Marianne also became chief executive of neighbouring Brighton and Sussex University Hospitals NHS Trust when, at the request of NHS Improvement, she and her fellow board entered into a three-year joint management contract to lead the teaching hospital and regional trauma centre, while continuing their tenure of Western Sussex Hospitals NHS Foundation Trust. In January 2018, BSUH was awarded a good rating by CQC, marking one of the most successful turnarounds of a trust placed in special measures by the health watchdog.

Dame Marianne originally joined the acute provider sector in 2009 from NHS South East Coast, where she was Deputy Chief Executive and Director of Commissioning and Delivery, prior to which she was Chief Executive at Kent and Medway Strategic Health Authority. Her many roles in the NHS have also included a joint appointment in West Sussex as Head of Commissioning Social Services and Director of Strategic Development for the Health Authority.

Chief Medical Officer and Deputy Chief Executive; Dr George Findlay

Dr Findlay joined the trust in January 2014 from one of Wales' largest integrated NHS organisations. He is an experienced clinical leader at national and regional level and a specialist intensive care consultant. In 2011, he was one of 18 people selected to participate in the Health Foundation's Generation Q leadership and quality improvement programme, where he gained skills and knowledge in clinical leadership and quality improvement. From 2008 to 2014, Dr Findlay was clinical advisor to the Welsh Government on organ donation and transplantation, drafting and consulting on new legislation which culminated in the historic introduction of "presumed consent" in Wales on 31 December 2015.

In addition, Dr Findlay led the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) over a 10-year period – an enquiry which aimed to identify and make recommendations to improve remedial factors in health care.

His work led to more than 20 national publications that significantly shaped health care standards and policy. His training as a medical student was at Dundee University, after which he entered the Royal Air Force as a medical officer on a short service commission, before returning to the NHS in 1995.

Chief Nurse; Dr Maggie Davies

Dr Davies joined Western Sussex in 2014 as Deputy Director of Nursing and has extensive nursing experience including being both an oncology nurse working for Macmillan Cancer Support and working as a District Nurse. She joined the trust from Brighton & Hove Clinical Commissioning Group where she was Head of Primary Care Strategic Development. In her five years at the trust, Dr Davies has championed patient safety and nurse recruitment and completed a doctorate in Clinical Practice. As Chief Nurse, Dr Davies represents nursing, midwifery, patient safety and allied healthcare professionals on the trust board.

Chief Operating Officer; Jayne Black

The Chief Operating Officer has a wealth of NHS experience, having also held senior nursing roles in surgery, medicine and critical care. Previously, she was Deputy Chief Executive and Chief Operating Officer at Croydon Health Services NHS Trust which provides integrated acute and community services.

Before that she was Director of Strategy & Transformation for Maidstone and Tunbridge Wells NHS Trust and West Kent Clinical Commissioning Group, where she was a joint appointment to improve access to NHS care, in and out of hospital, for people in the local community

Chief Delivery and Strategy Officer; Pete Landstrom

Mr Landstrom started his career as a management consultant and has held several senior positions in the NHS, including Head of Operations and Delivery for Cardiff and Vale University Health Board.

Chief Financial Officer; Karen Geoghegan

The Chief Financial Officer started her NHS career as part of the service's Financial Management Training Scheme and subsequently worked in several NHS organisations in London, including Guy's and St Thomas' NHS Foundation Trust, Northwick Park hospital and St Mark's hospital. In 2002, Karen joined Brighton and Sussex University Hospitals NHS Trust, where she held several posts including interim Chief Financial Officer.

Karen joined Western Sussex Hospitals NHS Foundation Trust in February 2014.

Chief Workforce and Organisational Development Director; Denise Farmer

Denise joined Royal West Sussex NHS Trust in February 2008 as Director of Human Resources and Organisational Development and was appointed to her current post on the merger with Worthing and Southlands hospitals. She came originally from Liverpool and has worked in the public sector for her entire career, most recently at Hampshire Primary Care Trust (PCT), where she was involved in major change programmes.

At South Central Strategic Health Authority, she led the recruitment process for PCT Chief Executives and Directors to the new PCTs.

Managing Director; Amanda Fadero

Ms Fadero joined Western Sussex Hospitals on 1 April 2019 as the trust's new managing director and executive board member. Amanda's remit includes responsibility for the operational performance of the trust as well as exploring closer partnership arrangements with neighbouring organisations, in line with the NHS Long Term Plan.

Having originally qualified and worked as a nurse, Amanda brings with her more than 40 years of NHS knowledge and experience. Her previous roles include Chief Executive of NHS Sussex and NHS England (Surrey & Sussex); Deputy Chief Executive, Director of Strategy and Change and interim Chief Executive at Brighton and Sussex University Hospitals NHS Trust; and Executive Director of Commissioning, Partnerships and Planning at Sussex and East Surrey Clinical Commissioning Groups and STP.

Non-Executive Director; Patrick Boyle

A resident of Peacehaven, Patrick has had a long career in the UK Public service. He brings to the trust 30 years senior leadership and governance experience at CEO level in central government

and the NHS. He is a fellow of the Chartered Institute of Personnel and Development and a member of the Association for Coaching.

Non-Executive Director; Joanna Crane

Ms Crane worked in the financial services industry for more than 25 years, beginning her career in private banking before moving to corporate banking and structured finance. After an exciting time working in IT during the years that lead to European Monetary Union (EMU) Joanna moved into HR, with a particular focus on strategic planning and change management. Most recently, Joanna worked at the European Investment Bank (EIB), with responsibilities for performance management, talent management, learning and organisational development, sitting on the EIB's Equal Opportunities joint-committee.

At Western Sussex Hospitals NHS Foundation Trust, Joanna chairs the trust's Quality & Risk Committee, and is a member of the Safeguarding Committee, Patient Experience and Feedback Committee, SIRI panel, Children's Board, and Diversity Matters Group. She is also a member of the trust's Charitable Funds Committee, Appointments and Remuneration Committee and the Senior Independent Director.

Non-Executive Director; Jon Furmston

Mr Furmston has had a career with a telecommunications company of more than 20 years to date and in that time has held roles in financial, marketing, general management and regulatory governance up to board level. He is also the trust nominated Non-Executive lead for Emergency Planning and Business Continuity.

He is a member of the Chartered Institute of Management Accountants and a member of the Institute of Engineering and Technology**.**

Non-Executive Director; Lizzie Peers

Ms Peers is a qualified chartered public finance accountant, with over 20 years' experience as an external auditor working across the UK public sector. She has worked as a senior manager for the Audit Commission and most recently for a global accountancy/consulting firm. Key health clients have included Strategic Health Authorities (SHAs), Acute, Mental Health and Community Health providers. Key local government clients have included county, unitary and district councils, police/fire authorities and probation trusts.

Lizzie has worked at national and regional levels on projects with the Audit Commission, other inspectorates and representatives of central government in areas such as the transition to Clinical Commissioning Groups, use of resources assessments, partnership development and Foundation Trust readiness.

As well as being a non-executive on the board, she is currently the financial adviser to the board of a non-foundation trust NHS hospital, a lecturer at the University of Portsmouth, specialising in governance, ethics, audit and accountancy and the treasurer and trustee for a national children's charity.

Non-Executive Director & Deputy Chairman; Mike Rymer

Mr Rymer became a non-executive director when he retired from his clinical role as a consultant gynaecologist for the trust, which he had held since 1992. After qualifying and initial training in Obstetrics and Gynaecology, Mike spent 12 years as a GP before retraining to become a consultant obstetrician and gynaecologist and was appointed in Worthing in 1992.

In 2013, Mike was elected as a staff governor representing the trust's medical workforce on the Council of Governors.

Outside of his gynaecology role, Mike has also been chair of the British Medical Association local negotiating committee, chair of the Sussex gynaecological tumour group, a member of the speciality training committee of the Royal College of Obstetricians and Gynaecologists and chair of the medical advisory committee of Goring Hall Hospital.

Mike is a trustee and board member of a local hospice and a board member of the East Sussex Clinical Commissioning Group.

Non-Executive Director & Deputy Chairman; Martin Sinclair

Mr Sinclair joined the board in May 2016. Martin qualified as a chartered public finance accountant in 1985. He has spent the last 20 years in senior roles at the National Audit Office leading the external audit of major government departments on behalf of Parliament. He has extensive experience of working internationally being lead partner on the audit of the United Nations from 2010 to 2015.

Martin has contributed to the development of accounting and auditing standards for the public sector through his membership and engagement with a wide range of professional committees and standard setting bodies. He is now a non-executive director and charity trustee. He is the Honorary Treasurer of the Chartered Institute of Public Finance and Accountancy and Chair of the Finance and Audit Committee of Asthma UK.

Martin is Chair of the Audit Committee.

Non-Executive Director; Kirstin Baker

Ms Baker joined the board in June 2016. She has had a long career in the civil service and was most recently HM Treasury's Finance and Commercial Director, overseeing the treasury's finances and corporate services and sitting on the Treasury Board. Kirstin previously worked as a senior policy official in the Treasury, heading the team responsible for coordinating public spending and managing many of the Treasury's interventions in individual banks in the wake of the 2008 crisis. Kirstin's earlier career was in European policy and she worked as a competition official in the European Commission and in policy advisor roles in the Cabinet Office and the Foreign and Commonwealth Office. More recently, Kirstin was seconded to the Scottish Government, leading work on infrastructure investment.

Kirstin is a member of the Chartered Institute of Management Accountants. She was awarded a CBE in 2011 for her work during the financial crisis. She is vice-chair of the Council of Sussex University and a non-executive member of the board of UK Financial Investments.

Kirstin is chair of the 3Ts Programme Board and a member of the Audit Committee.

Non-Executive Directors

The non-executive directors (NEDs) were very well informed and capable. They had the necessary skills and knowledge to provide robust challenge to the executive team. All of the NEDs we spoke with were able to articulate the trust strategy and vision and could talk in detail about the Patient First initiative. We held a focus group with the non-executive board members who told us they felt able to challenge the executive directors and gave examples of this. The group demonstrated unitary board behaviours and recognised their system and organisational responsibilities. They described a good working relationship between non-executives and executives with good engagement and the confidence to challenge, when necessary.

There was an embedded system of leadership development and succession planning. We saw examples of succession planning at board level. At all levels, leaders were offered formal training and development opportunities, as well as coaching and mentoring. The board had appointed associate non-executive directors to bring in additional skills and to support future recruitment from the local community to support succession planning that considered diversity. There was an estate and facilities supervisors' course, for example and a band 7 development programme.

Fit and Proper Person checks were in place. We reviewed twenty files for directors, consultants and senior staff. All were comprehensively completed and had the necessary checks and verifications in place. On our review of director's files, we found the required information was complete on board members' personnel files. We reviewed long standing and new appointee's files and found the level of detail and quality of information within each file was excellent. All files had competency and selection criteria clearly documented. We noted the trust board's "Register of Interests" which was individually signed by each trust board member.

Of the executive board members at the trust, 20% were Black and Minority Ethnic (BME) and 80% were female.

Of the non-executive board members 0% were BME and 33% were female.

| Staff group | BME % | Female % |
|---|---|---|
| Executive directors | 20% | 80% |
| Non-executive directors | 0% | 33% |
| All board members | 10% | 55% |

*(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)*

According to the national census, 93.7% of the West Sussex population are white. The trust board was broadly representative of the local community.

The trust executive team was led by the chief executive officer (CEO). Reporting directly to her was the chief nurse. The chief medical officer and deputy CEO, the chief financial officer, the chief delivery and strategy officer, the chief workforce and OD officer, the company secretary and the managing director also reported directly to the CEO.

Below each executive director were a number of senior leaders who provided additional capacity and ensured that whilst the executive team were supporting Brighton and Sussex University Hospitals NHS Trust there remained appropriate on-site leadership at the Western Sussex Hospitals.

Operationally, the trust was managed via four clinical divisions (medicine, surgery, women and children and core) and two enabling divisions (estates and facilities and corporate).

Medicine and surgery had a chief of service, a director or operations and a head of nursing. Women and children had a chief of service, a director of operations, a head of nursing and a head of midwifery.

The Heads of Nursing and Head of Midwifery were professionally accountable to the Chief Nurse. The Chief of Services were professionally accountable to the Medical Director and the Directors of Operations were accountable to the Managing Director.

The trust board and senior leadership team displayed integrity on an ongoing basis. Responses to complaints, acknowledgement of mistakes and staff files demonstrated an openness that went

beyond the statutory requirements. Observed meetings demonstrated a willingness to share learning where there were shortfalls identified, at all levels.

There was a programme of board visits to services and staff fed back that leaders were approachable. Staff across both sites knew who the executive team and chairman were. They talked to us about board and executive visits and spoke of approachability. Nursing staff told us that the Chief nurse was a frequent visitor and knew most of the ward staff by name.

Records showed that there were regular formal visits by the board to various areas of the trust. The chair talked about attending the annual awards ceremony and other internal events.

The Chief nurse had special 'Thanks a million' cards which she gave out to staff regularly; she was also a prolific nominator for staff awards.

We saw the CEO with a volunteer and with ambassadors, and it was clear they knew each other quite well and had a very relaxed relationship. We were also told by one member of staff about the way the CEO had supported them when they had experienced a particularly traumatic situation.

The Council of Governors acted as a link between Western Sussex Hospitals' members and the trust board. It promoted active membership, represented local views and stood as a 'critical friend' to the trust. It also appointed – and decided the remuneration of – the trust's Chair and the non-executive directors and would approve the appointment of the Chief Executive if the post became vacant. Meetings were held regularly with dates published in advance on the trust website. Minutes of their meetings were also available on the website.

The governors were involved in many areas beyond their statutory duties, such as:

Holding constituency meetings to communicate with members

Representing the views of members to the trust board

Developing and reviewing the membership strategy to ensure representation and engagement levels are maintained and increased as appropriate

Working with hospital volunteers

Giving talks to interested stakeholders

The trust's first public and staff governors were elected by its membership in September 2012.

**Governance structure**

In terms of the board committee structure, the main board was supported by an Appointments and Remuneration Committee, an Audit Committee, a Finance and Performance Committee, a Quality Assurance Committee and a Charitable Funds Committee.

Reporting to the Quality Assurance Committee, were a Patient Experience and Engagement Committee, a Patient-led Assessments of the Care Environment (PLACE) Review Group and a Patient Transport Service Forum.

Reporting to the Quality Assurance Committee were the Adult and Children Safeguarding Strategy Committee, the Health and Safety Committee, the Quality Board and the Quarterly Clinical Board.

Reporting through the Quarterly Clinical Governance Reviews were

- Four Clinical Service Divisions
- Estates and Facilities Division

- Information Management and Technology Division
- Access and Performance

Within the remit of the Adult and Children Safeguarding Strategy Committee were

- Safeguarding (Adults) team
- Safeguarding (Children) team
- Children Safeguarding Forum
- Dementia Strategy Group
- Learning Disability Group

Reporting to the Health and Safety Committee was the Radiation Protection Committee.

Reporting to the Trust Executive Committee were;

- Divisional Integrated Performance Review / Specialist Divisions Review
- Workforce and Efficiency Steering Group
- Capital Investment Group
- Information Management & Technology Strategy Planning Group
- CQUIN Delivery Group

Reporting to the Workforce and Efficiency Steering Group were the Temporary Staffing Group and the Recruitment Steering Group.

Reporting to the Capital Investment Group were the Divisional/Care Group Boards and Business Case Scrutiny Panel.

Reporting to the Information Management and Technology Strategy Planning Group was the Information Management and Technology Delivery Group.

Several groups had access to report any quality issues to the board via the Quality Review Group including

- Learning and Development Delivery Forum and Learning and Development Funding Panel via the Integrated Education Group.
- Health and Wellbeing Board
- Ambassadors Meeting
- Joint Local Negotiating Committee
- Employee Partnership Forum
- Diversity Matters incorporating feedback from the Disability Forum, the BAME Forum, LGBT Forum and Personal, Fair, Diverse Meeting

The Quality Board was the channel for numerous groups to report up to the board. These included;

- Research and Innovation Committee

- Triangulation Committee which received reports from the Thrombosis Committee, Resuscitation Committee and Hospital transfusion Group.
- Medicines Optimisation Committee which was fed by the Medical Gas Group and the Non-Medical Prescribing Group
- Quarterly Divisional Governance Meetings
- Cancer Board
- End of Life Board
- Quality Assurance Group which had several groups reporting into them including the Mortality Steering Group, Reducing Avoidable Harm Group, Patient Falls Collaborative, CAUTI Group and the Tissue Viability Group.
- Joint Private Patient Practice Committee
- Trust Infection Control Committee with several groups reporting to them including Infection Control Operational Group, Decontamination Committee, Water Hygiene Group, Joint Estates and IC Operational Group and the IC Link Nurse Forum via the ICOG
- Mental Health Board

## Vision and strategy

The trust had a very clear and well-known vision and strategy that was embedded across all staff groups.

The strategy, called Patient First, was a long-term approach to transforming hospital services. This strategy was an embedded commitment to continual improvement across all services.

Staff were encouraged to make improvements themselves using a standardised approach. We saw numerous examples of where this had worked in practice and produced measurable improvements in the outcomes for patients and staff.

There was a pictorial pyramid of the strategy with the patient at the top. The trust had made a commitment that everything they did, large and small, contributed to improving outcomes for patients. This direction with the patient at the pinnacle was described as the True North - the compass point that maintains travel in the right direction; it was a fixed point that was always referred to when considering improvements and projects to prioritise. The trust True North objective was to ‘Continually improve and enhance the patient experience’.

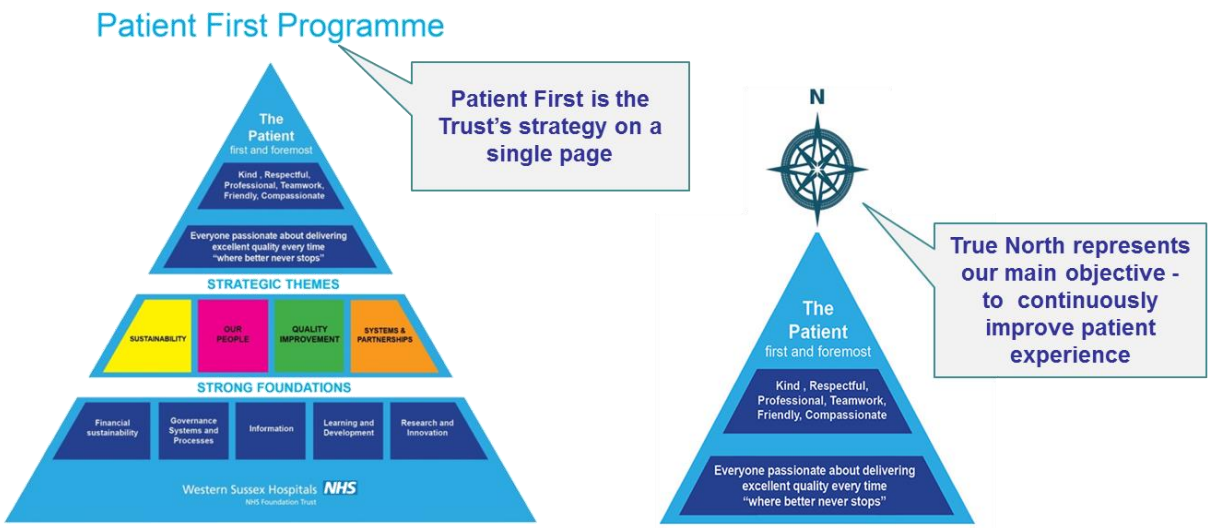
Underneath the patient was a layer of the pyramid that gave the trust values – kindness, respect, professionalism, team work, friendliness and compassion.

As the next layer of the pyramid were the four strategic themes for the Patient First strategy. They were sustainability, our people, quality improvement, systems and partnerships. Sustainability was about managing the budget and securing financial stability. Our people was about improving staff experience and engagement; the trust aimed to be a national employer of choice. Quality improvement focussed on reducing mortality and avoiding harm. The systems and partnership strategic workstream was about improving patient flow. These four workstreams were the focus of the work that was aimed at achieving a constant improvement towards True North.

Finally, the base layer of the pyramid was the ‘strong foundations’ that underpinned the care delivery and quality improvement programme. These were financial sustainability, good governance systems and processes, accurate information, a commitment to learning and development and valuing research and innovation.

We saw evidence on the core service inspection of where this approach and strategy had been affected in practice. Examples included an award-winning model that had been created by a doctor that allowed staff who managed complex airways to be taught and assessed in their competency to apply cricoid pressure correctly. Another example was the introduction of one-stop urology clinics; this was the first trust nationally to offer this in the absence of a dedicated unit.

At every operational level, the local divisional visions and strategies were based on the same Patient First model. Staff of all grades and disciplines used the language of Patient First and understood the value their own work brought to improving patient care.




Patient First used the methodologies of Lean Six Sigma improvement framework which enabled the trust to identify a True North metric and associated objective for each of the strategic themes.

Five underpinning ‘pillars’ had been created to achieve service transformation.

A Strategy Development Team that identified and reviewed the True North objectives for each strategic theme. They were responsible for cascading these across the trust to enable improvement initiatives to support the common goals.

The Kaizen Office was the trust’s centre of excellence for the lean techniques and home to a dedicated team who were tasked with enabling a consistent and sustainable trust-wide approach to improvement.

Capability building was about equipping staff with the skills to deliver continuous improvement. Training in the improvement processes began at induction and went all the way through to staff being trained as Lean practitioners.

The Patient First Improvement System was a trust wide lean management system which empowered staff to make changes aligned to the True North objective. It removed wasteful activities and improved processes to ‘give back’ time for staff to provide care.

Improvement initiatives were specific larger projects aligned to the True North metrics and breakthrough goals. These were led by Lean-trained staff and supported by the Kaizen Office.

**Mental Health Strategy**

The trust had established a multi-agency Mental Health Board to enable the trust to manage the care of complex patients with physical and mental health issues and provide the best possible service to patients and their families and carers.

The trust had a wide range of patients attending who had mental health needs as well as physical needs. The trust felt it was essential the clinical operational teams were supported to provide the best patient care. This support was achieved through working with partners in the provision of specialist mental healthcare such as the mental health trust, the police, commissioners, the local authority and voluntary sectors.

Good practice guidance as well as legal standards were used to drive the governance and operational procedures generated by the divisions. The Mental Health Board worked collaboratively with partners to ensure the trust maintained full compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) and Care Quality Commission (Registration) Regulations 2009 (Part 4) in respect of the Mental Health Act 1983.

There were a range of areas included in the overarching work programme which covered the mental health needs for working age adults, older people, children and young people and perinatal care. In addition, strategies supporting dementia, learning disabilities and autism were included in the strategic planning for the trust.

## Culture

Leaders across the trust promoted a positive culture that inspired, supported and valued staff, creating a sense of common purpose based on shared values. The trust values were embedded and promoted the culture of the organisation. There was an absolute focus on quality of care and patient experience, and this was central to the Patient First strategy. The culture of the primacy of the patient and meeting their needs permeated the whole organisation. There was a strong focus on collaboration, team working and support across all clinical and support functions on improving the quality of care and patients' experiences. Staff at all levels, from those in support roles to executives, articulated this and were aware of the contribution they made to providing safe, effective care with the best experience possible. There were high levels of satisfaction across all staff groups, and especially from those with protected characteristics. Staff said they were proud to work at the trust.

Governors and staff described the trust culture as open and trusting. We noted that staff and patient representatives were consulted and actively involved in all major developments. They were kept updated about these through a wide range of communication channels. Non-executive board members, executive board members and staff described the chief executive as "Amazing, completely committed to the trust, approachable and willing to listen, creative and always positive". They said she always found the good in any situation and preferred to build and celebrate success rather than apportion blame.

Staff side representatives told us they felt there was a good culture within the organisation. They felt that policies and procedures were correctly applied in a fair and consistent manner.

Multidisciplinary working was a very strong feature across the hospital that resulted in better patient care and outcomes. There was clear professional respect between all levels and

disciplines of staff. We saw real warmth amongst teams and an open and trusting culture. Exceptional examples of this included 'Harvey's Gang' which was growing and developing locally, nationally and internationally. Harveys Gang was created in the haematology laboratory at Worthing Hospital, when the manager was contacted about showing a little boy with leukaemia around the department. He was curious to see where his blood went when it was tested, why it needed to be done so many times, and how it would help the hospital staff to decide what blood he needed as part of his treatment. This simple request became the start of what has become an international patient blood management initiative to increase the involvement and knowledge of patients and their families in the laboratory aspects of their transfusion treatment.

The trust wide learning from incidents and complaints was well embedded. In all areas of the hospital, staff could give us example of where improvements had been made as a result of complaints, comments or incidents.

**Staff Diversity**

The trust provided the following breakdowns of staff by ethnic group.

| Ethnic group | Medical and dental staff (%) | Nursing and Midwifery Registered (%) | Qualified allied health professionals (%) |
|---|---|---|---|
| White | 63% | 73% | 85% |
| Mixed | 3% | 0% | 2% |
| Asian | 17% | 10% | 3% |
| Black | 4% | 2% | 2% |
| Chinese | 2% | 0% | 0% |
| Other | 3% | 7% | 2% |
| Unknown / Not stated | 9% | 6% | 6% |

*(Source: Routine Provider Information Request (RPIR) – Diversity tab)*

The Annual Equality Report 2018 showed that as part of the 2018 statutory and mandatory training programme the equality and diversity function and human resources advisors presented 124 face-to-face training sessions to help ensure the workforce was aware of their responsibilities under equality legislation. The three yearly update included general equality awareness, educating the terminology of a ‘hate crime’ which can constitute as a criminal offence and reiterating to staff that any kind of discrimination is unacceptable.

As at December 2018, 96.4% compliance of was attained for 6,764 staff receiving equality and diversity training.

Throughout 2019, equality and diversity training will be delivered face-to-face to 350 volunteers on the Worthing and Southlands site, with standalone sessions and an e-learning facility made available for staff requiring training.

Delivering a programmed equality and diversity training to the volunteers on the St Richards site will be put in place for 2019 / 2020.

The trust had a range of policies to support them in providing for the needs and preferences of staff and patients with protected characteristics including

- A Religion or Belief Policy. This set out the available facilities and resources, details of the chaplaincy service, time off for prayer and religious observance and

dress code requirements. The Chaplaincy Service was provided on a 24-hour, seven-day week basis and responded to emergency situations.

- Guidelines for Supporting Transgender Patients.
- Guidelines for Supporting Transgender Staff
- An Equality and Diversity Inclusion Policy

## NHS Staff Survey 2018 results – Summary scores

The following illustration shows how this provider compares with other similar providers on 10 key themes from the survey. Possible scores range from one to 10 – a higher score indicates a better result.


The trust's 2018 scores for the following themes were significantly higher (better) when compared to the 2017 survey:

- Quality of appraisals
- Safe environment - Violence

The trust's 2018 scores for the following themes were significantly lower (worse) when compared to the 2017 survey:

- Equality, diversity & inclusion
- Health & wellbeing

It should be noted that, despite the scores getting worse from 2017 to 2018, the trust still performed similar to or better than the average.

*(Source: NHS Staff Survey 2018)*

Since 2016, overall staff engagement and confidence in the organisation has remained consistent, ranking Western Sussex Hospitals in the top 20 for staff engagement compared with other acute trusts. Despite not achieving an increase since 2016 the trust remained above the average comparator for acute trusts scoring seven.

The trust had identified the nine key staff survey indicators of engagement that were most important in creating the working environment needed for positive, patient-centred change to take place. These included agreement with statements around opportunities to show initiative, ability to make improvement suggestions and ability to make improvements happen in the work area. These indicators supported the Patient First Programme, along with the trust's current breakthrough objective 'I am able to make improvements happen'.

A strategic theme of the trust's Patient First Programme was "Our People". An essential element of equipping staff with the skills to identify improvement opportunities and the support to see them through was said to be creating a culture of positive working relationships where staff felt able to challenge ideas and raise concerns.

The trust outlined the expected behaviours, through the Patient First Programme, that supported the creation of a positive working environment. These behaviours were outlined at the outset of the employment relationship through the recruitment process and reinforced at induction and through health and safety training and monitored through the trust appraisal process.

The trust's Dignity at Work policy, which was reviewed in March 2019 in conjunction with Staff Side colleagues, provided a framework for resolving working relationship issues and dealing with complaints of harassment and bullying. The trust's approach to employee relations matters was early intervention and informal resolution was actively encouraged before recourse to formal procedures. A two-day case management and case investigation training programme was available for clinical and operational leaders. In the last 2 years, 32 delegates have attended this intensive training.

The organisational culture in the trust was very strong with zero tolerance to harassment and bullying. In the event that staff feel unable to address their concerns directly, they were encouraged to report them to their manager. Support was available through the counselling service, occupational health team, trade union representative, employee relations team and the Freedom to Speak Up Guardians.

The Trust's Quality and Risk Committee received a report bi-annually on all employee relations cases and the identification of themes, trends and learning was discussed.

In response to the 2018 staff survey that identified an increase in the number of staff experiencing harassment and bullying, a corporate project "Reducing Abusive Behaviours" was established. The improvement plan to address the outcomes of Workplace race Equality Standards (indicators

five and eight) also included specific actions required to improve the experience of staff who identify as black, Asian or minority ethnic.

The trust's planned staff conference for this year is intended to engage participants to test a staff framework that outlines behaviours "above and below the line" prior to the launch of a trust-wide campaign to reduce harassment and bullying. The Freedom to Speak Up guardians were very pro-active and met regularly with the trust executive to discuss any themes and concerns shared with them. We were told about the development of standard words for staff to use when they experienced or saw behaviour that they felt was inappropriate. This had come about from staff sharing concerns about a member of staff making inappropriate comments in front of patients and relatives. Several staff felt they couldn't challenge in front of the patients in case the situation escalated into conflict but also felt they wanted to say something - they were just not sure what. Work was being done and was being rolled out following consultation and refinement staff conference to offer standard phrases that were as simple as "That's not OK" to ensure people knew when their behaviour or comments had not been well received.

## Workforce race equality standard

The Workforce Race Equality Standard became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

The scores presented below are indicators relating to the comparative experiences of white, black, Asian and minority ethnic staff, as required for the Workforce Race Equality Standard.

The data for indicators one to four and indicator nine is supplied to CQC by NHS England, based on data from the Electronic Staff Record (ESR) or supplied by trusts to the NHS England WRES team, while indicators five to eight are included in the NHS staff survey.

Notes relating to the scores:

- These scores are un-weighted, or not adjusted.
- There are nine WRES metrics which we display as 10 indicators. However, not all indicators are available for all trusts; for example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.
- Note that the questions are not all oriented the same way: for 1a, 1b, 2, 4 and 7, a higher percentage is better while for indicators 3, 5, 6 and 8 a higher percentage is worse.
- The presence of a statistically significant difference between the experiences of BME and White staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts' circumstances.

| WRES Indicators from ESR (HR data) (*) | | BME Staff | White Staff | Are there statistically significant difference between… | |
|---|---|---|---|---|---|
| | | | | BME and White staff? | Last year and this year? (BME staff) |
| 1a. Proportion of clinical (nursing and midwifery) staff in senior roles, band 8a+ | | 1.1% | 4.3% | ● | 0.6% ➡ |
| 1b. Proportion of non-clinical staff in senior roles, band 8+ | | 5.0% | 6.7% | ● | 0.6% ➡ |
| 2. Proportions of shortlisted staff being appointed to positions | | 9.7% | 11.8% | ● | -1.7% ➡ |
| 3. Proportion of staff entering formal disciplinary processes | | 0.4% | 0.2% | ● | -0.3% ➡ |
| 4. Proportion of staff accessing non-mandatory training and CPD | | 76.2% | 69.2% | Not assessed | |

| WRES Indicators from the NHS staff survey (**) | | Proportion of respondents answering "Yes" | | | Are there significant differences between… | | |
|---|---|---|---|---|---|---|---|
| | | BME staff | White staff | All staff | BME and white staff? | This trust and its peer group? | Last year and this year? (BME) |
| 5. Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months | Trust | 36.1% | 29.2% | 28.9% | ● | ● | 3.7% ➡ |
| | *Peer group* | *29.9%* | *27.9%* | *28.7%* | | | |
| 6. Staff experiencing harassment, bullying or abuse from staff in the last 12 months | Trust | 24.9% | 22.9% | 23.2% | ● | ● | -0.7% ➡ |
| | *Peer group* | *30.1%* | *26.0%* | *27.0%* | | | |
| 7. Staff believing that the trust provides equal opportunities for career progression or promotion | Trust | 82.7% | 89.8% | 88.1% | ● | ● | -0.9% ➡ |
| | *Peer group* | *69.8%* | *86.3%* | *83.3%* | | | |
| 8. Staff experiencing discrimination at work from a manager / team leader or other colleague? | Trust | 14.3% | 6.3% | 7.6% | ● | ● | 2.9% ➡ |
| | *Peer group* | *15.9%* | *6.7%* | *8.5%* | | | |

| Trust staffing numbers (*) | 2018 | | 2017 | |
|---|---|---|---|---|
| 9. [BME Voting Board Members] and Board compared to overall staff demographic | [1] | ● | [0] | ● |

**Key**

- Statistically significant or negative finding
- Not statistically significant
- Positive finding
- Statistical analysis not undertaken as less than 30 BME staff responded
- Statistically significant improvement
- No statistically significant change
- Statistically significant deterioration

As of July 2019, one of the ESR staffing indicators shown above (indicators 1a to 4) showed a statistically significant difference in score between White and BME staff:

1a. In 2018, BME candidates were significantly less likely than White candidates to hold senior (band 8+) clinical roles (1.1% of BME staff compared to 4.3% of White staff). This increased by 0.6% compared to/remained similar to the previous year, 2017.

Of the four indicators from the NHS staff survey 2018 shown above (indicators 5 to 8), the following indicators showed a statistically significant difference in score between White and BME staff:

5. 36.1% of BME staff experienced harassment, bullying or abuse from patients, relatives and the public in the past year (2018 NHS staff survey) which was significantly higher when compared to 29.2% of White staff. The score had increased by 3.7% when compared to the previous year, 2017.
7. 82.7% of BME staff believed that the trust provided equal opportunities for career progression and promotion (2018 NHS staff survey) which was significantly lower when compared to 89.8% of White staff. The score had decreased by 0.9% when compared to the previous year, 2017.
8. 14.3% of BME staff experienced discrimination from a colleague or manager in the past year

(2018 NHS staff survey) which was significantly higher when compared to 6.3% of White staff. The score had increased by 2.9% when compared to the previous year, 2017.

There was one BME Voting Board Members at the trust, which was not significantly different to the number expected, based on the overall percentage of BME staff.

*(Source: NHS Staff Survey 2018, NHS England)*

**Friends and Family test**

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

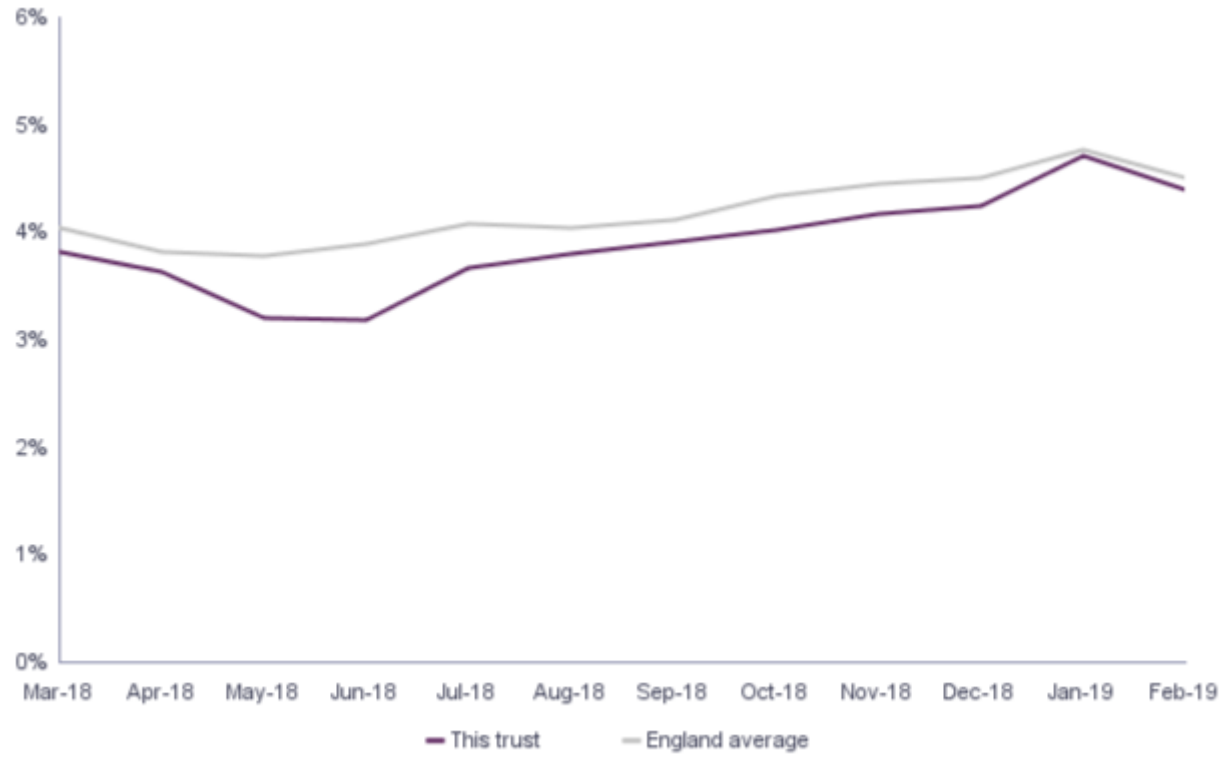
The trust scored between 95.8% and 97.8% between June 2017 and May 2019. The data appears to be stable with only random variation over the whole period. The trust outperformed most comparable trusts.

The trust aimed to sustain an inpatient Friends and Family Test results of 97%. This placed them in the top 25% of all trusts nationally. The outpatient's departments also scored 97% compared to a national average of 93%. The emergency department Friends and Family Test scored a consistent 95% compared to an 87% national average.

The Friends and Family Test response rate was much higher than for comparable trusts which meant there was greater validity to the scores.

**Sickness absence rates**

The trust's sickness absence levels from March 2018 to February 2019 were below the England average.




*(Source: NHS Digital)*

**General Medical Council – National Training Scheme Survey**

In the 2018 General Medical Council Survey the trust performed the same as expected for all indicators.

*(Source: General Medical Council National Training Scheme Survey)*

## Governance

**Board Assurance Framework**

The Board Assurance Framework had been prepared in conjunction with each of the five chief officers, focussing on respective strategic objectives and associated strategic risks and the Q4 update had been taken to the Trust Executive Committee in March and then to Board on the 28 March 2019.

The trust provided their Board Assurance Framework which detailed five strategic objectives and the accompanying risks. A summary of these are below.

- Patient
- Sustainability
- People
- Quality Improvement
- Systems and partnerships

The 2018 to 2019 quarter four BAF report was shared with the board. The trust executive committee considered the quarter four BAF at its meeting in March 2019 before being presented to the board.

The BAF summary in this report showed the position at 21 March 2019 for quarter four with regards to the five strategic objectives and the associated 11 strategic risks. The table also showed pictorially the movement in risk between the current score for quarter four and that recorded for quarter three.

From the report it was possible to see the recommended board action. In this case, the board was asked to consider the level of current risk recorded within the BAF against reported assurances via the various committees and the assurances provided direct to the board over the final quarter of the year and agree that this represented a balanced view of assurance and its impact on the key risks to the achievement of the trust's stated objectives.

The Draft Annual Internal Audit Report and Statement of Assurance for the year 2018/2019 detailed the work undertaken by internal audit for the trust and provided an overview of the effectiveness of the controls in place for the full year.

The internal audit work for the 12-month period from 1 April 2018 to 31 March 2019 was carried out in accordance with the internal audit plan approved by management and the Audit Committee. The plan was based upon discussions held with management and was constructed in such a way as to gain a level of assurance on the main financial and management systems reviewed. There were no restrictions placed upon the scope of our audit and our work complied with Public Sector Internal Audit Standards.

The role of internal audit is to provide an opinion to the board, through the Audit Committee (AC), on the adequacy and effectiveness of the internal control system to ensure the achievement of the organisation's objectives in the areas reviewed. The annual report from internal audit provides an overall opinion on the adequacy and effectiveness of the organisation's risk management, control and governance processes, within the scope of work undertaken by outsourced providers of the internal audit service. The trust had a good record in implementing audit recommendations. The trust closed nearly all prior year recommendations and management were proactive in discussing plans to address the risks identified in the 2018/19 audits.

| **Strategic objective** | **Description** | **Risk score (current)** | **Risk level (target)** |
|---|---|---|---|
| Patient | As a result of patients having a poor experience, adverse feedback is received which impacts on our Friends and Family Test scores | 12 | 6 |
| Sustainability | We cannot deliver ongoing efficiencies and flex our resources in an agile way resulting in failure to deliver our control total and to earn the full value of the PSF income available to the Trust. | 16 | 9 |
| Sustainability | The local health economy is not sustainable, and commissioners are not able to afford activity levels. | 16 | 9 |
| People | Operational pressures and available capacity impacts on staff availability to engage and<br>There is dissonance in organisational values and staff experience | 9 | 9 |
| People | The roll out of PFIS to clinical areas disengages some groups of staff | 6 | 6 |
| Quality improvement | The mortality reviews highlight patients with delays in recognising and responding to patients end of life care needs and the Trust capacity for structured judgement mortality case note reviews is limited | 9 | 9 |
| Quality improvement | As Safety Thermometer is a once a month prevalence measure and only measures 4 harms on that day (Falls; Pressure Damage; Catheter associated urinary tract infections; and Venous Thromboembolism) there may be other harms that are not immediately identified | 9 | 8 |
| Quality improvement | Maintaining a sustained reduction in falls whilst keeping our patients active to reduce the likelihood of de-conditioning. | 6 | 6 |
| Systems and partnerships | Increased volumes, reduced flow, and non-delivery of activity volumes lead to a poor patient experience and waiting times and there is a failure to achieve National RTT 18wk constitutional target | 12 | 12 |
| Systems and partnerships | Changes to system wide capacity increases demand on hospital services and impacts on A&E delivery and potential failure to meet STF metrics and as we are highly reliant on temporary staffing, there are possible shortfalls impacting pressures on existing staff. | 8 | 8 |
| Systems and | Winter Pressures impact upon the Trust's ability to | 9 | 9 |

| Strategic objective | Description | Risk score (current) | Risk level (target) |
|---|---|---|---|
| partnerships | meet patient demand and the Programme is unsustainable | | |

*(Source: Trust Board Assurance Framework – March 2019)*

There was evidence from the board and committee meeting papers and from observation of the interactions at board meetings and other meetings that the non-executive board understood their roles and were able to differentiate between strategic oversight and operational management. Records and observations showed high levels of both support and challenge.

Examples of challenge included,

- The records of Finance and Performance Committee from April 2019 showed that the chair had challenged an overspend in the medicine division and asked whether any improvement is being made. A discussion about the causality and the action being taken ensued.
- The minutes of the Audit Committee from July 2018 showed that there had been a Local Counter Fraud Specialist progress report presented. The committee was told that four policies have been reviewed in relation to information security and communications following an investigation into excessive use of trust issued mobile communications technology. One non-executive director had enquired about staff mobile phones and how they were monitored given the recent case. They were advised that there was an ongoing piece of work around the governance in place. The chair requested that an overview of how trust mobile devices were managed in the future be included in the future report.

The trust checked board to ward assurance through a system of board walkabouts. Board walkabouts involved executive and non-executive board members visiting both front-line teams and non-clinical services and having a focused discussion on patient related quality and safety issues. The board walkabout provided an informal method of engaging with staff and helped empower staff to find local solutions to issues and to seek resolution through current reporting structures.

The programme improved the visibility of the board throughout the organisation and provided an opportunity to hear from staff and patients and support change where necessary. Staff knew the executive team members well; we saw good relationships between the chief nurse, the chief executive office, the medical director and the front-line staff.

## Management of risk, issues and performance

### Risk

The trust had effective systems for identifying risks and planning to eliminate or reduce them. There were processes to monitor current and future performance. Performance issues were escalated to the appropriate board committees who provided oversight, challenge and assurance

to the full board. Financial matters were well managed and there were processes that ensured any financial pressures did not compromise the quality of care. Clinicians were fully engaged in the identification and management of all risk issues and in the monitoring of key performance indicators and their impact

The trust focussed on using risk registers and associated systems as a means of understanding and controlling risks, not as a mere record of risks. Risk was considered within the Patient First Strategy and identified risks were used to help determine the objectives within divisions and care groups.

Each division maintained its own risk register. We saw those as part of our core service inspections and heard how these were monitored at divisional governance meetings. The responsibility for identifying risks rested with all staff members who knew how to escalate potential risks for further management.

The chief pharmacist managed the pharmacy risk register, which also hosted corporate medicines risks. Department or division specific medicines risks were recorded on the relevant local risk register.

The trust risk register incorporated those risks identified at divisional level that posed the greatest risk to the organisation overall. Strategic risks to the delivery of the trust's objectives formed the basis of the Board Assurance Framework (BAF).

The corporate risk register consisted of those high-level risks identified by staff in the divisions. More strategic risks were managed via the board assurance framework. We saw a strong alignment between the risks staff talked about and those that appeared on the trust risk register and the BAF. The BAF was reviewed at the beginning and end of every board meeting.

The trust had a system of mortality and morbidity review using a structured judgement review process that was embedded in practice and was supported by clinicians. The purpose of the reviews was to identify, learn and inform the development of good practice. Clinicians were engaged with this process and took accountability for the timely review of deaths in their specialities.

The trust was committed to improving services by learning from when things go wrong. Training on root cause analysis (RCA) and investigations was provided for all those involved in investigating and managing serious incidents. Divisional teams were focussed on monitoring lessons learned and the implementation of action plans. We reviewed six serious incident reports and found they were of a very good standard. There were clear terms of reference for the investigation which was proportionate to the incident and level of risk. We noted there was a focus on leaning and opportunities for improvement rather than blame. We saw that any immediate actions to prevent recurrence were noted. The RCAs were made explicit and there were clear conclusions and recommendations for further action. Patients and their families were included in the review, where appropriate, and offered the opportunity to share their stories with the board. All incidents had senior clinical oversight and consideration of safeguarding issues raised.

The trust took actions to implement and embed learning from RCAs.

During our ongoing monitoring of the trust, we found the trust to be proactive, open and transparent in relation to incidents and actions taken. We were informed promptly of areas of concern, updated with the progress of investigations and supplied with RCA's and associated action and monitoring plans.

It was acknowledged among front line staff, managers and executives that staffing presented the biggest risk to the trust in terms of the ability to deliver its strategic objectives, mission and vision. The trust recruited from overseas and aimed to improve retention and recruitment further by building the trust hospitals into the national preferred place to work with high staff engagement levels and development opportunities. Retention of staff was viewed as being an area of improvement that would tackle staffing challenges. The trust carefully monitored data in terms of staff leaving with less than three or 12-months service and sought to understand the full range of factors that influenced the high levels of turnover.

The trust had arrangements to ensure adequate oversight of infection risks, and the minimisation of those risks. Each division also had a nominated lead for infection prevention and control. The Director of Nursing and Patient Safety was the nominated director of infection prevention and control. They were supported by an experienced team of infection control nurses and a microbiologist.

The increasingly complex challenge of caring for people with mental health and physical needs was detailed on the divisional and corporate risk registers. There was ongoing action to mitigate the risks. As part of the trust business as usual element, a new information dashboard was in design to capture a range of metrics which would assist with the monitoring and future planning of the service needs. It was apparent that there was an increase in demand across all areas of mental health services and that these trends were not necessarily captured in their current suite of reports

Private board minutes showed that there had been consideration of the risks posed by the UK exiting the European Union with a presentation of the EU exit risk assessment.

The Statutory Compliance Audit and Risk Tool (SCART) is a procedural desktop check of 38 areas of compliance. The Audit Team worked with the site team to complete the SCART. As part of the SCART, the team went through all the trust policies to check the level of compliance. The team found the average level of compliance within the trust was 89.2%.

The Six Facet Survey is about physical compliance and looks at environmental management, waste, water consumption and utilisation of space.

The trust had a current Emergency Preparedness, Resilience and Response Policy which was supported by an aide memoir for key contingency and emergency control staff, in the event of an incident.

**Finances Overview**

| Financial metrics | Historical data | | Projections | |
|---|---|---|---|---|
| | Previous Financial Year (2016/17) | Last Financial Year (2017/18) | This Financial Year (2018/19) | Next Financial Year (2019/20) |
| Income | £432.8m | £436.5m | £476.6m | £474.3m |
| Surplus (deficit) | £8.1m | £7.7m | £28.5m | £14.1m |
| Full Costs | (£424.7m) | (£428.8m) | (£448.1m) | (£460.2m) |
| Budget (or budget deficit) | £16.4m | £14.9m | £17.4m | £14.1m |

The surplus reported in 2017/18 was lower than the previous year. Projections for 2018/19 indicated that the surplus will increase.

*(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)*

The reporting hierarchy for financial management was clearly structured from frontline operations to the board and back again. There were summary statements and drill down reports for each cost centre and staff and managers at all levels were encouraged to take responsibility for trust spending.

The trust reference costs placed them in the top 20 best performing trusts in England. They have delivered a surplus every year since the introduction of the Patient First strategy in 2014/2015, rising to £30 million in 2018/2019. The trust had been given a financial risk rating of one.

In the past three years, the trust has reduced agency expenditure by more than 50% from £23.3million in 2015/2016 to £10.7million in 2018/2019.

The trust delivered a surplus of £1.19 million which meant they were awarded an additional £11 million bonus. This was over and above the £16million Provider Sustainability Fund (PSF) money. This money was ring fenced for capital investment.

We saw significant ongoing investment in services across the trust.

- Introduction of an ambulatory cardiology service at Worthing was being rolled out at St Richard's Hospital.
- There was a new children's audiology room at Worthing Hospital funded by a donation of £37k. The service will now provide resources for UKAS assessors.
- A new pharmacy dispensing robot had been installed.
- Investment in a new 64-slice CT scanner for Worthing radiology department. A 64-slice computed tomography (CT) scan is a radiological test used to assess the health of the heart in patients who have chest pain or shortness of breath. This rapid, non-invasive procedure allows early diagnosis and intervention for heart patients.
- There had been investment in new hybrid pressure relieving mattresses across the trust to further reduce the risk of pressure damage to vulnerable patients and to ensure ongoing compliance with national guidance.
- A £1 million endoscope replacement programme had commenced.
- The trust had opened a new ophthalmology centre which had adopted and developed several innovative approaches to increasing service demand.
- The gynaecology outpatient procedure facility at Worthing Hospital had recently been refurbished.
- The heating boilers at St Richards Hospital has been upgraded to improve business continuity and carbon reductions.

**Mortality**

The trust had a hospital standardised mortality rate (HSMR) of 92. Throughout 2018/2019 the trust had improved on this to move from the 28th centile nationally to being in the top 20% of trusts in England, in terms of HSMR.

The HSMR scoring system works by taking a hospital's crude mortality rate and adjusting it for a variety of factors – population size, age profile, level of poverty, range of treatments and operations provided, etc. The idea is that by taking these factors into account for each hospital, it is possible to calculate two scores – the mortality rate that would be expected for any given

hospital and its actual observed rate. It is the difference between these two rates that is important when it comes to HSMR. Nationally, the expected HSMR score for hospitals is set as being 100. It is important to remember that this figure does not represent deaths or percentages – it is just a baseline number used to compare performance. Better performance is a score below 100 and worse performance is a score above 100.

In the 2017/2018 reporting period, Mortality reviews showed that none of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient.

The trust monitored the HSMR position compared to others trusts at the Mortality Steering Group. This was a formal, multi-disciplinary group that included representation from the safeguarding team. There was evidence of learning from other organisations and consideration of how improvements might be developed within the trust.

A pilot of the daily mortality reviews was being arranged to trial the process used at another trust where daily reviews worked well.

Another example was a discussion about the link between complaints and poor care for people who had died unexpectedly. It was felt that the trust didn't necessarily pre-empt and reduce the number of complaints related to unexpected deaths through early communication with families. Ways of making improvements were discussed at the Mortality Steering Group.

The trust showed a consistent and robust approach to the reporting and investigating of serious incidents. Actions set specific, measurable, ambitious, realistic targets (SMART) and learning was embedded across the organisation. Duty of candour requirements were followed consistently and there was evidence in every investigation of patient / family involvement. The trust looked at themes and trends and focussed heavily on quality improvement of these, for example the recent falls project that had seen a reduction in falls and reduction in harm from falls.

Duty of candour for moderate and severe incidents had sustained 100% across quarter three and quarter four in 2018/2019.

A group of six mortality reviewers were trained to undertake structured judgement mortality reviews and began reviews in January 2018. Three new reviewers were recruited in January 2019.

Harm Free Care

The trust aimed to reach a 99% score on the patient safety thermometer across all sites. The current score was 98.7 % harm free care.

Emergency Department Performance

In July 2019, the trust had 91% compliance with the four hourly accident and emergency department target. In 2018/19, Western Sussex Hospitals had the ninth best type 1 emergency department performance in England. They finished the year in March with 95% of patients in the emergency department at Worthing Hospital or St Richard's Hospital in Chichester seen, treated, admitted or discharged within four hours.

The WSHFT Annual Quality report 2018/19 showed a trust wide falls reduction of 32% achieved through the Patient First methodology which had falls reduction as a True north objective.

Cancer Performance

WSHFT saw significant increases in demand for coastal patients in 2018/19 in comparison to the previous year, notably an overall rise of 8.9% rise in two-week referrals and a 7.7% rise in 62-day urgent referrals. Specialities that have seen a significant increase include colorectal, urology, skin,

breast and head & neck. Despite this, overall WSHFT exceeded national performance for all but one indicator and achieved compliance for five of the seven cancer performance indicators within target in 2018/19

Getting it Right First Time (GIRFT)

The trust was a leader in the GIRFT programme for gastroenterology with over 90% of bowel resections completed laparoscopically, which is one of the highest rates nationally. GIRFT is a national programme, led by frontline clinicians, created to help improve the quality of medical and clinical care within the NHS by identifying and reducing unwarranted variations in service and practice. Having started as a pilot within orthopaedic surgery, the GIRFT methodology and process has now been extended to a total of over 30 medical and clinical specialities.

The trust's breast surgery service performed very well in the GIRFT programme. The trust was meeting all breast cancer waiting times targets. The trust was in the top centile (best) for explanations after operations (86.5% vs 74.4% England average); and the top quartile for overall rating of care (9.1 vs 8.6 England average) and trust in their doctors (90% vs 80.9% England average)

The trust is in the lowest (best) quartile for breast surgery with a normal/ benign diagnosis (excluding risk-reduction) (8.5% vs 13.0% England average)

Bilateral surgery rates were below the England average, which was commendable.

For both ductal carcinoma in situ (DCIS) and invasive cancer, there were high rates of breast conserving surgery with higher rates of breast conservation, and higher reconstruction rates, at all age ranges.

The unit was not carrying out high levels of lipofilling, which is good practice (1.24 vs 1.37 England average, position 29 of 111 Trusts) (6.7)

The unit was in the lower quartile for the proportion of patients with DCIS undergoing wide local excision with concurrent sentinel node biopsy (5.3% vs 12.8% England average) which is good practice

Mental Health CQUIN

The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. This CQUIN is about ensuring that people presenting at emergency departments with primary or secondary mental health and/or underlying psychosocial needs have these needs met more effectively through an improved integrated service, with the result that attendances at accident and emergency are reduced. The CQUIN has been designed to encourage collaboration between providers across the care pathway and as such has been applied to both acute providers and mental health providers. While it takes account of different responsibilities for providers, performance by both acute and mental health providers will be measured and shared across the pathway and will affect overall achievement against the CQUIN indicator.

The notes of the Mental Health Board meeting dated January 2019 showed that the results for the year one exceeded the target of 20%, the actual reduction was 40%. The second cohort were on track to deliver the 20% target.

The trust also recognised that concerns had been raised around Mental Health Act detentions in the emergency departments. If a patient could not be admitted to a ward area they continued to be

looked after in the main department for safety reasons. Emergency Mental Health Act powers would need to be put into practice but if the patient is determined to leave they cannot be detained. It was agreed this should be recognised as a risk and entered onto the risk register. It was recognised that admitting to the clinical decision unit was not always an option as it was not a secure unit and had very limited space and also may pose more of a risk to the patient or other patients.

External accreditation

The trust achieved UKAS ISO 15189 Quality Management System compliance in all pathology disciplines. ISO 15189 accreditation involves an independent assessment of the medical laboratory that includes an examination of personnel qualifications and competence, equipment, reagents and supplies, quality assurance, and analytical, pre-analytical, and post-analytical factors. Qualified assessors conduct a thorough evaluation of all factors affecting the production of test data.

Both endoscopy units have secured outstanding Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation.

The trust won the OneTogether small steps award. The awards have been designed to recognise, celebrate and share best practice in reducing the risk of surgical site infections.

The maternity service had achieved the 10 standards required of the Clinical Negligence for Trusts (CNST) to support safe services.

Five-star environmental health officer rating for the trust catering services. There had sadly, been two patients affected by an independent catering company's provision of sandwiches which gave them a listeriosis infection. The trust had removed all the company's products from the trust sites with immediate effect once the source was identified.

WSHFT was the only trust nationally to achieve the CQUIN for 24-hour discharges from the critical care unit, once the patients were declared ward fit.

Urology was in the national top centile for the delivery of day case transurethral resection prostate surgery and had recently introduced the Holmium Laser Enucleation of the Prostate. Holmium laser enucleation of the prostate is a type of laser surgery used to treat obstruction (blockage) of urine flow as a result of benign prostatic Hyperplasia (BPH). In men with BPH, the prostate gland is not cancerous but has become enlarged. An enlarged prostate can result in a number of urinary tract symptoms such as frequent urination, inability to urinate, difficulty in starting urination, or loss of bladder control.

Winter pressures

The orthopaedic team at St Richard's Hospital had worked innovatively over the winter period to ensure there were no cancelled elective operations.

The general surgery team had made improvements and achieved and sustained referral to treatment compliance (for general surgery) from January 2019.

## Information management

The Accessible Information Standard was launched in August 2016 and sets out a consistent approach to identifying, recording, flagging, sharing and meeting the information and

communication support needs of patients, service users, carers and parents with a disability, impairment and sensory loss.

The workforce had access to a range of interpretation and translation services, hospital communication books and a Learning Disabilities Liaison Team. The equality and diversity function also provided support by: providing assistive listening devices to the Patient Advice and Liaison Service where patients and staff can request to book out a device, providing hospital pictorial communication books to wards / departments and were purchasing the 'Recite Me' system to improve accessibility of the trust's website, internal intranet and outpatients booking service.

In partnership with the Patient Experience Team, the Equality & Diversity lead has provided information and support during 2017 / 2018 to the Accessible Information Standard Steering group as the standard is rolled out throughout the Trust.

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. The trust invested in best practice and innovative information systems and processes. The board demonstrated a shared understanding of performance through agreed key performance indicators, "soft intelligence" and external reporting and benchmarking. Data was assessed as being accurate, valid, timely and reliable. Staff and leaders could access data, often in real time, to inform their work. Patient identifiable and other sensitive information was generally handled securely.

The trust had a designated information technology (IT) lead with responsibility for medical records, IT platforms, development and information governance.

The trust also used IT and digital systems to improve the safety of patient care. They were one of the first trusts to introduce electronic monitoring of patient observations and escalations and have built upon the system since then. This was seen as key to our responsiveness to learning from incidents and complaints about management of deteriorating patients.

The trust used information to better manage medicines. There was an internal medicines audit programme. These were scheduled to include security of medicines and medicines related stationary, controlled drug and medicines chart endorsements by the pharmacy team.

The medical director acted as the organisation's Caldecott guardian. The guardian demonstrated an in depth understanding of the potential information breaches and explained the actions the trust were taking to minimise the loss of personal data.

The trust had an executive identified as the senior information and risk owner (SIRO) who was the director of finance. They stated they saw part of this role as ensuring that digital developments were implemented safely. The trust used a national scoring system to assess the level of information risk and this enabled the SIRO to give board colleagues moderate assurance regarding risk levels. There was a commitment to advance digital applications as this was seen to have potential to free up time to improve clinical care and patient experience.

The information security policy had been reviewed but future updates were anticipated to be required as a result of the ongoing implementation of the General Data Protection Regulation (EU) 2016/679 (GDPR).

Senior managers in IT felt supported by the trust board to develop the service. They also described the engagement of clinicians in developing the IT infrastructure, the strategy and its application.

Throughout our inspection we noticed how the trust staff used technology to communicate with each other and to ensure key messages were delivered. We noted that the board were active on social media and used this to engage and inform staff. Raspberry Pi computers that were used to give out key messages in areas of high traffic and where they would be most effective. An example of this was in the treatment room of the critical care unit there were messages reminding prescribing staff about safe antibiotic stewardship.

There was range of accessible peer review benchmarked clinical and performance data available via desktops used. We saw applications that gave senior managers real time information on the trust position in terms of its access and flow. Clinical staff could access online information on injectable medicines, or the British National Formulary to ensure medicines management was safe.

The trust board were presented with a balanced score card which we noted was on each board meeting agenda. Additional information was supplied as part of a report to give further context, narrative and detail. The score card indicated key metrics in the areas of best outcomes, skilled motivated workforce, excellent experience and top productivity. Key performance indicators were made explicit. Achievement of key performance measures was rated red, amber or green. The scorecard contained information that showed the performance over the previous six months, and performance in month and year to date. There was also an assessment of data quality. Internal auditors indicated they were completely assured of data quality. This meant that it would be difficult for the board to take false assurance from the scorecard.

The quality of data used by the trust to monitor performance and to plan future developments was accurate and reliable. There was a clearly defined data quality policy detailing specific roles and responsibilities within the organisation providing a clear framework with regard to data quality. As part of this framework there was a data quality team with specific responsibility on an ongoing basis to monitor and review data, in particular with regard to data completeness and correctness, patient demographics, contact details and removal of duplication.

The trust considered current data quality across the majority of sources within the trust was good.

## Engagement

### Patient and Carer

Involving patients in service design and improvement on an ongoing basis was another key part of the Patient First approach and there were a number of formal ways in which the trust did this, including:

- Membership Engagement Committee
- Patient Experience and Engagement Committee
- Patient Advice and Liaison Service

The trust ensured patient views were sought and represented during specific service changes. For example, patients, as well as other stakeholders, were directly involved in the development of the new ophthalmology service at Southlands Hospital. A patient participation group was established during the design and implementation stage of the project, which played a key role in informing the way the service is now provided. This included the look and design of patient letters and information, the process for booking appointments, signage and wayfinding as well as the addition of a covered walkway to help patients access the centre.

The development of Quality Strategy also included involvement with service users and staff both during its origination and ongoing review. For example, open events were held at all three hospitals, supported by the trust's Membership Committee as well as a survey made available to members and the public. The feedback from the events and survey helped inform the strategy, including a strengthening of the approach to the provision of end of life care.

The Mental Health Board minutes dated January 2019 showed that there was patient or carer representation on the following policy development groups;

- Dementia – a focus group was planned
- Learning disability had patient involvement
- Children and young people – there was some representation but the trust felt that a more formal process was needed.
- Adult – the CQUIN programme directly involved patients in the care planning

The Wayfinding Steering Group which included staff from equality & diversity and facilities and estates were working together to redesign the signage and way finding at the hospitals. Careful thought was given to disability accessibility including physical way finding and the appearance of the signage. The signage was designed to meet the widest range of accessibility needs. This included the use of colour symbols and changing language to make it easier for patients and visitors when they arrived at the trust. Patients, families and staff were involved in the project from the start.

In partnership with a partner organisation, the trust purchased a two-year contract for the 'Recite Me' system to improve accessibility of the trust's website, internal StaffNet and outpatients booking service. 'Recite Me' is a web-based tool that allows patients and staff to customise the trusts website in way individuals need it to work for them personally. The easy to use facility included large font, text to speech functionality, dyslexia software, an interactive dictionary, a translation tool with over 100 languages and many other features. These functions not only benefit individuals with sensory impairments, but also benefit those with learning disabilities and people who used English as a second language.

The outpatient service at Worthing and Southlands Hospitals had introduced Makaton Mondays to improve the experience of patients with communication difficulties. Staff on the critical care units had also learned basic Makaton sign language to enable better communication with some patients with learning disabilities.

Whilst the trust had not been involved in any significant service change since the last inspection, should any be required the board was clear that they would follow the rules set out in section 242 of the NHS Act 2006. They would work with the clinical commissioning groups to help support their public involvement duties (as set out in s.13Q NHS Act 2006 as amended by the Health and Social Care Act 2012 for NHS England and s.14Z2 NHS Act 2006 for CCGs), as well as with the local authority in relation to the requirements set out in the Local Authority Regulations 2013.

**Members**

The trust Membership and Engagement Strategy 2018 to 2021 showed that the trust aimed to recruit a substantial and representative membership base that was actively engaged in working for the good of the trust. At the end of September 2018, the trust had 7,395 public members and 254 patient members.

Members were sent a letter of introduction each year and were eligible for election to the Council of Governors.

The average turn out for the trust's governor elections was 39%, which compared to a national average of 11%. The highest turnout for the trust was 57% which compared to the record for any acute trust of 59%.

There were 39 visitors on average to trust medicine for members' events and on average the monthly newsletter @westernsussex was opened by 34% of those members it was sent to (currently3400). In October 2018, the open rate was 43%. The industry standard for email opens of this type (health related) is 22%.

The trust employed a wide range of communication methods to communicate with the general public and, specifically to members. These included:

- Media relations - stories about the trust appeared in local media
- Internet - the trust has user-friendly versions of their website
- Email - the trust emailed individuals and groups with relevant information
- Newsletters - the trust has a staff newsletter, Headlines, as well as a members' e-newsletter, @westernsussex
- Information seminars - the trust provided regular briefings on specific areas of healthcare that were available for members – and anyone who is interested - to attend under the banner "Medicine for members". Attending non-members were encouraged to complete an application form at the event
- Stakeholder events – updates with members
- Membership packs - on registration as a member, the trust sends out a membership pack
- Members were invited to the Annual General Meeting, quarterly Council of Governors and trust board meetings.
- Members were offered opportunities to take part in trust surveys

**Quality Impact Assessments**

The process is a means of providing assurance that new policies, service changes and important decisions had been properly scrutinised. The scrutiny was to make sure no protected characteristics were unfairly impacted upon, and any opportunity to advance equality was taken. Staff networks (Celebrating Cultures Network, Disability Forum, LGBT Network and Employee Partnership Forum) reviewed policies to provide expert opinion on proposed policies and decisions.

During 2018, a full review was undertaken of the Equality, Diversity and Inclusion Policy. The updated policy had been ratified and approved by the relevant groups. The new policy launched on the staff intranet and a new review date of May 2021was set.

**Staff**

The level of 'buy in' from all staff to the trust vision and value base was exceptional. We were flooded with requests from staff wanting to tell us about specific pieces of work they were doing, how much they liked working for the trust and how supportive the trust executive team were of innovative ideas and further learning as a tool for improvements in patient care.

The anaesthetic department had received seven green flags from the General Medical Council training survey for the last two years. This was one of the best results nationally.

**Staff Conference 2019**

The theme for the trust 2019 staff conference was 'Inclusion'. This carried on from the last four years staff conference themes of launching the trust's Patient First Programme - Where Better Never Stops, Making Improvements, Staff Experience and Patient Experience. The 'Inclusion' theme demonstrated a clear link to the Patient, Our People and Trust Values.

The objective of the staff conference was to further integrate and increase awareness of diversity throughout the workforce; "By working in collaboration and understanding the different needs of patients and staff, WSHFT will improve patient services and establish stronger links in the local community".

**Supporting Equality**

The trust undertook a wide range of work and projects to support the equality agenda to benefit patients, the workforce and ensured as many people had a voice into the way services were delivered.

During 2017 / 2018 the trust had supported:

Celebrating Cultures Network - that worked towards improving patient care and working conditions for all staff from BAME and non-British backgrounds. This group was also involved in policy development, to ensure issues relating to culture were considered.

Disability Forum - provided a mechanism to ensure disabled people had a voice within the trust. One of the key objectives was to ensure that monitoring systems and processes in place to support disabled people, were fit for purpose. This group was also involved in policy development, to ensure issues relating to disability are taken into account.

Disability Confident - replaced the 'Two Ticks - Positive about Disabled People' scheme. The aim of this national programme was to ensure that the trust had mechanisms, systems and processes to support existing and newly disabled employees throughout their employment journey. The programme is administered by Job Centre Plus.

Diversity Matters Group - this key steering committee helped to ensure that equality, diversity and human rights were at the heart of the trust's strategic plans. All of the staff and patient networks and forums fed into this committee.

LGBT Network - the network helped to raise the profiles of Lesbian, Gay, Bisexual and Trans issues within the trust. The network provided support to LGBT staff, patients and visitors. This group was also involved in policy development, to ensure issues relating to sexual orientation and gender identity were considered.

In July 2018, Worthing hosted the first Pride event represented by WSHFT staff and LGBT network. The town event was a great success and plans are in place to participate in the 2019 event.

**Volunteer programme**

The trust had around 1,000 volunteers across all sites. They were recruited, trained and supported by the voluntary services teams at St Richard's and Worthing Hospitals. All volunteers were required to complete an application from and were interviewed. Occupational health clearance and a DBS checks were completed. Successful volunteers were then invited to an induction session.

Roles available to volunteers included administrative support, emergency department volunteers, cardiac buddies work in the children's centres and day surgery unit and on the emergency floor. There were also dementia support volunteers who supported patients with dementia during their stay by listening, helping with activities and befriending.

Ward volunteers assisted patients on the wards at meal times and helped staff with things like bedmaking and running errands. Welcome service volunteers helped on the main reception desk, offering guidance and support on locating wards. They could also point people towards the coffee shops, the cash point and parking pay points.

**Ambassadors**

The trust ambassadors worked to promote the positive work that the trust was doing to other staff and visitors. These were staff who volunteered to take on additional responsibilities in promoting the trust and developing a trust wide pride.

## Learning, continuous improvement and innovation

In 2018, Ford Ward commenced a coaching programme with NHS England called Always Events, the objective of this was to identify improvements based on the patient's perspective and experience. The team created a vision statement during their team away days: 'My family and I will be communicated with when there are changes in my condition'. The aim of the quality improvement work was to achieve 90% of patients/families stating they had been kept up to date about their condition and treatment.

The team recently introduced a communication aid which gave a general update of individual patient's care. The team was also reviewing the contents of a folder of information that is provided for patients and family with patients to see if the content was up to date and considered useful by the intended audience.

**Complaints process overview**

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

| Question | In days | Current performance |
|---|---|---|
| What is your internal target for responding to complaints? | 2 | 94% |
| What is your target for completing a complaint | 25 | 61% |
| If you have a slightly longer target for complex complaints please indicate what that is here | N/A | N/A |
| Number of complaints resolved without formal process in the last 12 months? | 6,146 (April 2018 to March 2019) | |

*(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)*

**Number of complaints made to the trust**

From April 2018 to March 2019, the trust received a total of 415 complaints. The highest number of complaints were for medicine, with 31.1% of total complaints, followed by outpatients (23.6% of complaints) and surgery (16.6%).

| Core Service | Number of complaints | Percentage of total |
|---|---|---|
| AC - Medical care (including older people's care) | 129 | 31.1% |

| | | |
|---|---|---|
| AC - Outpatients | 98 | 23.6% |
| AC - Surgery | 69 | 16.6% |
| AC - Urgent and emergency services | 66 | 15.9% |
| AC - Services for children and young people | 13 | 3.1% |
| AC - Maternity | 11 | 2.7% |
| AC - Diagnostics | 10 | 2.4% |
| AC - Gynaecology | 10 | 2.4% |
| Other | 8 | 1.9% |
| AC - Critical care | 1 | 0.2% |

*(Source: Routine Provider Information Request (RPIR) – Complaints tab*

**Compliments**

From April 2018 to March 2019, the trust received a total of 2,123 compliments. The highest number of compliments were for medicine, with 31.2% of total compliments, followed by outpatients (30.8% of compliments) followed by surgery (13.9%).

A breakdown by core service can be seen in the table below:

| Core service | Number of compliments | Percentage of total |
|---|---|---|
| AC - Medical care (including older people's care) | 663 | 31.2% |
| AC - Outpatients | 653 | 30.8% |
| AC - Surgery | 295 | 13.9% |
| AC - Services for children and young people | 215 | 10.1% |
| AC - Urgent and emergency services | 119 | 5.6% |
| AC - Critical care | 95 | 4.5% |
| Other | 42 | 2.0% |
| AC - Diagnostics | 11 | 0.5% |
| AC - Maternity | 11 | 0.5% |
| Other - PMS service | 9 | 0.4% |
| AC - Gynaecology | 6 | 0.3% |
| (blank) | 3 | 0.1% |
| Other - ASC service | 1 | 0.0% |

*(Source: Routine Provider Information Request (RPIR) – Compliments)*

**Innovation and learning**

- A 30% reduction in falls across the medicine division following the introduction of a Baywatch scheme.
- Consistent high performance against four-hour ED target with an overall 94.2% in 2018/2019 and 95.2% since March 2019.
- The radiology service won the Society and College of Radiographers team of the year award in 2018.
- The bariatric surgery service had been recognised by the International Society for Surgery of Obesity as a Centre of Excellence.
- The trust had a fully integrated one-stop sexual health and HIV service.
- Online STI testing service had recently been introduced to improve choice and access for patients.

- The neonatal unit provided a specialist outreach service allowing for earlier supported discharge.

**Sustainability**

- More than 80% of trust waste was recycled.
- Green travel initiatives had seen a reduction of carbon emissions by nearly 60 tonnes per year.

# Acute services

## Worthing Hospital

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## Critical care

### Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

#### Mandatory training

**The service provided mandatory training in key skills to all staff and there were processes to make sure everyone completed it. However, two out of seven modules for medical staff and one out eight for nursing staff were below the trust target of 90%.**

Mandatory training for all staff groups was comprehensive. The training was a mixture of face to face and online learning system. Mandatory training modules included, fire safety, infection control and information governance. Other training was role specific for example, consent, medicines management and advanced life support.

There was a trust wide electronic staff record where all training attended was documented. Staff we spoke with told us they felt their training was good. For nursing staff there was a dedicated practice educator who oversaw the mandatory training within the critical care unit. The practice educator would be notified of staff who were due to complete mandatory training and would book staff onto the training modules. The practice educator told us staff were given dedicated time to complete their mandatory training. Staff we spoke to confirmed this.

There was an up to date policy for sepsis. Staff were aware of the policy and how to access it.

Staff received training in recognising and managing deteriorating patients including those with confirmed or suspected sepsis. This was in line with National Institute for Health and Care Excellence, guidance (NG) 51, recommendation 1.12, training and education.

Medical staff new to the unit had sepsis training as part of their induction. This included three morning sessions a week for the first three months of their rotation into critical care. Additional training was given by the outreach team at the monthly critical care mortality and morbidity meetings.

In addition, Worthing has a dedicated critical care fellow of which 50% of their time is spent on sepsis research and training.

All new nursing staff to the critical care units completed a respiratory and cardiovascular study day as part of their induction. This included a dedicated session on sepsis. Nursing staff on the critical care pathway have additional training and completed competency documents on sepsis as part of their course.

Sepsis training was not included in the submitted mandatory training figures. The trust told us that regular simulation training for the management and treatment of sepsis was undertaken.

**Mandatory training completion rates**

The trust set a target of 90% for completion of mandatory training.

**Trust level**

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for qualified nursing staff in critical care is shown below:

| Training module name | April 2018 to March 2019 | | | | |
|---|---|---|---|---|---|
| | Staff trained | Eligible staff | Completion rate | Trust target | Met (Yes/No) |
| Equality and Diversity | 113 | 113 | 100.0% | 90% | Yes |
| Fire Training | 112 | 113 | 99.1% | 90% | Yes |
| Health and Safety | 112 | 113 | 99.1% | 90% | Yes |
| Infection Control | 112 | 113 | 99.1% | 90% | Yes |
| Information Governance | 111 | 113 | 98.2% | 90% | Yes |
| Resuscitation | 111 | 113 | 98.2% | 90% | Yes |
| Manual Handling - People | 110 | 113 | 97.3% | 90% | Yes |

In critical care the 90% target was met for seven of the seven mandatory training modules for which qualified nursing staff were eligible.

**Worthing Hospital critical care department**

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for qualified nursing staff in the critical care department at Worthing Hospital is shown below:

| Training module name | April 2018 to March 2019 | | | | |
|---|---|---|---|---|---|
| | Staff trained | Eligible staff | Completion rate | Trust target | Met (Yes/No) |

| | | | | | |
|---|---|---|---|---|---|
| Equality and Diversity | 61 | 61 | 100.0% | 90% | Yes |
| Manual Handling - People | 61 | 61 | 100.0% | 90% | Yes |
| Resuscitation | 61 | 61 | 100.0% | 90% | Yes |
| Fire Training | 60 | 61 | 98.4% | 90% | Yes |
| Health and Safety | 60 | 61 | 98.4% | 90% | Yes |
| Infection Control | 60 | 61 | 98.4% | 90% | Yes |
| Information Governance | 60 | 61 | 98.4% | 90% | Yes |

At Worthing Hospital critical care department, the 90% target was met for all seven mandatory training modules for which qualified nursing staff were eligible.

*(Source: Routine Provider Information Request (RPIR) – Training tab)*

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for medical staff working in the critical care department at Worthing Hospital is shown below:

| **Training Module Name** | **April 2018 to March 2019** | | | |
|---|---|---|---|---|
| | **Eligible staff** | **Completion rate** | **Trust target** | **Met (Yes/No)** |
| Equality and Diversity | 34 | 90% | 90% | Yes |
| Fire Training | 34 | 90% | 90% | Yes |
| Health and Safety | 34 | 90% | 90% | Yes |
| Infection Control | 34 | 93% | 90% | Yes |
| Information Governance | 34 | 86% | 90% | No |
| Resuscitation | 34 | 76% | 90% | No |
| Manual Handling – back awareness | 34 | 93% | 90% | Yes |

At Worthing Hospital critical care department, the 90% target was met for five of the seven mandatory training modules for which medical staff were eligible.

(Source: ADR RYR38 – Mandatory training figures for medical staff)

## Safeguarding

**Staff understood how to protect patients from abuse. Staff understood their responsibilities and the steps to take in the event of a safeguarding concern. Staff had training on how to recognise and report abuse, and they knew how to apply it.**

The trust had an up to date safeguarding adults' policy for staff, which was available to guide staff on how to protect people from abuse. This was up to date and referred to relevant legislation and guidance. The policy included flow charts providing a quick reference guide to staff on what to do should a concern be identified. The policies were available in the internal computer system. The policy included specific sections on female genital mutilation, domestic abuse, and 'Prevent' (identifying when vulnerable people may be exploited and drawn into terrorism).

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could identify the safeguarding leads for the trust and explain the actions they would take if they had any concerns. Named professionals have a key role in promoting good practice within their organisation, providing advice, and expertise for colleagues. The safeguarding referral form was

easily assessible on the intranet and staff knew where to find it. Staff told us the safeguarding team would respond to a request to attend the unit straight away.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff understood and could give examples of what constituted a safeguarding concern. For example, we were told about an elderly patient who had recently lost their husband, who was their main carer. There was concern about how the patient would cope once they were able to be discharged home. Staff explained what actions they had taken to resolve the concern, and where it was documented and who they went to for advice.

Safeguarding assessments were carried out for all patients admitted to the critical care unit during their initial assessment.

If patients on the unit were at risk of suicide or self-harm it was flagged on the patient records, and a referral made to the mental health team. Staff told us that the mental health team would respond in a timely way.

Children were not routinely admitted to the critical care unit. There were good relationships with children and young people services. Staff told us they felt supported by the service and gave an example where a child had to be admitted temporarily to the critical care unit. The safeguarding children and young people: roles and competencies for health care staff, intercollegiate document, sets out the requirements for safeguarding children and young people training levels. The document recommends all staff who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or a young person, should have level three safeguarding training. Although admission of a child onto the critical care unit, was an exceptional circumstance, data indicated that nursing staff did have a sufficient level of safeguarding children training as a minimum of a level three is required for staff having direct contact with child patients.

**Safeguarding training completion rates**

The trust set a target of 90% for completion of safeguarding training.

**Trust level**

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for qualified nursing staff in critical care is shown below:

| Training module name | April 2018 to March 2019 | | | | |
|---|---|---|---|---|---|
| | Staff trained | Eligible staff | Completion rate | Trust target | Met (Yes/No) |
| Safeguarding Adults (Level 2) | 95 | 113 | 84.1% | 90% | No |
| Safeguarding Children (Level 2) | 76 | 113 | 67.3% | 90% | No |
| Safeguarding Children (Level 1) | 36 | 113 | 31.9% | 90% | No |
| Safeguarding Children (Level 3) | 0 | 113 | 0.0% | 90% | No |

In critical care the 90% target was met for none of the four safeguarding training modules for which qualified nursing staff were eligible. However, the trust provided updated data after the inspection which showed five out of six safeguarding training modules were above the trust target of 90% for nursing staff, and four out of six were above the trust target of 90% for medical staff.

**Worthing Hospital critical care department**

Nursing staff received training specific for their role on how to recognise and report abuse.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for qualified nursing staff in the critical care department at Worthing Hospital is shown below:

| Training module name | April 2018 to March 2019 | | | | |
|---|---|---|---|---|---|
| | Staff trained | Eligible staff | Completion rate | Trust target | Met (Yes/No) |
| Safeguarding Children (Level 2) | 61 | 61 | 100.0% | 90% | Yes |
| Safeguarding Adults (Level 2) | 51 | 61 | 83.6% | 90% | No |
| Safeguarding Children (Level 1) | 0 | 61 | 0.0% | 90% | No |
| Safeguarding Children (Level 3) | 0 | 61 | 0.0% | 90% | No |

At Worthing Hospital critical care department, the 90% target was met for one of the four safeguarding training modules for which qualified nursing staff were eligible. However, after the inspection the trust provided updated data. This showed Worthing Hospital critical care department, was meeting the 90% target in five out of six safeguarding training modules for which nursing staff were eligible.

*(Source: Routine Provider Information Request (RPIR) – Training tab)*

Medical staff received training specific for their role on how to recognise and report abuse.

A breakdown of safeguarding compliance training courses from April 2018 to March 2019 for medical staff working in critical care department at Worthing Hospital

| Training Module Name | April 2018 to March 2019 | | | |
|---|---|---|---|---|
| | Eligible staff | Completion rate | Trust target | Met Yes/No |
| Safeguarding Adults (level 1 & 2) | 34 | 86% | 90% | No |
| Child Protection | 34 | 91% | 90% | Yes |

At Worthing Hospital critical care department, the 90% target was met for one of the two safeguarding training modules for which medical staff were eligible. However, data provided after the inspection showed Worthing Hospital critical care department the 90% target was met in four out of six safeguarding training modules for which medical staff were eligible.

*(Source: ADR RYR38 – Mandatory training figures for medical staff and ADR RYR39 Safeguarding training data for medical staff broken down by level of training received)*

## Cleanliness, infection control and hygiene

**The service controlled infection risk in line with best practice. There were policies to manage effective infection control and hygiene processes. We saw staff cleaned their**

**hands at the correct times, and were bare below the elbow, in line with trust policy. Equipment and the environment were visibly clean.**

Intensive Care National Audit Research Centre (ICNARC) data showed there had been 5 (0.8) unit acquired infections in the blood per 1000 patient bed days between April 2018 and March 2019. This was worse than similar units who had a rate of 0.5.

The service had carried out significant work on the root cause of the identified blood borne infections within the unit. An initial investigation of the data identified the insertion of arterial lines in critically ill patients admitted in an emergency as a common factor for patients with sepsis. The medical leaders had collated all the notes of the affected patients and were in the process of reviewing them. Work had begun with the quality improvement team to consider what action could be taken to reduce the risks.

The Intensive Care National Audit Research Centre (ICNARC) report for April 2018 to March 2019 showed there had been no cases of unit acquired Meticillin -resistant *Staphylococcus aureus* (MRSA), on the unit. There had been one case each of unit acquired *Clostridium difficile* (C. diff) and Vancomycin-resistant *Enterococci* (VRE)

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw staff contacts with patients were compliant with key trust infection control trust guidelines, for example hand hygiene, PPE and isolation. We saw information on display about how to manage blood spills.

There were sufficient handwashing sinks and alcohol-based hand sanitising gel within all areas we visited, and we saw there was soap and paper hand towels available next to the sinks. During our inspection we saw staff either washing their hands or using the hand sanitising gel correctly, in line with the ‘five moments of hand hygiene’ and National Institute for Health and Social Care Excellent (NICE) quality standard (QS) 61, statement three.

Data supplied to us from the trust showed the units hand hygiene compliance for January, February and March 2019, which were 100%. We spoke with staff who undertook the audit who told us they had received training and were confident to challenge staff if they did not clean their hands at the right moments.

During our inspection, we undertook a 20-minute observation of staff cleaning their hands, during the 20 minutes we saw there were 15 times when hands should be cleaned. We saw on all occasions staff cleaned their hands in accordance with trusts hand hygiene policy.

There were dedicated housekeeping staff responsible for cleaning all areas of the unit. We found all areas were uncluttered, clean, tidy and well maintained. Patients and relatives told us they thought the level of cleanliness in the unit was of a good standard.

There were enough clinical and domestic waste bins available which were clearly marked for appropriate disposal. We noticed information explaining waste segregation procedures and waste segregation instructions.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We found equipment was visibly clean on the unit and staff had a good understanding of responsibilities in relation to cleaning and infection control. Disinfectant/detergent wipes were available on the unit to clean equipment between patient contacts.

Furniture was clean and in good condition, fully wipe-able and compliant with Health Building Note (HBN) 00-09: Infection Control in the Built Environment.

We saw patients who had invasive devices in place such as a urinary catheter or peripheral venous line, had the appropriate care bundles in place and were fully completed. This was in line with National Institute for Health and Care Excellence, quality standard (QS) 61 infection prevention and control, statement five, vascular access devices and statement four, urinary catheters.

Staff could take precautions to prevent the risk of infection spreading. On the unit there were two side rooms available to isolate any patient who were found to have an infectious condition or had a poor immune system. We saw gloves and aprons were available in sufficient quantities, outside the rooms. At the time of inspection, there were no patients requiring isolation. Staff told us, if a patient required isolation, they would place signs on doors, and designate equipment to the patient.

## Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Safe managed clinical waste well, However, the high dependency unit did not meet the minimum bed space dimensions as recommended in national guidance.**

The critical care unit at Worthing Hospital had 12 beds, including two side rooms. Six were designated for level three patients (intensive care), and six for level two (high dependency).

The enhanced surgical care unit had five beds. The unit had a bay with four beds, and one side room.

The design of the high dependency unit did not follow national guidance. The bed spaces in the high dependency did not comply with the Department of Health, Health Building Note (HBN) 04-02: critical care units: planning and design. The health building note applies minimum dimensions to bed spaces for all adult inpatient. Minimum dimensions are important to allow staff to access the patient from all sides of the bed and move equipment safety. All new builds must comply with the health building note. However, existing facilities that do not comply with the health building note should note that as part of their risk register. We looked at the critical care service risk register and saw the lack of space in the high dependency was included. In addition, the trust told us they were currently working on plan to rebuild the critical care unit and comply with all relevant guidance.

The critical care unit had two isolation rooms, which could be used in the event of a patient with an infection. The Department of Health, Health Building Note (HBN) 04-02, sets out standards and states that no critical care unit should have less than 20% of their beds as isolation beds.

Staff carried out daily safety checks of specialist equipment. At the start of each shift nursing staff were responsible for completing a checklist of bedside equipment for their allocated patient. One member of staff talked us through the checks they completed, and what to do if they found something was missing or not working.

Emergency equipment was available, safe and fit for purpose. We checked the resuscitation trolley and difficult intubation trolley. All equipment and drugs were within their use-by dates. We also saw checklists for all trolleys showing evidence staff checked the trolleys daily.

We checked 20 pieces of equipment across the units and found they were visibly clean.

The service had enough suitable equipment to help them safely care for patients. The service complied with the core standards for critical care ‘Guidance for the Provision of Intensive Care Services’ (GPICS 2015) safe use of equipment standard. Staff received training in all equipment

used in the critical care services. The practice educator monitored completion of staff competencies on each piece of equipment to make sure the safe use of equipment.

There was a technical support service department based in the critical care corridor. They were responsible for the maintenance of the majority of medical equipment. The equipment was monitored and managed to make sure each item was in good working order. This meant they were accessible to staff and in a position to respond directly to any issues. The technician would attend the daily huddles and provide any support and updates on equipment.

If equipment failed it was the staff members responsibility to report the problem and take the equipment out of service. Staff were responsible for completing a form detailing the problem, the date they removed the piece of equipment and confirming it had been adequacy cleaned. This prevented any piece of equipment going back into service before it had been fixed.

The critical care outreach service had 10 pieces of equipment, which could be used to on patients on the wards who required additional support. The equipment was managed by the outreach team? and kept centrally on the critical care unit. Once it had finished being used it would be returned to the unit and the technician would check and clean it ready for use on the next patient.

The critical care unit was secure. Entry to the unit was via an intercom entry system, and staff swipe card access only. We saw these systems consistently in use during out inspection.

The enhanced surgical care unit did not have an entry system. However, members of staff were present at all times and we saw that visitors reported directly to the nursing staff before entering the unit.

The medicines room on the critical care unit was locked with swipe card lock to prevent unauthorised access. Linen cupboards and store rooms were appropriately stocked and tidy.

Corridors were wide and where equipment was parked, for example the cleaner's trolley or food trolley, it could be done without causing an obstruction. All fire extinguishers we examined had an annual maintenance record. All wards had visible fire action signs and exit signs in the event of an emergency. Fire exits were clearly signposted and free from obstruction.

Staff disposed of clinical waste safely. We saw that waste was separated in different coloured bags to identify the different categories of waste. This was in accordance with Health Technical Memorandum (HTM): Safe Management of Healthcare Waste, control of substances hazardous to health (COSHH), and health and safety at work regulations.

Disposable equipment for once-only use was safe and fit for purpose. In all the clinical areas we visited, we checked disposable supplies and pieces of equipment such as needles, syringes and equipment to manage blocked airways, and we saw they were all sealed and in date.

The service had suitable facilities to meet the needs of patients' families. The relative's rooms were clean and tidy. There was comfortable seating available and facilities for making tea and coffee, along with a water fountain.

## Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.**

Staff completed risk assessments for each patient on admission / arrival and updated them when necessary and used recognised tools. The service carried out a review of all patients on admission to establish if their needs would be suitably met by the department.

Staff knew about and dealt with any specific risk issues. Staff completed relevant risk assessments and care bundles. For example, pressure ulcer, venous thromboembolism and intravenous cannula risk assessments were completed in all of the electronic patient records we looked at.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. In line with National Institute for Health and Care Excellence (NICE), guideline (NG), 51, sepsis: recognition, diagnosis and management, the service used the National Early Warning System (NEWS) track and trigger flow charts. National Early Warning System is a simple scoring system of physiological measurements (for example, blood pressure, temperature and pulse) for patient monitoring.

We saw evidence that a sepsis bundle for the management of patients with presumed/confirmed sepsis was in place. The trust used the acronym of BUFALO (Blood cultures, measure accurate urine output, administer Intravenous fluids, administer broad spectrum antibiotic, measure serum lactate, administer high flow oxygen), to highlight actions to be undertaken when sepsis was identified. Staff told us that most patients who had sepsis had already had sepsis diagnosed and treatment commenced before they were admitted to critical care. Staff said they had excellent support and response from doctors who were on the unit 24 hours a day and would ensure timely assessment and treatment of sepsis.

The unit had daily safety briefings which highlighted potential risks to patients. We observed a safety briefing during the inspection. These were multidisciplinary meetings where safety issues on the unit were discussed so all team members were aware of them. The meetings were attended by a mix of staff on duty.

The guidelines for provision of intensive care services recommends that critical care outreach teams should be available 24 hours a day seven days a week. The critical care outreach team operated a seven-day 7.30 am to 8 pm service. At night the service was maintained by the site practitioners within the site management team. A formal handover took place twice a day between the site team and the outreach team to inform them of any patients who needed follow up. The overnight escalation calls and bleeps were diverted to ensure the correct team responded. 24-hour outreach provision was being reviewed by the trust to detail the benefits and investment required for this provision.

The outreach team were involved in managing and treating sepsis on the wards. They supported all aspects of the acutely and critically ill patient pathway including follow up of patients post discharge from critical care, responding to the needs of the deteriorating patient, facilitating timely admission to critical care, and providing on-going support to patients until their admission. They also provided training in the management of critically unwell patients, tracheostomy, non-invasive ventilation, and in resuscitation training.

The critical care outreach team followed up all patients discharged from critical care. Data provided to us by the trust showed between July 2018 and June 2019, the critical care outreach team had followed up 558 patients.

The critical outreach team led on a sepsis awareness programmes across the trust. Their work and the work of staff across the trust had seen the Dr Foster standardised mortality ratio on this measure decreased from 112 to 98. Sepsis Week ran across the hospitals at the end of

September with a focus on not just recognising the potentially life-threatening condition but acting fast when its signs are spotted.

We were told that this year's campaign will adding an extra focus on making sure clinicians are able to act fast whenever they see sepsis. Outreach nurses will be attending safety huddles (short daily ward meetings) and visiting wards and departments throughout the week to get the awareness and act-fast messages across, as well as answer questions about sepsis, its identification and responses.

The trust had launched a campaign to raise awareness of the signs of sepsis among staff, patients and their relatives. As well as starting a series of training sessions using a high-tech simulation dummy to help clinicians recognise the early signs of sepsis, they had also introduced a new screening tool to the emergency department to alert doctors and nurses to markers of the condition.

In addition, automated screening for severe sepsis was now functional on the trust's electronic observation and assessment system on the Emergency Floor. The screening system helped emergency department staff to diagnose severe sepsis and deliver the care bundle in a timely manner. This action in the emergency department had a knock-on effect on the number of patients admitted to the critical unit with sepsis and outcomes for those patients.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Staff could access mental health support for patients if they were concerned about risks associated with a patient's mental health. Staff reported there was generally good support available for those patients that required mental health support.

## Nurse staffing

**The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.**

The critical care unit had the right number of nurses and the right skill mix for the acuity of patients. Nurse staffing was sufficient to meet professional standards, of one to one registered nurse for each level three patient, and one to two registered nurses to level two patients. Supernumerary band six nurse shift leaders were on each unit shift. This was in line with the Guidelines for the Provision of Intensive Care Services 2015.

There were systems and processes in place to assess, plan and review staffing levels on the critical care unit, including skill mix. Rotas were planned, which allowed for adjustments to be made to make sure the correct skill mix was in place to ensure safe patient care. Shortfalls in the staffing levels were covered by hospital bank staff. In line with the Guidelines for the Provision of Intensive Care Services 2015, the critical care unit used bank staff when filling gaps in rotas. The bank staff used were staff who worked regularly on the unit. The unit did not use more than 20% of registered nurse from bank/agency staff on any one shift when they were not their own staff.

There was a standardised handover procedure, for nursing staff, both for shift handovers and discharge of a patient back to parent teams. At the beginning of each shift a whole team handover was given and then a one to one handover at the patients beside took place. A more detailed handover took place between the shift leaders. On discharge, when a ward bed was allocated to a patient, nursing and medical staff contacted the speciality teams to give a handover. There was a

comprehensive discharge form which was completed, which detailed the patient stay in the critical care unit, including plan of care, changes to medication and any mobility or social issues.

Staff told us they had enough staff to provide good nursing care. Relatives and patients that we spoke with told us that they felt there was enough staff to provide care.

On the critical care unit there was a team of 61 registered nurses, (three band seven, 16 band six and 42 band five nurses) supported by a team of six healthcare assistants, one technician and one administration and clerical staff. We saw there were nine registered nurses (including the supernumerary nurse), and one healthcare assistant on duty 7.30 am to 8 pm and the same at night from 7.30 pm to 8 am. This allowed for effective handovers to take place.

The outreach team was staffed by five band seven nurses and one band six. All staff had a background of working in critical care. We saw there were two nurses available between 7.30 am to 8 pm, seven days a week.

The enhanced surgical care unit was led by the outreach team supported by, a team of 14 registered nurses, and two healthcare assistants. We saw there were two registered nurses and one healthcare assistant on duty between 7.30 am to 8 pm and two registered nurses on duty between 7.30 pm and 8 am.

The critical care unit had their own full-time pharmacist. The units had pharmacy provision five days per week.

There were dedicated physiotherapists for the critical care unit, with additional training in respiratory management. All staff we spoke with confirmed physiotherapy staffing was adequate to provide the respiratory management and rehabilitation components of care.

**Trust level**

The table below shows a summary of the nursing staffing metrics in medicine at trust level compared to the trust's targets, where applicable:

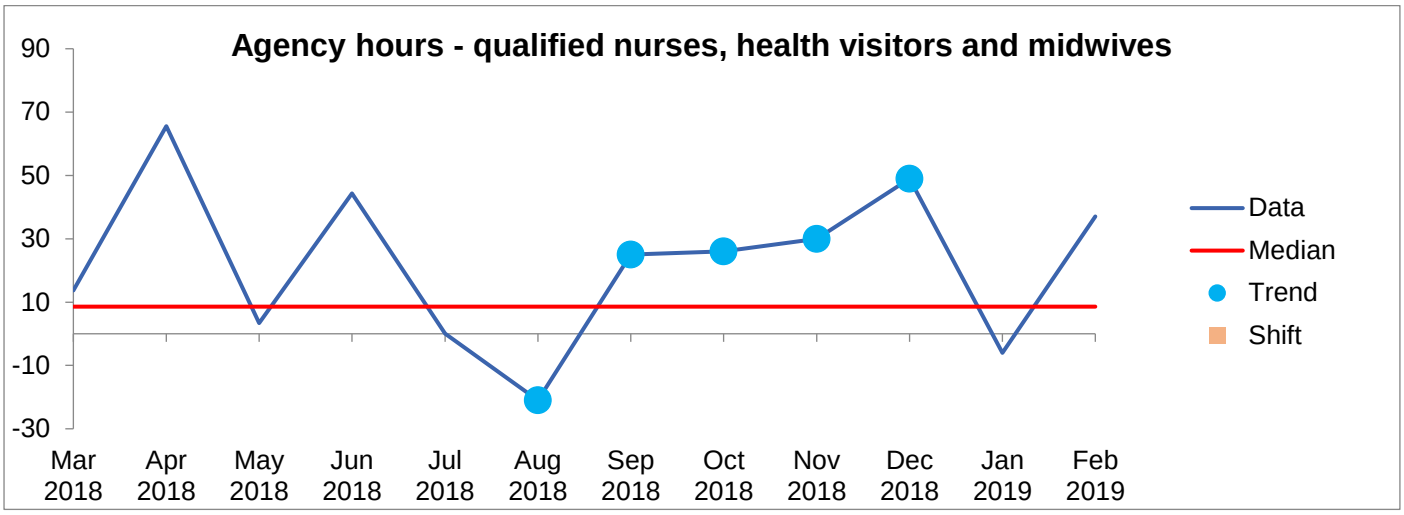
| | **Core service annual staffing metrics** | | | | | | |
|---|---|---|---|---|---|---|---|
| | April 2018 – March 2019 | | | | | | |
| **Staff Group** | **Annual average establishment** | **Annual vacancy rate** | **Annual turnover rate** | **Annual sickness rate** | **Annual bank hours (% of available hours)** | **Annual agency hours (% of available hours)** | **Annual unfilled hours (% of available hours)** |
| **All Staff** | 116.1 | 1% | 5% | 4.9% | | | |
| **Qualified Nurses** | 104.0 | 0% | 4% | 4.3% | 6,763 (3%) | 267 (<1%) | 20,604 (9%) |

*(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)*

Nurse staffing rates within this core service were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness and bank use.

The following information and chart highlight specific staffing areas where there is noteworthy evidence that may prompt further investigation on site.

**Bank and agency staff usage**




Monthly 'agency hours' over the last 12 months for qualified nurses, health visitors and midwives show an upward trend from August 2018 to December 2018.

*(Source: Routine Provider Information Request (RPIR) - Nursing – Bank and Agency tab)*

**Worthing Hospital**

The table below shows a summary of the nursing staffing metrics in medicine at trust level compared to the trust's targets, where applicable:

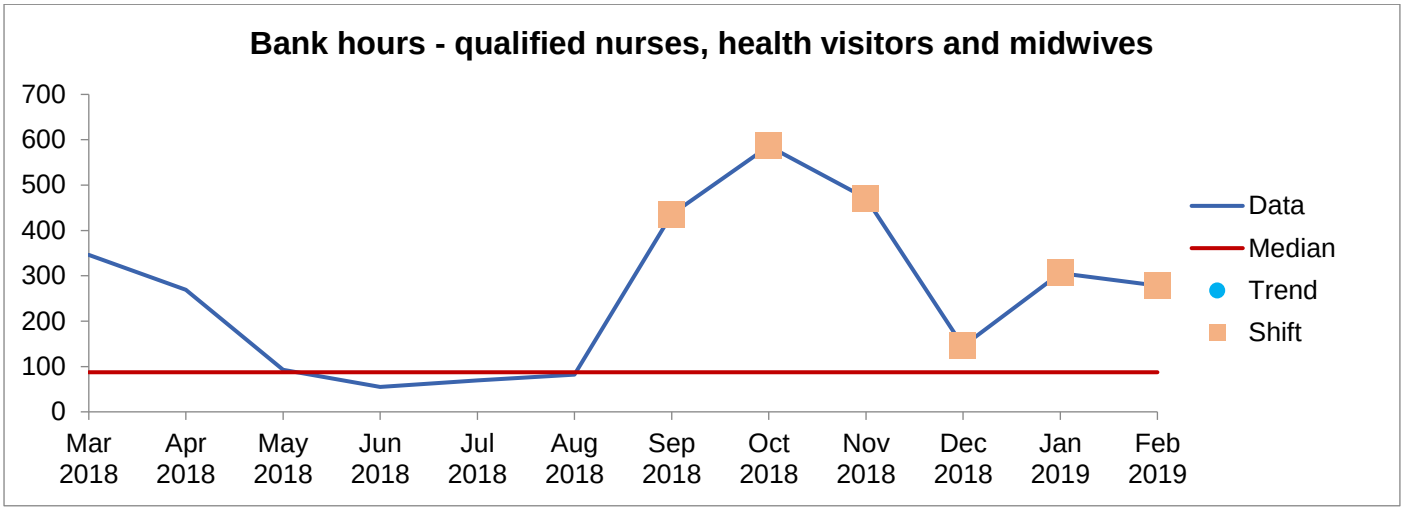
| | Core service annual staffing metrics | | | | | | |
|---|---|---|---|---|---|---|---|
| | April 2018 – March 2019 | | | | | | |
| **Staff Group** | **Annual average establishment** | **Annual vacancy rate** | **Annual turnover rate** | **Annual sickness rate** | **Annual bank hours (% of available hours)** | **Annual agency hours (% of available hours)** | **Annual unfilled hours (% of available hours)** |
| **All Staff** | 62.7 | 3% | 3% | 5.8% | | | |
| **Qualified Nurses** | 56.0 | 4% | 4% | 4.8% | 3,136 (3%) | 237 (<1%) | 14,484 (12%) |

*(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)*

Nurse staffing rates within this core service at Worthing Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness and agency use.

The following information and chart highlight specific staffing areas where there is noteworthy evidence that may prompt further investigation on site

**Bank and agency staff usage**




Monthly 'bank hours' over the last 12 months for qualified nurses, health visitors and midwives show a shift from September 2018 to February 2019.

*(Source: Routine Provider Information Request (RPIR) - Nursing – Bank and Agency tab)*

## Medical staffing

**The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix.**

Critical care was consultant delivered and led. Consultants led twice daily ward rounds seven days a week. The critical care service had a lead clinician. There were nine consultants providing medical cover to the critical care unit, and the outreach team. The consultants were supported by 11 senior middle grade doctors and eight junior middle grade doctors.

Consultants were available on the critical care unit between 8 am and 6.30 pm seven days a week. Out of hours, one consultant was available on call. All consultants on-call were available to attend the critical care unit within 30 minutes, 24 hours a day, seven days a week. The availability requirements were set out within their job descriptions and checked during appraisals. During inspection we looked at five medical staff appraisals and saw, where appropriate for their job role, their ability to attend the unit within 30 minutes was checked.

There was a registrar (a doctor who is receiving advanced training in a specialist field of medicine to become a consultant) were available on the unit, 24-hours a day, seven days a week.

The critical care unit had a consultant ratio of 1:5 to 1:9. This was in line with the guidelines for the provision of intensive care services, 2015: the consultant to patient ration should not exceed 1:8 – 1:15.

**Consultant patient ratio for the last 12 months:**

| 07/18 | 05818 | 0918 | 10/18 | 11/18 | 12/18 | 01/19 | 02/19 | 03/19 | 04/19 | 05/19 | 06/19 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1:8 | 1:5 | 1:8 | 1:9 | 1:8 | 1:8 | 1:8 | 1:8 | 1:8 | 1:8 | 1:9 | 1:9 |

*(Source: ADR RYR 20 what is the consultant ratio at critical care)*

Consultants responsible for patients on the unit were free from other clinical commitments, when covering the critical care unit.

Patients in critical care were reviewed by a consultant within 12 hours of admission. We looked in seven patient records and all seven showed evidence of a review. This is in line with national guidance.

The critical unit did not use outside locum agencies to cover shortfall in staffing levels. The critical care unit used ‘in house’ locums, to cover, this meant only medical staff familiar with the trust covered the critical care unit.

## Records

**Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**

Patient records were recorded in an electronic patient record (EPR), that had been specifically designed for use with critical care patients. All medical, nursing and allied health professional’s notes were recorded onto the critical care electronic patient record. There were clear prompts for the various teams to make sure vital data was not omitted. Care plans were in place and there was evidence that these were reviewed daily. Patients allergies were clearly identified on the system and all patient’s lines and drains were detailed on a body map as well as any wounds or injuries.

Patient records were comprehensive, and all staff could access them easily. Records were shared by doctors, nurses and other healthcare professionals. This meant that all professionals involved in patient care and could access the records as required. This is in line with National Institute for Health and Care Excellence (NICE), quality standards (QS) 15, statement 12, patient experience in adult services. This says health and social care professionals should make sure they support coordinated care through clear and accurate information exchange.

When patients transferred to a new team, there were no delays in staff accessing their records. Critical care outreach nurses had access to both the critical care electronic patient records system and the hospital-wide electronic patient records system, which made sure they could access the most up to date observations and results of the patients they were asked to assess.

Medical records were completed in line with trust and professional standards. We saw that patients were reviewed by a consultant within 12 hours of admission to critical care and there was daily multidisciplinary team (MDT) input. We also saw there was clear documentation of the time and decision to admit to the critical care unit. This was in line with National Institute for Health and Care Excellence (NICE), clinical guidance 50; acutely ill adults in hospital: recognition and response to acute illness in adults in hospital.

On the critical care unit there were enough computers available for staff, this meant that records could be updated in a timely way. All staff working in the critical care unit had personal log in detail for the electronic patient records. This meant when information was entered onto the system it was dated, timed and the name of the person entering the information was recorded. Throughout the inspection we observed staff using their own login details on the electronic patient record and not entering information under other staff logins.

The unit had a dedicated critical care nurse that maintained and updated the critical care electronic record. All staff were encouraged to suggest changes that would make the system fit the needs of patients and make the recording of information more effective.

New staff were given comprehensive training on the system. Staff we spoke with told us the system was quick and easy to use and was integral to the care and safety of patients being looked after on the unit.

There were processes and back up plans in place should the electronic record fail. Paper records were available in the event of such failure. This made sure data was not lost and patient's treatment and safety was not compromised.

There were processes in place for the stewardship of antimicrobials (drugs used to treat infections due to bacteria, viruses or fungi). we looked at five medical records for patients who were prescribed an antimicrobial, we saw the clinical indication, dose and duration documented. This is in line with National Institute for Health and Care Excellence (NICE) quality standard (QS), 121, statement 3, recording information.

When patients were discharged from the critical care unit had a formulised comprehensive electronic discharge summary was completed and sent to the relevant healthcare team. This was in line with National Institute for Health and Care Excellence (NICE), clinical guidance 50; acutely ill adults in hospital: recognition and response to acute illness in adults in hospital.

## Medicines

**Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.**

Medicines were stored securely behind locked doors with access restricted to appropriate staff. Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored securely. Two nurses checked the quantities daily and any discrepancies were reported. Medicines administration was recorded electronically, and we saw medicines were given as prescribed.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. There was good clinical pharmacy support with a pharmacist who visited the unit daily. They were able to provide advice to patients and carers if needed.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy.

Room and fridge temperatures were recorded daily to ensure medicines were stored at appropriate temperatures, however we did see the maximum fridge temperature had been outside the recommended range over the previous two months and there was no evidence action had been taken. It was unclear if staff had been resetting the thermometer after each check.

Staff followed current national practice to check patients had the correct medicines. Policies and protocols were available for all staff on the intranet. The pharmacist was also contactable when they were not on the unit. Checks were completed when patients came to the unit to ensure they were prescribed their regular medication.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Medicine related alerts and recalls were communicated to the nurse in charge of the ward and cascaded to all ward staff. Medicines incidents were recorded on electronic reporting system. Examples were given to show how improvements have been made following recent incidents to prevent them from re-occurring.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff explained how they would support patients who lacked capacity to make a decision on their medicines. Staff knew when it was appropriate to administer medicines which were prescribed to be taken when required.

## Incidents

**The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

There were effective systems in place to report incidents. Incidents were monitored and reviewed and staff gave examples of learning as a result. Staff understood the principles of Duty of Candour regulations, were confident in applying the practical elements of the legislation. Regular mortality and morbidity meetings were held to discuss patient deaths and other adverse events in an open manner, review care standards and make changes if needed.

Between 26 July 2018? and 26 July 2019, there were 137 incidents reported by the critical care service. Of these, 102 were reported for intensive care, and 35 for high dependency. The biggest category was none (no harm caused), which accounted for 88 of incidents followed by low (minimal harm caused) (49). The service reported no moderate/severe harm or death in the last 12 months.

All staff knew what incidents to report and how to report them. An electronic based system was used to report incidents. Staff were aware of the system and found it easy to use. Staff told us if they reported an incident they did receive feedback on the investigation and any outcomes or actions following it.

Staff reported all incidents that they should report. Staff were encouraged to report incidents and they were confident about reporting issues or raising concerns with senior staff. They were aware of the type of incidents they needed to escalate and report. Staff told us they made time to report incidents. Staff also said there was an open, no-blame culture for reporting incidents. This meant the hospital could be confident that all incidents including 'low risk' or near 'misses' were reported as staff were not afraid of any critical or negative feedback. For example, we saw incidents were discussed at the daily huddles, all staff were made aware of what happened, and any actions put in place to prevent the incident from happening again.

The duty of candour was well embedded, and staff were supported to acknowledge any shortfalls and helped to reduce the impact. Duty of candour, Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant person) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff were committed to openness and transparency with patients, their loved ones and each other. This was demonstrated when staff talked about having difficult discussions with patients to help them understand their condition and prognosis. Senior staff supported others to allow patients to fully understand the likely outcomes from treating or not treating their particular condition. For example, we saw an incident where an incorrect bag of fluid had been attached to a patient's arterial line, we saw the patient's family were notified.

The service held regular mortality and morbidity meetings. Mortality and morbidity meetings allow clinicians to discuss patient deaths and other adverse events in an open manner, review care standards and make changes if needed. The trust sent us copies of the minutes of the last three meetings. We saw there was evidence of individual cases discussed along with outcomes and any learning.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2018 to May 2019, the trust reported no never events for critical care.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from June 2018 to May 2019.

## Safety thermometer

**The service used monitoring results well to improve safety. However, it was not displayed. for staff, patients and visitors to see.**

During our inspection, we were told safety thermometer information was collected. However, we did not see this information on display to keep patients and visitors informed about ward performance.

Risk assessments for pressure ulcers and falls were part of the nursing assessment documentation and we saw these were up to date, completed and regularly reviewed. In records which identified patients who were at risk of developing pressure ulcers, we saw actions were appropriately followed up, such as use of a pressure care relieving mattress.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported eight new pressure ulcers, no falls with harm and no new catheter urinary tract infections from May 2018 to May 2019.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at Western Sussex Hospitals NHS Foundation Trust**

1

**Total Pressure ulcers (8)**


1 Pressure ulcers levels 2, 3 and 4

*(Source: NHS Digital)*

## Is the service effective?

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patient's subject to the Mental Health Act 1983.**

The service contributed to and uploaded data regularly to the Intensive Care Audit Research Centre (ICNARC). This provided information and feedback about the quality of care to those who work in critical care to allow service benchmarking against similar critical care units nationally. We saw in eleven standards the service was within the expected range, and in seven of the standards was equal or better than other similar services.

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance. Polices and guidance were accessed on the trust intranet or on the critical care computer system. Staff showed us how they accessed them.

Staff assessed patient's physical, mental health and social needs holistically, and their care, treatment and support was delivered in line with legislation, standards and evidence-based guidance, including National Institute for Health and Care Excellence (NICE).

The service promoted and participated in a programme of organs and tissue donation. This was in line with National Institute for Health and Care Excellence (NICE), clinical guideline 135; organ donation for transplantation: improving donor identification and consent rates for deceased organ donation. We saw, in 2018/19 the trust achieved 100% early referral of potential organ donors.

Physiotherapists assessed the rehabilitation needs of all patients admitted to critical care. We saw they worked collaboratively with the critical staff to make sure they tailored the rehabilitation to the specific requirements of the patient.

The service used evidence-based 'care bundles'. A care bundle is a set of evidence-based interventions that, when used together, can improve patient outcomes. We saw care bundles such as central line bundles, ventilated patients care and peripheral access care bundles were in use. All care bundles were fully embedded into practice. They audited compliance with care bundles to make sure staff followed best practice.

Sepsis management was in line with the National Institute for Health and Care Excellence (NICE) guidelines (NG51). A policy was available to staff on the trust's intranet, and staff we spoke to were aware of it and knew how to find the policy. The trust used a recognised national tool to

screen patients for sepsis. Staff we spoke with had received annual training on sepsis, including the use of sepsis screening tools and use of the care bundle.

Patients were assessed for their risk of developing venous thromboembolism (VTE), in line with National Institute for Health and Care Excellence (NICE), quality statement (QS) 3; venous thromboembolism in adults: reducing the risk in hospital. We looked at seven sets of medical records and saw that all seven had been risk assessed for the development of a venous thromboembolism.

The Guidelines for the Provision of Intensive Care Services 2015, states that patients discharged from an intensive care unit must have access to an intensive care follow up clinic. Patients who had been an inpatient in the critical care unit for more than 72 hours, were offered to attend a follow up clinic.

There was a dedicated audit nurse for the critical care unit who was responsible for electronic patient data collection, which they regularly input into the services performance dashboard system and into the Intensive Care National Audit Research Centre (ICNARC) database.

## Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.**

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Nursing staff completed a nutritional risk assessment when patients were admitted to hospital, this is in line with National Institute for Health and Care Excellence, quality standard 24, statement one: screening for the risk of malnutrition. The risk assessment included a malnutrition universal screening tool (MUST) used throughout the United Kingdom, to assess people for risk of malnutrition. We looked at seven nutrition screening tools and saw all seven were fully completed.

Specialist support from staff such as dieticians and speech and language therapists were available for patients who needed it. The critical care ward was supported by a dietitian, who visited the ward Monday to Friday and who could be called if any advice or urgent situation occurred. Staff said they did not encounter any issues with this arrangement despite the dietitian not being a permanent member of the critical care team.

Staff made sure patients had support with nutrition and hydration to meet their needs. Patients who could take oral nutrition were offered a menu with a wide range of dietary requirement food, and healthy choices. There was access to meals for different dietary requirements religious or cultural needs. Staff told us they would support patients who were able to eat or assist them if they required any additional support. Staff also highlighted that they would regularly educate families and how to feed patients to maximise independence.

Protected mealtimes were in place across the hospital. Protected mealtimes encouraged the hospital to stop all ‘non-urgent’ clinical activity on the unit during mealtimes. This meant patients could eat their meals without being interrupted and allowed staff to assist those who needed it.

Staff fully and accurately completed patients’ fluid and nutrition charts where needed. During our inspection we saw that water was available for those patients able to drink and assistance was provided as required for those patients. We found fluid balance charts were fully completed in all of the seven records we looked.

The unit had a feeding protocol in place. This provided guidance for staff on feeding patients who were unable to eat and needed to be fed by nasogastric tube, or via total parenteral nutrition (TPN) (fluids are given into a vein to provide most of the nutrients a body needs). This meant there was no delay in the feeding of patients if a dietitian was not available.

The service had implemented the 'Promoting safer measurement and administration of liquid medicines via oral and other enteral routes', we saw there were dedicated purple feeding syringes. This reduced the risk of accidental administration of intravenous medications through feeding tubes.

## Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave pain relief to ease pain.**

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Patients received pain relief soon after it was identified they needed it, or they requested it. We spoke with five patients, with told us that their pain was managed well, and staff responded quickly if they needed pain relief.

Pain levels were regularly reviewed and discussed at ward rounds; this was recorded in the electronic patient record. Consultants on the units managed pain relief, with input from the specialist pain team available on request.

Staff prescribed, administered and recorded all pain relief accurately.

We saw that pain scores were recorded, before and after pain relief was given, to check if it had been effective.

## Patient outcomes

**All staff were actively engaged in activities to monitor and improve quality and outcomes (including, where appropriate, monitoring outcomes for people once they have transferred to other services). Opportunities to participate in benchmarking and peer review are proactively pursued, including participation in approved accreditation schemes. Outcomes for people who use services are positive, consistent and regularly exceed expectations.**

We saw the service participated in national audits, Intensive Care National Audit Research Centre and the NHS Blood and Transplant national potential donor audit. The results were used to benchmark and compare with other trusts nationally. Information provided by the department identified that it audited a range of pathways including those used from the Intensive Care National Audit Research Centre. Action plans were in place to improve areas in the audit that were not at the required level.

We saw the Intensive Care National Audit Research Centre was prominently displayed on the critical care unit for staff to see and monitor progress. We saw for the majority of indicators the

trust performed better than or similar to the national aggregate. Where the trust was worse than the national average, they were able to give the reason why.

For example, we saw that the trust was worse the national aggregate for patients being discharged directly to their own home. This was due to elective rapid discharge of patients from the critical care unit to their preferred place of care for their end of life care. The unit staff worked with the Specialist Palliative Care team to make sure patients who were identified as approaching the end of their life could be transferred home direct from the critical care unit. This meant that the data submitted to Intensive Care National Audit Research Centre would look worse for the trust because of the number of patients.

Staff had still considered why they had these discharges and were able to identify the individual patients and the reasons these discharges which been in their best interest.

| Number of cases | Metric | 2018/19 | Similar units | All unit average |
|---|---|---|---|---|
| 514 admissions | Discharges direct to home | 11.3% | 8.5% | 5.5% |

*(Source: ADR RYR43 – up to date Intensive Care National Audit Research Centre data)*

We saw the service participated in the Commissioning for Quality and Innovation (CQUIN) to reduce the delayed discharges from adult critical care to ward level care by 30%. We saw the trust achieved a 75% reduction in their delayed discharges from the critical unit to the ward, which they have maintained.

The trust participated in organ donation and reported to the NHS Blood and Transplant National Potential Donor audit. In 2018/19 the trust achieved 100% early referral of potential organ donors. Audits also showed that a specialist nurse for organ donation was present for 100% of the organ donation discussions with families in 2018/19. When compared with UK performance, the trust was rated ‘gold’ for specialist nurse for organ donation presence when approaching families to discuss organ donation.

The service does not undertake sepsis audits. The trust told us management of patients with sepsis is discussed at the critical care monthly mortality and morbidity meetings. There had been no concerns raised with delayed recognition or management of sepsis. As a result of this the critical care service have not undertaken a local sepsis audit within the last 12 months.

**ICNARC Participation**

The trust submitted data to the Intensive Care National Audit & Research Centre (ICNARC). The most recent data was only made available during the week preceding the inspection visit. It was not yet available on the Intensive Care National Audit & Research Centre website, but we were provided with it by the trust. They were able to explain and provide details of what the data and annual report were showing for their service. All indicators showed performance about comparator trusts and within two standard deviations from the average. Both sites had performance that was better than expected and better than peers.

The trust has two units which 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. We used data from the 2016/17 Annual Report. Any available quarterly data should be considered alongside this annual data.

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

**ICNARC results**

**Worthing Hospital**

The table below summarises the performance at Worthing Hospital Critical Care Unit in the 2017/18 ICNARC Audit.

| Metrics *(Audit measures)* | Trust performance | Comparison to other Trusts | Meets national standard? |
|---|---|---|---|
| **Crude non-clinical transfers** *(Transfers made for non-clinical reasons often relate to patient flow and capacity issues which may add to patient risk, prolong intensive care unit stay and cause distress to patients and carers)* | 0.9% | Within expected range | ✘ (National standard 0%) |
| **Crude, non-delayed, out-of-hours discharge to the ward proportion** *(Discharge out-of-hours is associated with increased risk of mortality)* | 1.1% | Within expected range | ✘ (National standard 0%) |
| **Crude delayed discharge (% bed-days occupied by patients with discharge delayed more than 8 hours)** *(Discharge from critical care should be within four hours of decision to discharge and occur as early as possible in the day)* | 5.3% | Not in the worst 5% of units | ✘ (National standard 0%) |
| **Risk-adjusted hospital mortality ratio (all patients)** *(Risk-adjusted measures take into account the differences in the case-mix of patients treated)* | 1.0 | Within expected range | No current standard |
| **Risk-adjusted hospital mortality ratio for patients with predicted risk of death less than 20% ('lower risk' patients)** *(Risk-adjusted measures take into account the differences in the case-mix of patients treated)* | 0.9 | Within expected limits | No current standard |

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

**Hospital mortality (all patients)**

For the Critical Care unit at Worthing Hospital, the risk adjusted hospital mortality ratio was 1.0 in 2017/18. This was within the expected range. The figure in the 2016/17 annual report was 1.1.

| Number of cases | Metric | 2016/17 | 2017/18 | National aggregate | Asp Standard | Comparison |
|---|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| 620 admissions | Risk-adjusted hospital mortality ratio (all patients) | 1.1 | 1.0 | 1.0 | none | Within expected range |

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

The trust supplied us with the latest Intensive Care National Audit Research Centre (ICNARC) audit data for 2018/19 that for risk adjusted hospital mortality ratio was 1.03 for 595 admissions. Although this was within expected range it was higher than when compared with similar units.

**Hospital mortality (for low risk patients)**

For the Critical Care unit at Worthing Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.9. This was within expected limits. The figure in the 2016/17 annual report was 1.3

| Number of cases | Metric | 2016/17 | 2017/18 | National aggregate | Asp Standard | Comparison |
|---|---|---|---|---|---|---|
| 403 admissions | Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk) | 1.3 | 0.9 | 1.0 | none | Within expected limits |

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

The trust supplied us with the latest Intensive Care National Audit Research Centre (ICNARC) audit data for 2018/19 that the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.96 for 441 admissions. This was better than when compared with similar units.

**Unplanned readmission within 48 hours of discharge**

The unplanned readmission to critical care within 48 hours of discharge to a ward should be kept to a minimum. For the Critical Care unit at Worthing Hospital, the unplanned readmission within 48 hours of discharge was 2.4%. This was within expected limits.

| Number of cases | Metric | 2018/19 | Similar units | All unit average |
|---|---|---|---|---|
| 329 admissions | Unplanned readmission within 48 hours of discharge. | 2.4% | 1.2% | 1.2% |

*(Source: ADR RYR43 – up to date Intensive Care National Audit Research Centre data)*

For five of the last 12 months we saw there were no unplanned readmissions.

| 07/18 | 05818 | 0918 | 10/18 | 11/18 | 12/18 | 01/19 | 02/19 | 03/19 | 04/19 | 05/19 | 06/19 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 6.1% | 0% | 2.1% | 0% | 0% | 1.9% | 0% | 2.3% | 4.2% | 0% | 1.7% | 1.7% |

*(Source: ADR RYR14 rate for unplanned discharges within 48 hours of discharge care in the last 12 months)*

## Competent staff

**The continuing development of the staff's skills, competence and knowledge was recognised as being integral to ensuring high-quality care. Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice. Managers made sure staff received any specialist training for their role.**

Managers made sure staff received any specialist training for their role. Information provided by the trust showed that as of April 2019, 52.5% (31 out of 59) had a post-registration award in critical care. This meant the service was meeting the national guidelines minimum recommendation of 50% specialist nurses for the provision of intensive care services. Additionally, the unit had a 89.4% completion rate in training in specialised unit equipment.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We saw that 95.6% of staff on the critical unit had an up to date appraisal, which was better than the trust target of 90%. All staff were required to have annual appraisals. We looked at five files for nursing staff and five for medical staff. All documents were completed accurately and comprehensively.

Nursing appraisals had clear and current objectives, a values and attitudes assessment and a health and wellbeing check in.  All included a review of mandatory training and a revalidation date.

The medical staff appraisals included their scope of work, their qualifications and revalidation, quality improvement activities, reflection on any significant events and feedback from colleagues and patients.

There were enough practice educators to support staff learning and development. There was a practice educator for the critical care unit. We spoke with the practice educator, they were in a dedicated role in line with Guidelines for the Provision of Intensive Care Services standards. They provided a variety of education and maintained central records for equipment training, mandatory training and post-registration training on the units.

Nurses new to the critical care nursing received four to six weeks of supernumerary shifts in order to learn essential skills to care for level two and three patients safely. Nursing staff that had previously worked in the critical care environment had four weeks of supernumerary shits. Until staff had completed these periods they would be encouraged to work the shorter shift patterns.

The critical care unit had a structured development programme for all staff that included unit and role specific induction programmes, competency frameworks and career development matrixes.

All registered nurses in critical care were required to complete Step one of the National Competency Framework for Adult Critical Care Nurses within 12 months of commencing employment on the units. While completing Step one competencies; there was a mentor and buddy system in place, time to complete training and support from the practice educator. The

practice educator logged the type of experience nurses were gaining to track progress and facilitate skills development.

Step one competencies aim to provide core generic skills required to safely and professionally care for the critically ill patient in a general critical care unit under the supervision and support of a mentor, lead assessor and /or practice educator.

New staff to the unit would initially be placed in the team that the practice educator managed, this allowed for them to work alongside them, address issues and training needs.

Staff were involved in quality improvement programmes or initiatives. One initiative we heard of was a KUDOS. This had been set up on unit computers and it was a way to provide feedback to a colleague who had done something well.

New consultants had a robust programme of induction and were excluded from any on call responsibilities.

For non-registered staff there were opportunities to progress to apprentice support workers then on to advanced support workers. The trust was committed heavily to staff development at all levels and was supporting unqualified staff to work towards professional registration through formal and informal learning programmes.

The trust had developed a Clinical Improvement Scholarship programme in collaboration with an outside organisation. The programme aimed to support practitioners in combining their everyday clinical role alongside development of their research, leadership and continuous improvement.

Divisional leaders supported staff to develop innovative ways of supporting staff learning and competency. Individual and teams of staff had designed complex teaching tools that enabled other staff to become familiar with and competent in key skills such as managing complex airways. For example, the trust won the national safety prize for the Annual Association of Anaesthetists twice in the last six years. One of these was for a doctor who had developed a new gel to enable the creation of simulation models for training clinical staff in the management of patients with different body shapes or anomalies.

**Appraisal rates**

From 17 April 2018 to 16 April 2019, 96.0% of staff within the critical care department at the trust received an appraisal compared to a trust target of 90%. The appraisal target was met by all staff groups.

**Trust level**

| Staff group | 17 April 2018 to 16 April 2019 | | | | |
|---|---|---|---|---|---|
| | Staff who received an appraisal | Eligible staff | Completion rate | Trust target | Met (Yes/ No) |
| Add Prof Scientific and Technic | 1 | 1 | 100.0% | 90% | Yes |
| Additional Clinical Services | 8 | 8 | 100.0% | 90% | Yes |
| Administrative and Clerical | 2 | 2 | 100.0% | 90% | Yes |
| Estates and Ancillary | 1 | 1 | 100.0% | 90% | Yes |
| Nursing and Midwifery Registered | 107 | 112 | 95.5% | 90% | Yes |
| **Total** | **119** | **124** | **96.0%** | **90%** | **Yes** |

From 17 April 2018 to 16 April 2019, 95.6% of staff within the critical care department at Worthing Hospital received an appraisal compared to a trust target of 90%. The appraisal target was met by all staff groups.

**Worthing Hospital**

| Staff group | 17 April 2018 to 16 April 2019 | | | | |
|---|---|---|---|---|---|
| | Staff who received an appraisal | Eligible staff | Completion rate | Trust target | Met (Yes/ No) |
| Add Prof Scientific and Technic | 1 | 1 | 100.0% | 90% | Yes |
| Additional Clinical Services | 5 | 5 | 100.0% | 90% | Yes |
| Administrative and Clerical | 1 | 1 | 100.0% | 90% | Yes |
| Nursing and Midwifery Registered | 58 | 61 | 95.1% | 90% | Yes |
| **Total** | **65** | **68** | **95.6%** | **90%** | **Yes** |

*(Source: Routine Provider Information Request (RPIR) – Appraisal tab)*

**Qualified nursing staff**

As of 17 April 2019, the trust reported that 56 nursing staff had a post registration award in critical care nursing.

Site breakdown can be seen below:

| Site/Location/Unit | Total number of nursing staff in unit (qualified) | Total number of nursing staff with post registration award |
|---|---|---|
| Worthing Hospital Critical Care Unit | 59 | 31 |
| St. Richard's Hospital Critical Care Unit | 54 | 25 |

There were also 113 staff with training in specialised equipment.

Site breakdown can be seen below:

| Site/Location/Unit | Total number of staff (qualified and unqualified) | Total staff with up to date training in specialised unit equipment |
|---|---|---|
| Worthing Hospital Critical Care Unit | 66 | 59 |
| St. Richard's Hospital Critical Care Unit | 58 | 54 |

*(Source: Acute Routine Provider Information Request (RPIR) – CC-staffing tab)*

## Multidisciplinary working

**Staff, teams and services were committed to working collaboratively and had found innovative and efficient ways to deliver more joined-up care to people who use services.**

Staff worked across health care disciplines and with other agencies when required to care for patients. There was good multidisciplinary team working. Staff had input into the planning, assessing and delivering of patients' care and treatment. Staff told us they were proud of good multidisciplinary team working, and we saw this in practice. Staff were courteous and supportive of one another. For example, the unit staff worked with the Specialist Palliative Care team to enable patients who were identified as approaching the end of their life to be transferred home direct from the critical care unit.

Junior doctors told us consultants were supportive, and actively listened to them. They felt they could contribute to decisions over care and treatment and be listened to.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. There were daily ward rounds on unit which involved nursing and medical staff together with the physiotherapist and other therapist as required.

Physiotherapists, a dietician, a pharmacist, speech and language therapy staff, consultants and nurses attended a twice weekly meeting to set treatment goals for patients who had been on the unit for longer than four days.

The unit worked closely with the specialist nurses for organ donation (SNOD). The specialist nurses for organ donation supported families in the critical care unit in making informed choice on organ donation, depending on their loved ones wishes and then facilitating the process of donation.

The critical care outreach team worked across the whole hospital, supporting ward staff in the care of patients who had recently been discharged from critical care or who were or were likely to become critically ill. They also facilitated learning and good practice in regard to the deteriorating patient for staff across the trust.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. At present although, the team referred patients to mental health professionals, the psychological needs of patients were mainly addressed by the critical care staff. However, there was currently a business case to have a dedicated psychologist attached to the unit.

Our review of seven electronic patient records, talking with 18 members of staff, five patients and three relatives, confirmed there were effective multidisciplinary working practices. This involved nurses, doctors, physiotherapists, occupational therapists and pharmacy. Staff told us they felt supported by their colleagues and that their contribution to overall patient care was valued

All relative teams, services and organisations were informed when people are discharged from the service. There was a holistic approach to planning people's discharge, transfer or transition to other services, which is done at the earliest possible stage. One of the doctors on the unit had undertaken a research project on what information should be included in the discharge notification and had sent a questionnaire to teams within the hospital and general practitioners, for what should be included in the discharge notification. We saw the discharge notifications were multidisciplinary, comprehensive and contained all the patient's history, treatment, plan of care.

## Seven-day services

**Key services were available seven days a week to support timely patient care.**
Consultants were on site every day from 6.30am until 6.30 pm. All on-call consultants were available over the phone and available to attend within 30 minutes. A registrar was available on

the unit 24-hours a day seven days a week. Junior doctors confirmed they were encouraged to call consultants if needed and they were always accessible.

The critical care outreach team were available seven days per week between 7.30am and 8pm, to follow up on patients who had been stepped down from critical care. They also reviewed and assessed patient who showed signs of deterioration.

The critical care unit had a dedicated pharmacist. Pharmacy staff were available Monday to Friday and there was an on-call service at weekends and out of hours.

A microbiologist ward round would take place Monday to Saturday at midday to review that the patient was on the most appropriate antibiotic.

Physiotherapists provided treatment seven days a week with an on-call service available overnight.

Speech and language therapists provided treatment Monday to Friday.

Diagnostic services were available 24 hours a day, seven days a week. This allowed critical care staff access to consultant-directed diagnostic services such as x-ray, ultrasound, CT and MRI, seven days a week to support clinical decision-making. This was in line with the NHS Services, Seven Days a Week, Priority Clinical Standard Five (2016).

The trusts palliative care team provided a five day a week service, they took referrals and attended the critical care services as needed.

## Health promotion

**Staff gave patients practical support and advice to lead healthier lives.**

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. There were guidelines in place to support patients withdrawing from drugs or alcohol. Consultants would provide advice and support. If patients smoked, nicotine patches could also be prescribed and provided to patients.

They referred patients to specialist teams as needed, for example the diabetes team and pain team.

Follow up clinics took place once a month. This meant that the service made sure they had opportunities for ongoing assessment and providing advice on rehabilitation and health promotion.

A range of patient information leaflets were available for patients and families. This included information such smoking cessation.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff understood their roles and responsibilities under the Mental Capacity Act 2005.**

Staff knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Staff understood the relevant consent and decision-making requirements of current legislation and systems were in place to ensure compliance with deprivation of liberty safeguards

Staff demonstrated a good understanding of the Mental Capacity Act. Staff we spoke with were clear about how to assess a patient who lacked capacity. Specialist teams, such as dementia or

learning disabilities were available to give guidance on the Mental Capacity Act and Deprivation of Liberty Safeguards if required. Staff told us they worked with family members at best interests' meetings where patients lacked capacity, to get the best outcomes for patients.

During the inspection we observed staff obtaining consent and procedures being explained to patients and carers by doctors and nurses. Staff we spoke with understood the importance of shared decision-making with patients. All patient records we looked showed consent was sought and clearly recorded in the patients' notes.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. It was recognised that gaining consent from patients in critical care could be difficult. However, staff we spoke with demonstrated a good understanding of consent, and where possible, would always seek consent from patients. Where patients could verbalise, we observed staff seeking consent before undertaking any interventions.

Staff reported that they felt well supported by the psychiatric liaison team and mental health liaison team and could call them at any time for assistance. They reported that within work hours support would be provided in a timely manner.

The trust did not provide data for Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. However, they stated that MCA and DoLS training are included within the safeguarding level 2 training module. Data supplied to us, showed that both medical and nursing staff were below the trust target of 90%, for safeguarding adults (level 2).

**Mental Capacity Act and Deprivation of Liberty training completion**

**Trust level**

The trust did not provide data for Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training. Because they stated that MCA and DoLS training are included within the safeguarding level 2 training module. There is also a separate MCA e-learning module available to staff.

A breakdown of compliance for MCA/DOLS training courses (as part of the safeguarding level 2 training modules) from April 2018 to March 2019 at trust level for qualified nursing staff in critical care is shown below:

| Training module name | April 2018 to March 2019 | | | | |
|---|---|---|---|---|---|
| | Staff trained | Eligible staff | Completion rate | Trust target | Met (Yes/No) |
| Safeguarding Adults (Level 2) | 95 | 113 | 84.1% | 90% | No |
| Safeguarding Children (Level 2) | 76 | 113 | 67.3% | 90% | No |

In critical care the target was met for one of the two safeguarding level 2 training modules for which qualified nursing staff were eligible.

**Worthing Hospital critical care department**

A breakdown of compliance for MCA/DOLS training courses (as part of the safeguarding level 2 training modules) from April 2018 to March 2019 at Worthing Hospital for qualified nursing staff in critical care is shown below:

| Training module name | April 2018 to March 2019 | | | | |
|---|---|---|---|---|---|
| | Staff trained | Eligible staff | Completion rate | Trust target | Met (Yes/No) |
| Safeguarding Children (Level 2) | 61 | 61 | 100.0% | 90% | Yes |
| Safeguarding Adults (Level 2) | 51 | 61 | 83.6% | 90% | No |

At Worthing Hospital critical care department, the 90% target was met for one of the two safeguarding training level 2 modules for which qualified nursing staff were eligible.

*(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)*

| Training Module Name | April 2018 to March 2019 | | | |
|---|---|---|---|---|
| | Eligible staff | Completion rate | Trust target | Met Yes/No |
| Safeguarding Adults (level 1 & 2) | 34 | 86% | 90% | No |

## Is the service caring?

### Compassionate care

**There was a strong visible person-centred culture to providing care in the critical care unit. Patients were treated with dignity and respect at all times. All staff we spoke with were very passionate about their roles and were dedicated to making sure patients received the best individualised patient-centred care possible.**

Staff introduced themselves, and their role, and asked either patients, if able, or relatives, how they wanted to be addressed. We saw them explain who they were and what was going to happen in a discreet way. This is in line with National Institute for Health and Care Excellence, quality standard 15, statement three.

Staff took time to interact with patients and those close to them in a respectful and considerate way. All the patients and relatives we spoke with were highly complementary about the care and support they received. They said that the staff were ‘marvellous’ and were always around to provide help and support.

There was a strong, visible person-centred culture, to care on the unit. Staff were highly motivated and inspired to offer care that is kind and promotes people's dignity. Relationships between people who use the service, those close to them and staff were witnessed to be strong, caring, respectful and supportive.

For example, we were told about a patient whose mood was low as they were missing their dog. The team worked with the patient family, and arranged for the patient to be taken outside, so the family could bring in their dogs. This helped to motivate the patient and aided in his recovery.

We saw and heard staff delivering kind and compassionate care, going above and beyond and helped patients, relatives or carers feel at ease. Staff interacted with people in a positive, professional, and informative manner. This was in line with National Institute for Health and Care Excellence Quality Standard 15, statement one.

People were always treated with dignity by all those involved in their care, treatment and support. We saw that staff-maintained patient’s privacy and dignity, including during physical or intimate

care. Staff were seen maintaining patient's dignity by drawing curtains when delivering care and spoke to them quietly so as not to be overheard.

Staff understood and respected the personal, cultural, social and religious needs of people and how these may relate to care needs. Information about this was recorded as part of individual 'knowing me' documents and staff demonstrated an understanding of respecting patients' wishes in all aspects of their care. We saw this documented in 'knowing me' documents of patients that we looked at. Knowing me documents help give staff an awareness of their patient before they became unwell. The document included likes, dislikes, preferences, beliefs, pets and occupations.

When we spoke with staff they told us they were aware of cultural differences that arise and how they had to adapt communication styles to make sure the service provided the right support to people. For example, staff told us about a patient who was admitted with learning difficulties, who had trouble communicating. Staff learnt Makaton, in order to communicate with them effectively.

Staff members showed an understanding and a non-judgemental attitude when talking about patients who had mental ill health or a learning disability. Staff responded to patients who might be frightened, confused or have a phobia about a medical procedure or any aspect of their care in a respectful and understanding way. For example, staff were aware of the impact having a relative in intensive care can have on family members. They explained before they take relatives onto the unit for the first time they would take time to ease their anxiety and answer any questions they may have.

Another example we were given, was a patient with learning difficulties. In order meet their needs and relieve any anxiety and provide consistency for the patient, the team arranged for their carers to visit and help with providing care.

Feedback from people who used the service and those who were close to them was continually positive about the way staff treat people. We looked at feedback, such as cards that had been sent to staff. We saw the responses were overwhelmingly positive. Comments such as, "your care and support were truly outstanding", "supportive", "amazing", "kind and caring "and "sensational treatment" were seen.

## Emotional support

**Staff understood the impact that a person's care, treatment or condition had on their wellbeing and on those close to them, both emotionally and socially. People's emotional and social needs were seen as being as important as their physical needs.**

Staff demonstrated a good understanding of the impact that a person's care, treatment or condition had on their wellbeing and those close to them. Staff recognised that peoples emotional and social needs were as important as their physical needs. For example, we were told about the partner of a patient who was dying, who wanted one last cuddle before they died. The staff removed lines and attachments to monitors and positioned the patient, so they could lie in the hospital bed together for one last cuddle.

Staff gave patients and those close to them help, emotional support and advice when they needed it. The unit offered follow up clinics to all patients who had a stay of more than three days in the critical care unit. Patients could have multi-faceted problems related to a stay in the critical care unit, including both physical and psychological problems. The follow up clinic followed up patients by inviting them to an outpatient appointment at intervals after their discharge from hospital. This provided patients with the opportunity to discuss any issues they or their family had. Patients were

given their ‘knowing me;’ diaries at the appointment. The team would also signpost patients to relevant support groups or referred patients to appropriate health care professionals. For example, there was a ‘Time to Talk’ leaflet in the visitors waiting area which included a contact number for patients to talk to if they were feeling stressed, anxious or depressed.

Staff we spoke with told us that they would constantly provide reassurance to anxious patients and would communicate to them in a calm manner which helped them to be relaxed. One patient told us how she felt down following her caesarean and told us how staff spoke to her like a friend and cheered her up.

We heard how staff could support bereaved relatives and were available to assemble memory keepsakes such as handprints and locks of hair if families requested this.

Staff told us they had time to support patients, relatives and visitors and told us that this was the reason they loved their work. An example given, was where the family of a young patient who had died, wanted to spend extra time with them. They arranged for the transfer of the young patient’s body to be transferred to a ‘bereavement suite’ at a nearby local hospice. The ‘bereavement suite’, is a specialist bedroom, where a patient can lay at rest, allowing their family to say goodbye in a familiar, supportive, and sympathetic environment.

The trust was committed to drive awareness and culture surrounding organ donation. Staff worked closely with the specialist nurse for organ donation to provide care and support to both relatives and patients at the end of life. The unit had a lead organ donation specialist nurse, who was available at all times.

Staff we spoke with told us how important it was to be honest and open when breaking bad news so that the families were kept well informed and aware of the situation. Nurses told us doctors included them when breaking bad news to families and this would normally be the named nurse who was looking after that particular patient.

Staff we spoke with told us patients’ faith and spiritual needs were respected and the unit had a side room to accommodate their needs where possible.

## Understanding and involvement of patients and those close to them

**Staff involved patients and those close to them in decisions about their care and treatment. Relatives of patients told us they felt involved in decisions. We observed staff communicated with patients and their relatives in a way which they could understand, and they asked patients if they understood what had been discussed.**

People valued their relationships with staff and felt that they often go 'the extra mile' for them when providing care and support. For example, the critical care team organised a funeral for one of their patients’ spouses. They escorted the patient to the hospital chapel, where the service took place. Another example was where the team decorated their quiet room for a patients eighteenth birthday, so they could celebrate with their friends and family.

Staff recognised that people need to have access to, and links with, their advocacy and support networks in the community and they supported people to do this. They ensure that people's communication needs were understood, sought best practice and learn from it. For example, a patient who was ventilated via a tracheostomy (an opening in the neck so a tube can be inserted into the windpipe to help with breathing), wanted to see their husband who was at the end of his

life. The team organised for the patient to visit their husband and fitted them with a speaking valve to give the patient time and the ability to say goodbye.

We saw staff explaining to patients, or families the care they were receiving and the purpose of the equipment helping them to do this. Staff did this in an empathetic way and allowed and encouraged questions. If they were busy staff always gave an explanation to patients or families and came back to deal with their query as soon as they were able. For example, we saw a consultant explaining to patients and their relatives the care and the treatment that was being provided.

Patients and relatives we spoke with confirmed this and told us their care had been discussed with them. Patients and relatives told us they were given time and could ask questions and felt included in the decisions about their care. This is in line with National Institute of Health and Care Excellence, quality standard 15, statement 4.

Staff communicated well with patients and those close to them in a manner so they could understand their care, treatment and condition. Staff responded positively to patient's questions and took time to explain things in a way patient could understand. This is in line with National Institute of Health and Care Excellence quality standard 15, statement 2.

Staff had accessible ways to communicate with people when their protected equality or other characteristics make this necessary. Information leaflets were available for people with sensory loss or impairment, or with a learning disability or communication need. Staff said that if patients were unable to communicate or were unconscious they would involve the next of kin and if no one was identified they would make decisions based on the best interests for the patient.

Staff we spoke with knew the procedure for approaching relatives for organ donation when treatment was being withdrawn. Staff had access to a specialist nurse for organ donation and were aware of the referral process surrounding organ donation.

## Is the service responsive?

### Service delivery to meet the needs of local people

**The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**

The intensive care unit was a twelve-bedded unit that provided care for patients requiring advanced respiratory support (ventilation), advanced renal support (hemofiltration) and other complex therapies. Patients received one to one or one to two nursing, depending on their needs. A doctor was available at all times and patients were seen regularly throughout the day.

Managers planned and organised services so they met the needs of the local population. Critical care provision on the unit was able to be flexed to meet the differing needs of level two and level three patients. The high dependency provided level two care and there were clear pathways between the units if the patient needed to be stepped up or down. The critical care outreach team reviewed all patients who were discharged from intensive care to ward areas.

The enhanced surgical care unit took level one patients who needed extra care following their operation.

A relative's room was available in the unit and people had access to a kitchen with hot and cold drinks and food preparation facilities. There was no facility for overnight accommodation for relatives.

The service had systems to help care for patients in need of additional support or specialist intervention. Follow-up clinics were in place in line with the Guidance for the Provision of Intensive Care (2015). Appointments were offered to any patients who were on the units for three days or more. Patients were offered an appointment three months after discharge from the unit. Patient diaries were discussed at the follow up clinic to identify individual patient needs post discharge. The clinic was run by the critical care outreach team. if patient needs were identified referrals were made via their general practitioner.

There was clear signage indicating where services and individual wards were located. Staff were readily available to help provide directions if needed.

A physiotherapist told us that there was a procedure when a patient was being prepared for transfer to a ward. This included optimising the patient's chest for transfer, liaising with the ward about special needs and equipment and setting goals for rehabilitation. The service did not have access to regional home ventilation weaning unit, all patients with complex weaning problems were referred to the respiratory team.

## Meeting people's individual needs

**The service was inclusive and took account of patients' individual needs and preferences. There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that meets these needs, which is accessible and promotes equality. This included people with protected characteristics under the Equality Act, people who may be approaching the end of their life, and people who are in vulnerable circumstances or who have complex needs.**

Staff told us they treated every patient as an individual, which meant they made reasonable adjustments to meet the needs of patients with a learning disability, mental health issues or who were living with dementia, and their family members. Electronic patient records we looked at showed that peoples' individual needs were taken into consideration before care was delivered.

There was a good awareness among staff of the delirium that patients experience as a result of their treatment in the critical care environment. The unit was committed to humanising the environment and took measures to control noise levels and lighting in an attempt to normalise the care environment.

The unit promoted protected sleep times and they told us that the lights were dimmed for rest periods and raised for daytime hours. The unit had large windows which allowed in natural light and again we saw curtains being open and closed to indicate day and night times for the patients.

The critical care unit provided evidence of strong links with external services such as general practitioners, end of life care teams and social care services. These links were used to support gathering of information or occasionally to support discharges from the service to the community. Discharges from the unit to the community were supported and monitored on a patients' individual needs basis. This was in line with guidelines for the provision of intensive care services, 2015, and the National Institute for Health and Care Excellence (NICE) CG83: rehabilitation after critical illness.

Patients with complex needs, such as learning disabilities, autism or living with dementia, received care through a coordinated multi-disciplinary approach. We reviewed patient records that showed patients were supported to meet their needs through a holistic approach that incorporated spiritual, psychological and social needs as well as the physical care needs at the end of life. This was in line with National Institute for Health and Care Excellence (NICE) quality standard 13, statement five.

There were arrangements in place for patients with complex health and social care needs. Patients' individual needs were identified on admission to the unit. At every stage of their journey through the unit, we saw care was tailored to their needs and circumstances taking into account coexisting conditions. This was in line with the National Institute for Health and Care Excellence (NICE), quality standard 15, statement nine.

Bariatric equipment was readily available for patients, who may require it. They contacted the manual handling team who had a list of where all equipment was kept, which would be in place for the patients' admission. Bariatrics is the branch of medicine that deals with the causes, prevention and treatment of obesity.

Staff supported patients and those close to them during referral, transfer between services and discharges. We were told that staff would always inform patients of possible changes to their care before it occurred. Before discharges staff would inform the patient and their family of where they would be discharged to and what expectations to have of the services being provided. Staff said this was particularly important as some patients reported a feeling of abandonment due to the reduction of one to one or two to one nursing care given on the critical care unit.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patients who were able to eat and drink could choose their meals from a selection of menus. These included vegan, gluten-free, kosher and halal choices. We saw that different textured food was also available, such as soft, thickened or pureed.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Appropriate information was available in English as a matter of routine. Information in other languages could be provided on request. Staff told us interpreters were available both in person and via the telephone and gave examples of when they had used these services.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The units used a wide range of communication aids including laminated paper sheets with alphabets, electronic tablets with an app which allowed patients to communicate through the basic language tool, if they were unable to speak.

The trust had Wi-Fi for public use. The unit had invested in mobile electronic tablets, to allow patients to keep in touch with friends and family who were unable to visit the hospital.

Relatives and patients were able to purchase food on site and had access to variety of catering services locally.

The service had information leaflets available in languages spoken by the patients and local community. Information was available in leaflet format and on notice boards in the units for patients and families.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. In addition, the unit used the' knowing me 'documents to help give staff an awareness of their patient before they became unwell. The document included likes,

dislikes, preferences, beliefs, pets and occupations. The staff encouraged visitors to write in the document, about their visit or what is happening. The 'Knowing me' document is given to patients at the follow up clinic, where staff talk through with the patient their experience in the unit. We were told about a patient where the 'knowing me' document had helped tailor a rehabilitation programme specific to the patient, this included the use of the hydrotherapy pool and also address the sensory problems the patient was experiencing.

## Access and flow

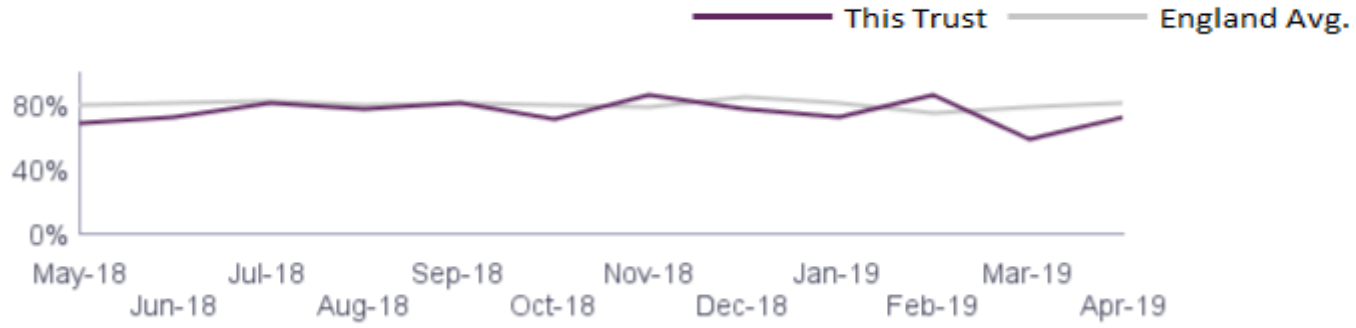
**People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.**

**Bed occupancy**

From May 2018 to April 2019, Western Sussex Hospitals NHS Foundation Trust has seen adult bed occupancy that has shown some variation for the last six months of the period. Overall the trust's performance is in line with the England average, though it has been better than the average for the last two months of the period.

The Royal College of Anaesthetists recommends 70% occupancy for critical care services, in order to allow capacity for emergency admissions. The data below shows that the Worthing Hospital critical care service was mostly below the recommended 70% occupancy rate, with an average percentage of 64%. From April 2018 to March 2019, Worthing Hospital has seen adult bed occupancy vary between over 77% in October 2018 to lower than 44% in August 2018. It has generally performed in line with the England average.

**Adult critical care Bed occupancy rates, Western Sussex Hospitals NHS Foundation Trust.**




Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

*(Source: NHS England)*

Between April 2018 and March 2019, there were 625 admission to the critical care unit at Worthing Hospital. Of those, 86 were planned admission, for example for elective surgery.

The service made sure that the critical care service did not impact on the elective care. The critical care service at Worthing Hospital included five enhanced surgical care unit beds. Within the reporting period no patients had their elective surgery cancelled due to a lack of critical care beds.

Patients had timely access to initial assessment and were all seen by a critical care consultant within 12 hours of admission

There were no instances of ventilated patients being cared for outside of the critical care unit in the last twelve months. The trust told us ventilated patients may receive care outside of critical care in

the theatre's recovery area, following a surgical procedure that required an unplanned admission to critical care. The trust told us this had happened five times in the last 12 months.

**Non-delayed out of hours discharges to the ward**

Transfer from critical care areas to the ward between 10 pm and 7 am should be avoided. We saw on the 2017/2018 Intensive Care National Audit Research Centre (ICNARC) audit data that 1.1% of admissions were non-delayed, out of hours discharges to the ward. The figure in the 2016/17 annual report was 1.5%.

| Number of cases | Metric | 2016/17 | 2017/18 | National aggregate | Asp Standard | Comparison |
|---|---|---|---|---|---|---|
| 369 admissions | Crude, non-delayed, out-of-hours discharge to ward proportion | 1.5% | 1.1% | 2.0% | 0% | Within expected range |

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

Data supplied to us showed that between April 2018 and March 2019, there were 20 (3.2%) discharges between 10 pm and 7 am. We were told that all out of hours discharges on the ward were reported as adverse incidents. This was in line with guidance

**Non-clinical transfers**

The Guidelines for the Provision of Intensive Care Services 2015 says that patients should not be transferred to other intensive care units for non-clinical reasons. We saw on the in 2017/2018 Intensive Care National Audit Research Centre (ICNARC) audit data that 0.9% of patients were transferred for non-clinical reasons. The figure in the 2017/18 annual report was 0.4%.

| Number of cases | Metric | 2016/17 | 2017/18 | National aggregate | Asp Standard | Comparison |
|---|---|---|---|---|---|---|
| 648 admissions | Crude non-clinical transfers | 0.4% | 0.9% | 0.3% | 0% | Within expected range |

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

The trust supplied us with the latest Intensive Care National Audit Research Centre (ICNARC) audit data for 2018/19 that showed out of 624 admissions, 0.2% of patients were transferred for non-clinical reasons.

Data supplied to us showed that between April 2018 and March 2019, there were two patients transferred for a non-clinical reason. Within the same reporting period, there were 22 patients transferred to other units for clinical reasons. We were told this was due to them requiring more specialist critical care, such neurological.

Within the last 12 months there was one non-clinical transfer. This was lack of bed capacity at the critical care unit.

**Non-clinical transfers for the last 12 months:**

| 07/18 | 05818 | 0918 | 10/18 | 11/18 | 12/18 | 01/19 | 02/19 | 03/19 | 04/19 | 05/19 | 06/19 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |

*(Source: ADR RYR11 number of non-clinical transfers out of critical care in the last 12 months)*

**Delayed discharges**

Managers and staff worked to make sure patients did not stay longer than they needed to.

For the Critical Care unit at Worthing, there were 4380 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 5.3%. This compares to the national aggregate of 4.6%. This meant that the unit was not in the worst 5% of units. The figure in the 2016/17 annual report was 9.6%.

| Number of cases | Metric | 2016/17 | 2017/18 | National aggregate | Asp Standard | Comparison |
|---|---|---|---|---|---|---|
| 4308 available critical care bed days | Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours) | 9.6% | 5.3% | 4.6% | 0% | Not in the worst 5% of units |

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

**Percentage of patients admitted to critical care within four hours of decision to admit**

The trust made sure that people with the most urgent need have their care and treatment prioritised. Data supplied to us by the trust showed that the average percentage of patients admitted to critical within four hours of decision to admit was 96%.

| 07/18 | 05818 | 0918 | 10/18 | 11/18 | 12/18 | 01/19 | 02/19 | 03/19 | 04/19 | 05/19 | 06/19 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 94.1% | 100% | 83.3% | 100% | 100% | 100% | 100% | 100% | 100% | 75% | 96% | 100% |

*(Source: ADR RYR16 what percentage of people are admitted to critical care within 4 hours of decision admit)*

## Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.**

Staff told us, they encouraged people to give feedback, make complaints and raise concerns. Staff we spoke with told us they always tried to address complaints or concerns immediately to see if they could be addressed by the team as they wanted to resolve any issues before concerns escalated to become formal complaints.

If the problem could not be resolved by the team, staff told us patients would be given contact details of the Patient and Liaison Service (PALS). Information regarding Patient and Liaison

Service, the services they offered and how to contact them was displayed in prominent areas throughout the hospital.

The trust website had a dedicated section that patients could access, detailing how to make a complaint. There was a leaflet available for patients, explaining how to make a complaint, and expected timeframes.

Patients and relatives told us that they felt safe and comfortable to raise any concerns.

**Summary of complaints**

From April 2018 to March 2019 the trust did not receive any complaints in relation to critical care at Worthing Hospital.

*(Source: Routine Provider Information Request (RPIR) – Complaints tab)*

**Number of compliments made to the trust**

From April 2018 to March 2019 there were 95 compliments about critical care at the trust. A breakdown of compliments by site is below

| Site | Number of compliments | Percentage of total |
|---|---|---|
| St Richards Hospital | 91 | 96% |
| Worthing Hospital | 4 | 4% |
| **Total** | **95** | **100%** |

*(Source: Routine Provider Information Request (RPIR) – Compliments tab)*

## Is the service well-led?

### Leadership

**Leadership was compassionate, inclusive and effective. Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. Leaders had the skills, knowledge and experience to perform their roles.**

The leadership team for critical care services had a clear leadership structure. Critical Care services sat in the surgical directorate. The division was led by a director of operations, chief of service and head of nursing. This leadership style is referred to as a triumvirate. Members of the triumvirate told us they had clear roles and responsibilities and they were clear what these were.

The unit had a designated critical care lead consultant and a critical care lead nurse. We met with the leads for critical care who worked well together and interacted with each other appropriately. There was a designated supernumerary clinical coordinator nurse.

The critical care lead nurse was responsible for the nursing elements of the service and was visible on the unit.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. Staff told us they felt well supported by their immediate line manager. They felt there was a clear management structure within the team and leaders and senior staff were very approachable. If there was any conflict within the service, they would go to their line manager and seek support.

There was evidence of good local leadership. Local leaders had the skills, knowledge, integrity and experience to deliver good quality care at local levels. Staff told us clinical leaders operated an open-door policy and they could discuss concerns. The critical team worked closely with other services in the hospital and had a good understanding of the priorities for the service and the challenges faced.

Leadership development opportunities were available, including opportunities for staff below team manager level. We saw that several staff had been supported to develop further leadership skills and a leadership course was available to staff to develop.

Medical staff told us that senior medical staff were accessible and responsive, and they received good leadership and support. All newly appointed consultants were both anaesthetic and intensivist trained. All longer serving intensivists were appropriately qualified anaesthetists with additional intensivist recognition through significant experience. This meant there was always appropriately qualified expertise and medical leadership available to unit staff.

Leaders were visible in the service and approachable for patients and staff. Staff said that senior managers were supportive. Staff reported there was clear visibility of members of the trust board throughout the service. Staff could explain the leadership structure within the trust and the executive team were accessible to staff. All nursing staff spoke highly of the service managers as leaders and told us they received good support. We observed good working relationships within all teams.

We met with the matron, registered nurses, health care assistants and medical staff during the inspection and found they were organised and demonstrated good and supportive teamwork and leadership. They were knowledgeable about the ward's performance against the priorities around critical care and the areas for improvement.

The trust had a Mental Health Strategy that was known to the staff on the critical care unit. Staff recognised both the short and long erm impact of critical illness on patients and their families. They had developed ways to help them in dealing with this. A business case for the unit to employ a senior clinical psychologist was awaiting sign off.

## Vision and strategy

**Leaders and staff had a deep understanding of issues, challenges, priorities and vision for their service. The strategy places patients' safety and individual needs at the core of its strategy.**

The trust had a clear vision and strategy that all divisional visions and strategies underpinned.

The trust had adopted and developed a strategy called 'Patient first'. Patient first is based on a standardisation, system redesign and ongoing development of patient care pathways built on incremental and continuous improvement.

The strategy is presented visually as a triangle, with the patient shown at the top of the triangle. This was described as 'True North', which was described as the constant direction of travel. The layers underneath showed the supporting trust values, strategic themes and foundations that help to enable the desired improvements. We saw the strategy on display throughout the critical care unit.

The strategic themes are then translated into objectives for the trust. Staff knew and understood the provider's vision and values and how they were applied in the work of their team. For example,

staff explained to us that the patient was at the top of the triangle and were actively encouraged to recognise that everything that they do contributed to improving outcomes and experiences for their patients and families.

The services operational objectives were based on this vision and these objectives were understood by staff and formed the basis for their own personal objectives found in annual appraisals.

The division had a business plan which was aligned to the Trust Site Master Plan. One of the challenges facing the critical unit was the estate which, whilst not currently having a negative impact on patient care or safety, was less than ideal and was not 'future proof'. The Trust Site Master Plan included steps to enable the expansion and reconfiguration of the critical care units.

## Culture

**There was strong collaboration, team-working and support across all functions and a common focus on improving the quality, safety and sustainability of care. Staff are proud of the organisation as a place to work and speak highly of the culture. Staff at all levels are actively encouraged to speak up and raise concerns.**

The service promoted a positive, inclusive and collaborative culture that supported and valued staff. There was a sense of common purpose based on shared values.

It was clear that an open, transparent, 'no-blame' culture had been established where the emphasis was on quality of care delivered to the patients. Staff we spoke with felt supported, respected and valued in their working environments and by senior staff. Staff felt listened to and said they worked well as a team. Openness and honesty was encouraged at all levels and staff said they felt able to discuss and escalate concerns

Staff we spoke with expressed pride and commitment working for the critical care unit. Staff reported the multidisciplinary team worked effectively together, with staff across all teams respecting each other and working together to provide the best possible care and treatment to patients.

We found the care and service delivered in the critical care unit showed a strong cohesive team approach to work. Administration staff and the unit cleaners told us they felt valued in their roles and felt very much part of the team. We attended safety briefings, ward rounds and bed meetings during our inspection and found that there was respect for each member of the multidisciplinary team and the contribution they made.

Staff we spoke with understood their responsibilities to implement duty of candour, Duty of candour requires providers of health and social care services to notify patients (or other relevant person) of 'certain notifiable safety incidents' and provide reasonable support to that person. Patients and their families were told when they were affected by an event where something unexpected or unintentional had happened.

There was a culture of learning and development, innovation and creativity within the unit.

## Governance

**Governance arrangements were proactively reviewed and reflected best practice. A systematic approach was taken to working with other organisations to improve care outcomes.**

There were clear lines of accountability from the department to the board, through the directorate governance structure. The critical care service sat in the Surgical Division. The Surgical Division held bi-monthly strategy meetings which involved the multidisciplinary team. There were representatives from the critical care service at groups and committees that fed into the Quality Board. This fed into the Quality Assurance Committee of the Trust Board. These included a Mortality Steering Group, a Resuscitation Committee, a Research and Innovation Committee and an End of Life Board.

Patient stories were presented monthly at divisional governance meetings as a standard agenda item.

The critical care team led by the critical care leaders, the Surgery Divisional triumvirate leaders and the sponsoring executive director reviewed the service after the last inspection in 2015. An action plan was put in place to address the issues identified and mapped against the Guidelines for the Provision of Intensive Care Services (2015). Funding had been secured to enhance the service staffing and the action plan was completed, providing assurance that the service was compliant with the national recommended standards.

In line with national guidance, there was an identifiable supernumerary clinical co-ordinator in every shift.

The critical care outreach team were an integral part of the unit and was manged in accordance with the principles in Guidelines for the Provision of Intensive Care Services (2015). The outreach reach team was a multidisciplinary organisational approach which cared for acutely unwell, critically ill and recovering patients, irrespective of location or pathway.

There were named sepsis leads for critical care. The outreach team were involved in managing and treating sepsis on the wards. The critical care unit had a dedicated nurse champions who acted as the sepsis lead overseeing the unit's sepsis management. These lead or champions oversaw the services management of sepsis. We saw there were policies, pathways and tools in place for the screening, assessment and management of sepsis. This is in line with National Institute for Health and Social Care Excellence (NICE), guideline 51.

Nursing staff said they attended ward meetings. Staff also confirmed learning from incidents, complaints, audits and other quality improvement initiatives were communicated to them in a variety of ways such as; handover meetings, quality safety meetings, e-mails and information on the notice board.

All deaths were reviewed in the critical care unit and post discharge with mortality and morbidity meetings which were held monthly.

## Management of risk, issues and performance

**There was a demonstrated commitment to best practice performance and risk management systems and processes. The service reviewed how they functioned and made sure that staff at all levels had the skills and knowledge to use the systems and processes effectively. Problems were identified and addressed quickly and openly.**

The service had effective systems for identifying, planning to eliminate or reduce risks and coping with both the expected and unexpected. Clinical and non-clinical leaders at all levels were well informed about the performance data for the service. They understood the service and used data to drive service improvements. For example, the chief of surgery told us about the cases of discharge direct from the critical care unit and could explain how this impacted on the Intensive Care Audit Research Centre scores. We found the leaders of the service knew and understood the fine detail of the quality of care they were providing.

Daily “safety huddles” took place every day to identify potential risks and allocate resources effectively. We observed one of these meetings and saw good participation from all members of the critical care service. where any issues, concerns or risks could be escalated.

There were also three-time daily bed management meetings which we saw the senior sister attended daily to represent the critical care service and provide data about the service.

The service had a risk register which was current and up to date. The risk register was used as a tool for driving improvement and reducing risks. The service risk register fed into the trust risk register. Each risk was given an initial risk score and a current risk score after risk reduction strategies had been put in place. The trust sent us a sample of the risks included on their risk register. The risk register had an explanation of the risks, the matron for the department had overall responsibility for the risk register, ensuing existing risk controls and actions were completed for each identified risk. Risks were reviewed on a regular basis, discussed at the governance meeting, and escalated according to risk status; we saw these had been reviewed within the last 12 months.

Each risk was categorised as green (negligible risk), yellow (minor risk), orange (moderate risk), and red (major risk). The risk register was incorporated into the online incident reporting system and could be accessed by other departments or the clinical leads for the directorate.

The senior staff we spoke with were clear about the challenges the services faced and they were committed to improving the patients journey and experience. For example, they told us their top risk was recruiting and retaining staff. They told us there was a commitment not only to recruiting and retaining enough staff but of recruiting and retaining staff of the right competence. It was essential they appointed the right staff, with the right attitude and commitment to continuous improvement. There was also a strong learning programme that supported the culture of ‘growing our own’. For example, staff could join the trust as apprentices or as healthcare assistant and were encouraged to develop through formal learning programmes to professional registration. Postgraduate study was also supported to develop a strong research base and encourage staff to remain at the trust.

There were regular meetings where such risk, issues and performance reports were monitored and managed. This included senior staff critical care unit meetings, governance meetings, sepsis meetings, and mortality and morbidity meetings which all took place monthly.

The trust had access to trust infection prevention and control policies and procedures and took part in the auditing of clinical practice. This is in line with National Institute for Health and Social Care Excellent, quality standard 61, statement 2 says ‘organisations that provide healthcare have a strategy for continuous improvement in infection prevention and control, including accountable leadership, multi-agency working and the use of surveillance systems’. We found the service-controlled infection risk well, and staff followed policies to protect patients against cross infection.

There were processes in place for the stewardship of antimicrobials. We saw there were guidelines in place on the main trust website and could be accessed by both staff and members of the public. We saw regular audits were undertaken by the pharmacy department to review

antimicrobial usage; this was then fedback to the department. This was in line with National Institute for Health and Social Care Excellent, quality standard 121, statement five.

The trust was in the process of developing Local Safety Standards for Invasive Procedures (LocSIPPs) using the National Safety Standards for Invasive Procedures (NatSSIPs). For example, we saw the local safety standards for invasive procedures for prevention of a retained foreign object, such as a guidewire following insertion of a central venous catheter. We saw these were integrated into the services electronic patient records. The service had an action plan in place, which showed all actions had been completed with the exception of a regular programme of audit. The reason for this is that it is in the process of being designed, the action is due to be completed in August 2019.

Standardisation of equipment, processes and the information technology systems allowed seamless and safe movement between the units for staff. Staff did not move often, but it was occasionally necessary where one unit was much busier than the other. The staff did not have to work with unfamiliar equipment and could provide care of a consistently high standard and with reduced risk because of this.

## Information management

**The service routinely collected, managed and used information to support its activities. Staff had access to up to date information on patient care and treatment and were aware of how to use and store confidential information. The information used in reporting, performance management and delivering quality care was consistently found to be accurate, valid, reliable, timely and relevant.**

There was a demonstrated commitment at all levels to sharing data and information proactively to drive and support internal decision making as well as system-wide working and improvement. We saw information on the unit's performance with Intensive Care Audit Research Centre (ICNARC) was prominently displayed on notices boards for both the staff and public to see. Staff told us, this was discussed during the huddles and any trends and themes were identified.

Whiteboards were used to highlight the needs of individual patients, but these were coded and initials were used to protect patient identity.

The critical care unit had an audit lead who was responsible for coordinating the annual audit cycle, facilitate identified priorities for new and repeated clinical audits and to make sure staff were aware of audit findings and recommendations.

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. The critical care units submitted data to Intensive Care Audit Research Centre (ICNARC) which supported monitoring of the unit's performance against national standards in comparison to similar critical care units.

Information governance systems included confidentiality of patient records. The use of appropriate information technology was supported by the service with ongoing training and support for staff using the systems. Electronic patient records were well established and understood by staff. It provided information on monitoring and planning patients care.

Information governance training was part of the trust's statutory and mandatory training requirement for all staff. Data supplied to us showed that 98.2% of nursing staff and 98.4% of medical staff were up to date with this training, which was better than the trust target of 90%.

Staff had access via the unit's computer information system to policies, procedures and guidance required when working in the critical care unit. During the inspection we saw staff using these points of reference and all commented on how easy it was to find the information on the system.

Information technology and technology research was encouraged to support improvement in patient care. One example was a member of staff who had developed a teaching model that was used to teach clinical staff about the use of cricoid pressure in managing complex airways.

## Engagement

**The service engaged with patients, staff and the public to plan and manage services. Patient, relatives and carers were encouraged to contribute to the running of the service through feedback. Staff were actively engaged, and their views were reflected in the planning and delivery of the service.**

People's views and experiences were gathered and acted upon to shape and improve the service. Patients were invited to attend a follow-up clinic which included talking through and understanding their experience on the critical care unit. During the clinic they encourage the patient and their relatives to feedback about their experiences and any way it could be improved.

Staff felt engaged, able to raise concerns or, able to suggest new ways of working. They told us that their managers were receptive, and although their ideas may not always be implemented, they felt they were listened too. Daily safety huddles were well embedded within the service. Staff were able to make suggestions to bring about improvements to the service and identify concerns so solutions can be found as team.

The NHS Staff Survey showed that the staff engagement score for the directorate was better than both the trust average of 7.2 and the national average of 7.00. The friends and family test showed that 72.4% of staff would recommend the trust as a place to work and 81.3% as place to be treated.

The unit had introduced annual feedback to individual consultants based on the General Medical Council (GMC) survey. The unit leaders were concerned that three years ago there had been some indicators scoring poorly around the questions of the unit being a supportive environment. An in-house survey was introduced and reported annually with feedback to each consultant. The most recent GMC survey showed all indictors were rated good/green with a narrative that trainees felt it was a supportive learning environment.

One consultant talked to us about their own feedback and how, initially, they had felt it was quite uncomfortable because it was holding a mirror up to their practice and they were found wanting. They had made one small change that involved asking for a very short delay when they were woken in the middle of the night by junior doctors. This allowed them to 'come to', gather their thoughts and be more positive in their response. Their personal feedback had improved because of this.

One of the trusts objectives was to become an NHS model employer. They had a workstream, 'Our People' aimed at becoming the top performing Acute Trust by 2020. Based on the new methodology scoring a trust wide target has been agreed to achieve a score of 7.6. To support staff in parallel to the 'Reducing Abusive Behaviours' project the trust was participating in the 'Best Place to Work' cultural transformation scheme.

The lowest scoring parameter for the staff survey was around a safe environment and staff experiencing violence/aggression. There was trust wide work involving the Freedom to Speak Up Guardians, the Health and Wellbeing Group and the mental health sub group.

An 'Above and Below the Line' Behaviour Framework had been agreed and had involved a group of staff looking at values and behaviours. The framework was shared at a staff conference to gain 'buy in'. There was now work in progress to give staff words they could use when they observed or experienced inappropriate behaviour. The suggestions that were being considered were around non-confrontational, simple statements that made the point that the behaviour was unacceptable whilst reducing the risk of it escalating to open hostility.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and deliver services that meet the needs of the local populations. Critical care staff and leaders worked with two local networks to provide support and care in the best interests of patients. They had worked with the network to make sure that they could share learning and get specific expert advice when needed.

There were rewards for staff that had been exceptional. For example, we saw the critical care team at Worthing Hospital had been nominated by a patient for the trusts Patient First Star Awards, award for excellence for being a 'wonderful team'. The award for excellence is for staff whose skills and actions helped the trust exceed quality objectives for the continuous improvement of patient outcomes, experience, safety or staff wellbeing. The patient who nominated the team stated they were 'blown away by their knowledge', they explained how they went above and beyond and that they were 'truly remarkable people'.

## Learning, continuous improvement and innovation

There was a fully embedded and systematic approach to improvement which made consistent use of a recognised improvement methodology. Improvement was seen as a way to deal with performance and for the organisation to lean. Improvement methods and skills were available and used across the service and staff were empowered to lead and deliver change.

Safe innovation was celebrated. There was a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care. There is a strong record of sharing work locally, nationally and internationally.

The service made regular data submissions to the Intensive Care Audit Research Centre, which allowed patient outcomes to be benchmarked nationally. We saw evidence of actions being implemented as a result of noncompliance's found.

There was a fully embedded and systematic approach to improvement which made consistent use of a recognised improvement methodology. For example, the trust used their Patient First strategy to make sure staff were supported and encouraged to develop innovative ways of working and to undertake research aiming towards publication. A recent example was a consultant who designed a simulation model to allow staff to practice and be assessed in their competency in applying cricoid pressure to patients requiring intubation. Cricoid pressure is used in endotracheal intubation to try to reduce the risk of regurgitation. The technique involves the application of pressure to the cricoid cartilage at the neck, thus occluding the oesophagus which passes directly behind it.

The trust had held an open Schwartz Round that had a consultant only audience. They had recognised that the consultant body was less likely to access other support systems but had the

additional pressure of supporting junior staff with their wellbeing. Schwartz Rounds provide a structured forum where staff, come together regularly to discuss the emotional and social aspects of working in healthcare. The purpose of rounds is to understand the challenges and rewards that are intrinsic to providing care, not to solve problems or to focus on the clinical aspects of patient care. Rounds can help staff feel more supported in their jobs, allowing them the time and space to reflect on their roles.

The trust was two years into a Clinical Academic Pathway Programme which allowed staff to combine clinical and academic careers for nursing, midwifery and allied health professionals. Staff could apply for Clinical Improvement Scholarships that involved working on improvement projects within their own practice area. They were offered two days a week dedicated time and a learning programme that included leadership and change management and well as research and knowledge development. It was open for all staff in bands 5 to 8a. Year one had offered four scholarships and year two, eight. The outcomes of the programme showed improved recruitment, retention and promoted a culture of evidence-based practice.

Patient stores were used throughout the organisation to enable staff to understand the impact of the care they provided. Stories were published in the trust Patient Safety Newsletter via the Huddle Headlines, the Trust Brief and on the intranet.

In 2018/2019 the critical care team participated in several international research trials including;

- POETICS2 (VIP2). The VIP2 study is an international, multicentre study of the old intensive care unit population. The aim is development and validation of a mortality risk score for very old intensive care patients.
- STARRT AKI which is a research programme that compares standard versus accelerated initiation of renal replacement therapy in Acute Kidney Injury (AKI). Acute kidney injury is a common and devastating complication of critical illness. Once AKI is established, treatment is largely supportive, and no intervention has been found to restore kidney function or improve overall survival. Renal replacement therapy (RRT), usually in the form of haemodialysis, is frequently needed to manage patients with severe AKI. Such patients have an in-hospital mortality that consistently exceeds 50% with delays in RRT initiation implicated as a possible contributor.
- The ’65’Trial which is a programme evaluating the clinical and cost-effectiveness of permissive hypotension in critically ill patients aged 65 years or over with vasodilatory hypotension.

The trust won the national safety prize for the Annual Association of Anaesthetists twice in the last six years. One of these was for a doctor who had developed a new gel to enable the creation of simulation models for training clinical staff in the management of patients with different body shapes or anomalies.

# Outpatients

## Is the service responsive?

**The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**

Managers planned and organised services so that they met the changing needs of the local population. The trust has invested in the ophthalmology centre at Shoreham hospital to meet the increasing need for eye care because of an ageing local population. Facilities and specialist staff were all based in one place to optimise care and treatment and reduce the need for several appointments,

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. An example of this was a first appointment' one-stop clinic for urology patients.

Facilities and premises were appropriate for the services being delivered. The hospital had invested in services to ensure they were appropriate to deliver outpatient services. Adult services for diagnosis, treatment and monitoring were based at two dedicated cancer units at St Richard's and Worthing Hospitals. At St Richard's Hospital there was a £3.5 million purpose-built cancer unit where patients with cancer attended as day patients for chemotherapy and also had outpatient appointments. There was a Macmillan information centre on site supported by volunteers. Prior to the Fernhurst centre opening in 2009, patients had to travel to an adjacent trust in Portsmouth.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia).

The service had systems to help care for patients in need of additional support or specialist intervention. The trust website made it easy for people to access information and there were volunteers to guide people around the hospitals. A recent Way finder project with learning from a local airport and which involved staff, patients and other stakeholders had resulted in clearer pictorial signs that meant people arriving at the hospital could quickly and easily find where they needed to go. This include a medicine bottle sign to guide people to pharmacy and a skeletal hand picture to guide people towards the x-ray department. Painted murals of trees on junction walls encourage the eye in the direction of travel and helped people see where there were direction signs.

Managers monitored and acted to minimise missed appointments. The Did Not Attend rate for all trust hospitals was consistently better than the national comparators.

Managers ensured that patients who did not attend appointments were contacted. Letters were sent to patients and copied to their GPs explaining that an appointment had been missed and asking the patient to telephone to make a new appointment.

### Service delivery to meet the needs of local people

The trust provided outpatient services in a variety of settings outside of their hospitals. For example, outpatient appointments were held in a health centre in Littlehampton for children and young people. This means that families living in poverty who need to see a paediatrician are able

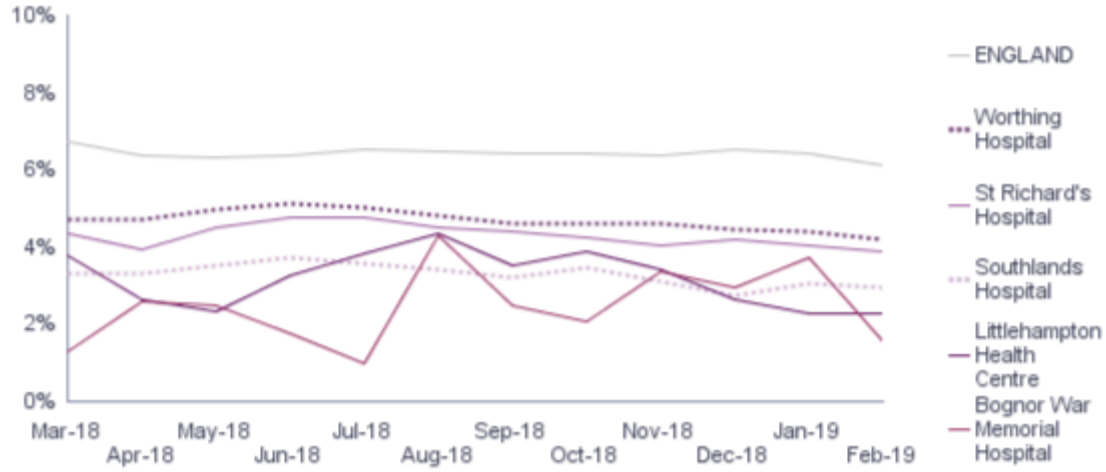
to make local appointments, which do not involve the costs of travel. In relation to “neighbourhood level” deprivation, West Sussex now has three areas, all in Littlehampton, falling in the 10% most deprived areas in England.

The board minutes from March 2019 showed that the Board was advises that the trust was working with commissioning partners in the development of demand, activity and capacity planning for 2019/20, the methodology drew on historic trending, forecast projections on the basis of typical historic phasing by service area to create a baseline activity level. This was adjusted for expected age specific growth in the catchment, aligned to the age and sex distribution of main service areas, plus an assessment associated with non-demographic growth, this approximated to a 1.1% increase against baseline for outpatients.

**Did not attend rate**

From March 2018 to February 2019 the ‘did not attend’ rates for all sites at the trust were lower than the England average. The chart below shows the ‘did not attend’ rate over time.

**Proportion of patients who did not attend appointment, Western Sussex Hospitals NHS Foundation Trust.**




*(Source: Hospital Episode Statistics)*

The trust had worked hard to ensure that patients were able to negotiate their appointments at a time to suit them. Follow up appointments could be booked directly with outpatient department staff following attendance at a clinic.

Letters sent out provided a direct dial number to ensure people could speak with medical secretaries when they were unable to attend a planned appointment.

The trust used an automated telephone reminder system to remind patients about appointments. Patients received an automated appointment reminder and were asked to select the appropriate options when asked.

The trust website provided a graph that showed the number of calls made for outpatient departments hourly on each day which allowed patients to see when the telephone lines were likely to be busiest. This allowed patients to choose a quieter time to telephone.

## Meeting people’s individual needs

The trust strategy and quality improvement methodology, Patient First' permeated all areas of the trust services and was the key driver to ensuring care was provided that met the individual needs of patients and their families.

The trust scored above the national average for questions related to outpatients in the National Cancer Patient Experience Survey. The average rating given by respondents when asked to rate their cancer care provided at WSHFT on a scale of 0, (very poor) to 10, (very good) was 8.8. Ninety-four percent said that the hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital. Ninety-one percent said that they were given the name of a Clinical Nurse Specialist who would support them through their treatment.

The trust had Guidelines for Staff on Caring for Adult Patients with a Learning Disability in the Acute Hospital. This provided advice and made clear the role of outpatient nursing staff in helping to meet the needs of people with learning disability. Where a patient was a regular attendee to the Out-Patient Department the clinic nursing staff liaised with the patient's main carer to discuss and identify specific care needs the patient may have during attendance. Additional support and reasonable adaptation was offered such as:

- Scheduling or rescheduling the appointment to the first or other suitable slot on the clinic list, e.g. to reduce chance of delay in seeing the doctor, waiting room being quieter.
- Offering a double appointment
- Providing easy read information relevant to the appointment
- Planning additional support, sedation and / or other adjustments as appropriate prior to the appointment

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. In addition to leaflets about specific conditions, the trust provided complaints management information in different languages and formats on request (e.g. audio tape and web based and easy read) to meet the needs of individuals. They used trained interpreters, when required, and ensuring interpreting services are aware of the complaint's management process.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports**.**

There was a dementia strategy that detailed the care and facilities available to support people living with dementia and their carers. The trust had installed 4 rest stops with images on each acute, site supporting the dementia friendly hospitals charter. The trust had pledged to John's Campaign and provided appropriate signage for the main hospital areas.

The Trust Dementia website had been renewed to highlight the care provision available for people with a dementia and their carers.

The Wayfinding Steering Group which included staff from Equality & Diversity and Facilities & Estates had worked together to redesign the signage and way finding at the trust. Careful thought had been given to disability accessibility including physical way finding and the appearance of the signage. The signage has been designed to meet the widest range of accessibility needs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

In partnership with Brighton and Sussex University Hospitals Trust, the trust had purchased a 2-year contract for the 'Recite Me' system to improve accessibility of the trust's website, and outpatients booking service. 'Recite Me' is a web-based tool that allows patients and staff to customise the trust website in way individuals need it to work for them personally. The easy to use facility included large font, text to speech functionality, dyslexia software, an interactive dictionary, a translation tool with over 100 languages and many other features. These functions not only benefit individuals with sensory impairments, but also benefit those with learning disabilities / difficulties and overseas language speakers.

The trust had produced Guidelines for Supporting Trans Patients which made explicit the expectations of staff behaviours and attitudes as well as the legal framework. Some clinics provided gender-specific or gender segregated services. An example of the former may be a clinic performing prostate examinations. It would be unacceptable to require a trans woman to use a waiting room for men in the former case, or for a trans man to share a female clinic waiting area in the case of a gynaecological condition. If an examination needed to be conducted in a specific room because it contained appropriate equipment, but which would not ordinarily be used for a person of that gender (for example, a trans man needing to be examined in a room ordinarily used for the examination of women), this should be clearly explained to the patient and sensitively managed

## Access and flow

The trust had seen performance slip in some referral to treatment times for elective procedures. There was an agreed recovery plan and data showed that there was an Improvement Plan which was on target to recover performance to compliant position by end of 2019/2020. The data to April 2019 was nationally available data but local data held by the trust showed sustained improvement towards meeting the action plan for recovery.

**Referral to treatment**

From May 2018 to April 2019 the trust's referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. The latest figures for April 2019, showed 81.6% of this group of patients were treated within 18 weeks versus the England average of 87.0%.

The commissioners had agreed a recovery plan and the trust had met this. A new target had ben agreed for 2019/2020 and the trust was showing evidence that they would meet this. The current RTT performance was 92%.

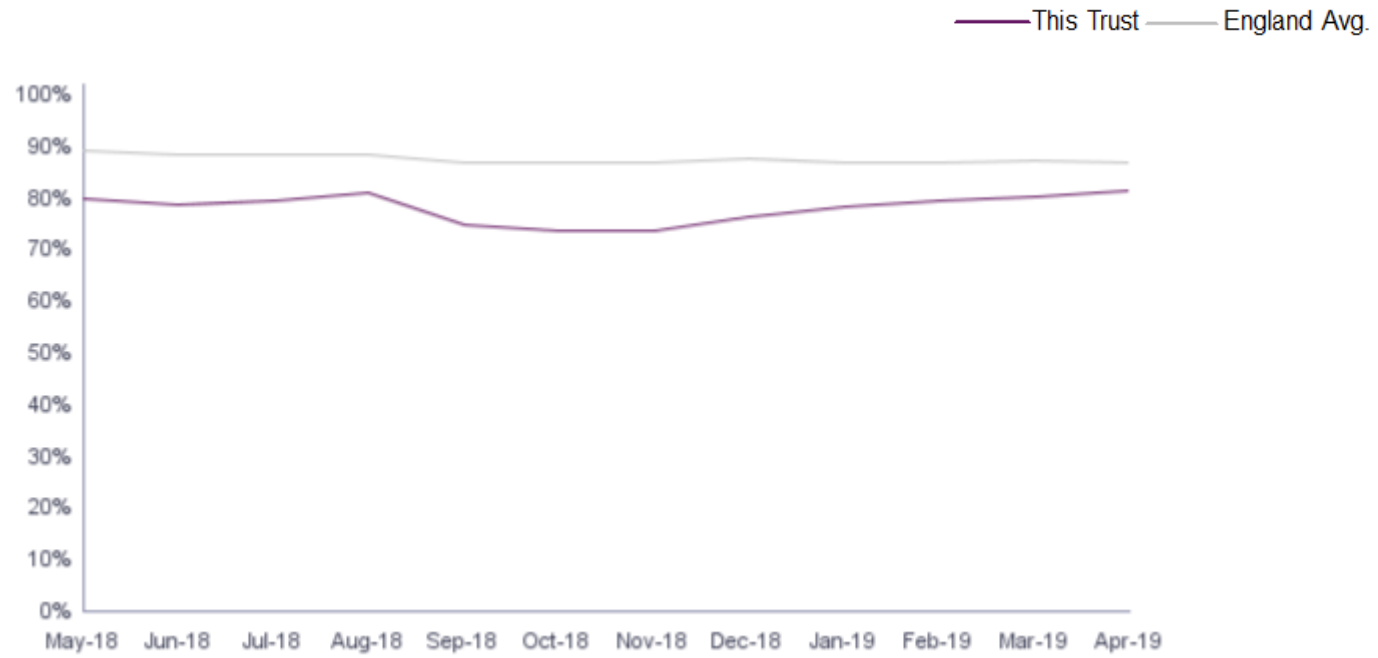
Cancer Performance – The trust have observed significant increases in demand for Coastal West Sussex CCG Patients in 2018/19 in comparison to the previous year, notably an overall rise of 8.9% rise in 2-week referrals & a 7.7% rise in 62-day urgent referrals. Specialities that have seen a significant increase include Colorectal, Urology, Skin, Breast and Head & Neck.

Despite this, overall the trust exceeded national performance for all one indicator & achieved compliance for 5 of the 7 Cancer performance indicators with a target in 2018/19

18 Week RTT Performance – The trust achieved compliance with the revised NHSE target that their waiting list in March 19 should be no higher than that of March 2018 both for Coastal West Sussex CCG patients and as a trust.

The latest published data (May 2019) showed that the trust had no 52+ week breaches. Provisional data showed the waiting list at WSHFT for Coastal West Sussex CCG patients was currently 3.1% higher than for March 2019 while the backlog is 6.4% lower. The number of completed pathways in May 2019 was 5.6% higher than for March 2019 with the number of 'clock starts' being 1.2% higher.

**Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Western Sussex Hospitals NHS Foundation Trust.**




*(Source: NHS England)*

Three specialties were above the England average for non-admitted pathways RTT (percentage within 18 weeks).

| Specialty grouping | Result | England average |
|---|---|---|
| Dermatology | 92.4% | 88.0% |
| Gynaecology | 92.0% | 91.2% |
| Trauma & Orthopaedics | 86.0% | 85.6% |

Thirteen specialties were below the England average for non-admitted pathways RTT (percentage within 18 weeks).

| Specialty grouping | Result | England average |
|---|---|---|
| Geriatric Medicine | 91.1% | 95.0% |
| General Medicine | 89.0% | 90.8% |
| Other | 86.4% | 90.0% |
| General Surgery | 85.4% | 88.3% |
| Urology | 83.0% | 84.8% |
| Thoracic Medicine | 80.8% | 86.0% |
| Ear, Nose & Throat (ENT) | 71.4% | 83.7% |
| Ophthalmology | 68.4% | 88.5% |
| Cardiology | 66.1% | 85.4% |
| Oral Surgery | 63.1% | 80.4% |
| Gastroenterology | 60.7% | 81.2% |
| Rheumatology | 59.8% | 86.3% |

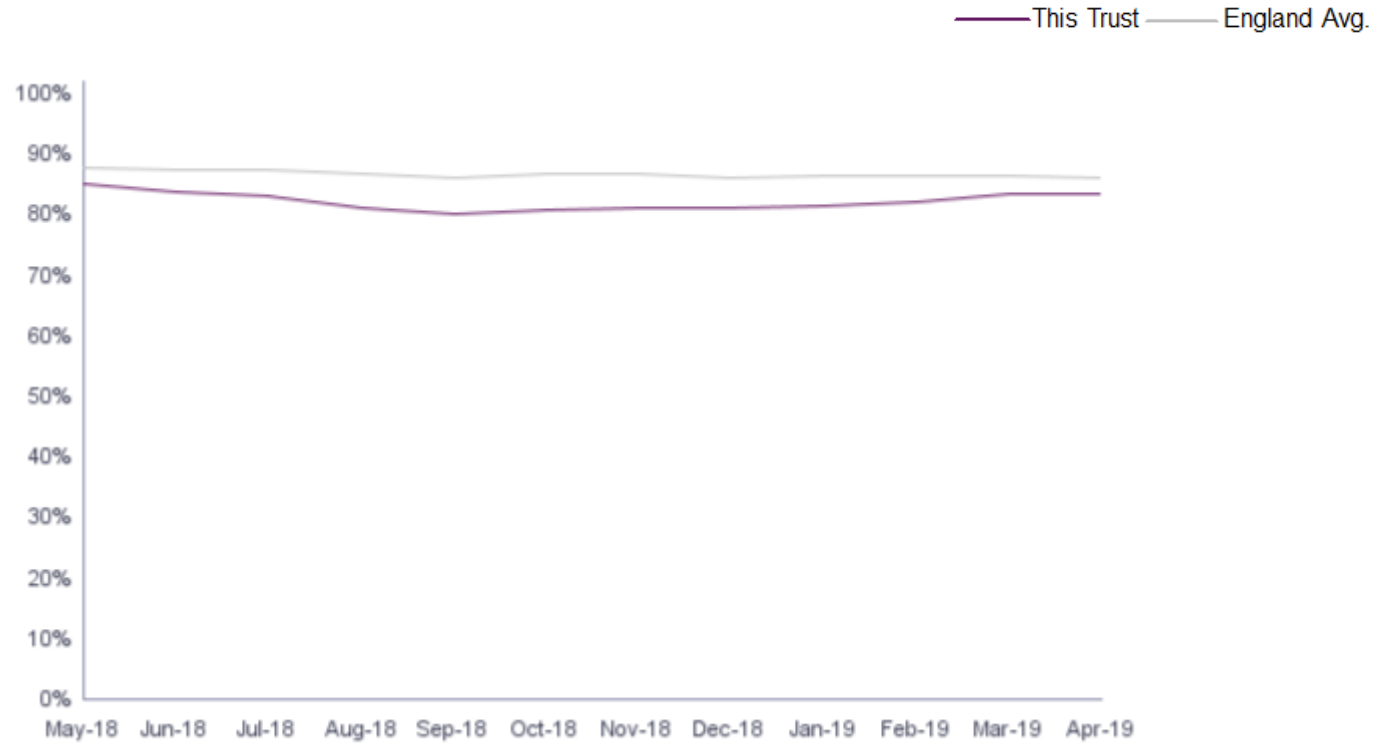
| Specialty grouping | Result | England average |
|---|---|---|
| Neurology | 44.9% | 77.3% |

*(Source: NHS England)*

From May 2018 to April 2019 the trust's referral to treatment time (RTT) for incomplete pathways has been worse than the England overall performance. The latest figures for April 2019, showed 83.3% of this group of patients were treated within 18 weeks versus the England average of 86.1%.

The commissioners had agreed a recovery plan and the trust had met this. A new target had been agreed for 2019/2020 and the trust was showing evidence that they would meet this.

**Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Western Sussex Hospitals NHS Foundation Trust.**




*(Source: NHS England)*

Six specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

| Specialty grouping | Result | England average |
|---|---|---|
| General Medicine | 94.7% | 91.5% |
| Thoracic Medicine | 92.1% | 88.9% |
| Other | 90.9% | 89.1% |
| Gynaecology | 90.8% | 87.8% |
| General Surgery | 87.5% | 83.8% |
| Urology | 85.9% | 85.1% |

Ten specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

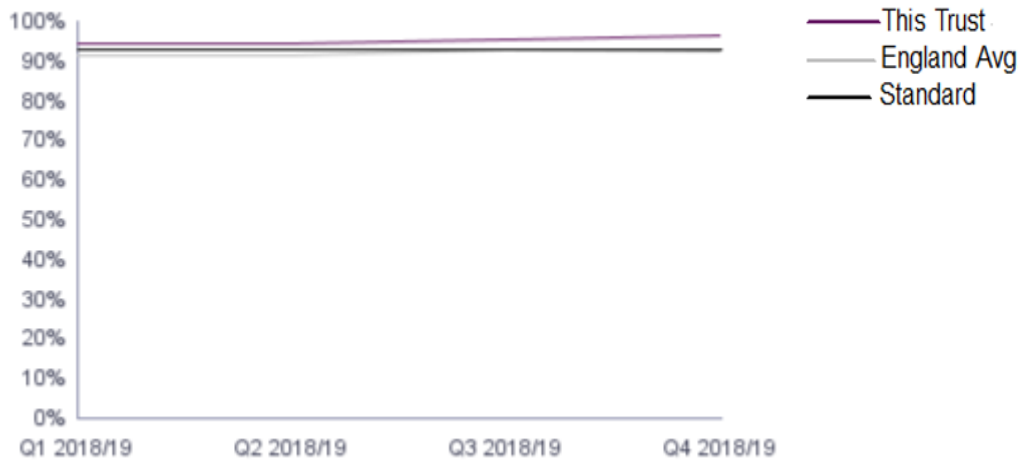
| Specialty grouping | Result | England average |
|---|---|---|
| Geriatric Medicine | 93.9% | 95.8% |
| Dermatology | 86.2% | 89.6% |
| Cardiology | 85.8% | 89.4% |
| Rheumatology | 85.2% | 91.3% |
| Gastroenterology | 78.8% | 88.2% |
| Ophthalmology | 77.8% | 86.7% |
| Ear, Nose & Throat (ENT) | 77.2% | 83.9% |
| Oral Surgery | 76.2% | 82.3% |
| Trauma & Orthopaedics | 73.2% | 81.3% |
| Neurology | 72.0% | 86.6% |

*(Source: NHS England)*

**Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)**

The trust is performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The performance over time is shown in the graph below.

**Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Western Sussex Hospitals NHS Foundation Trust**

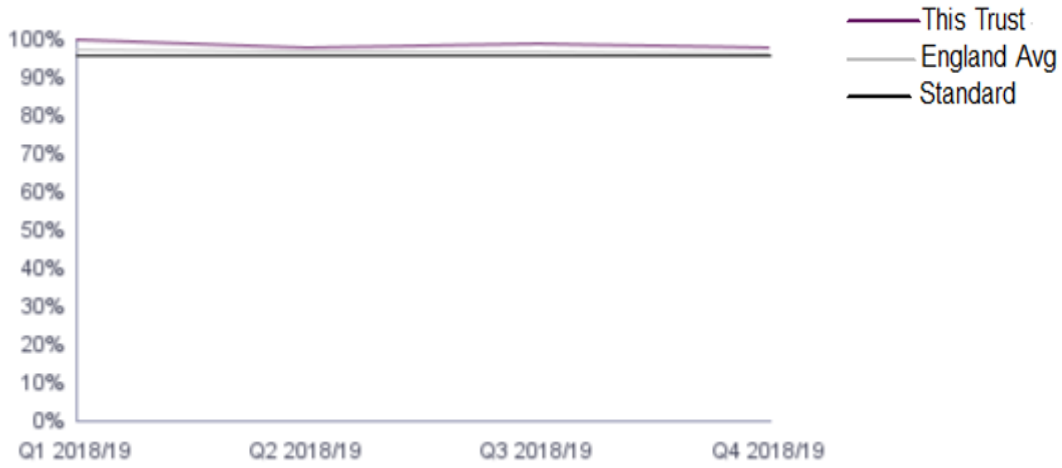



*(Source: NHS England – Cancer Waits)*

**Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)**

The trust is performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.

**Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Western Sussex Hospitals NHS Foundation Trust**



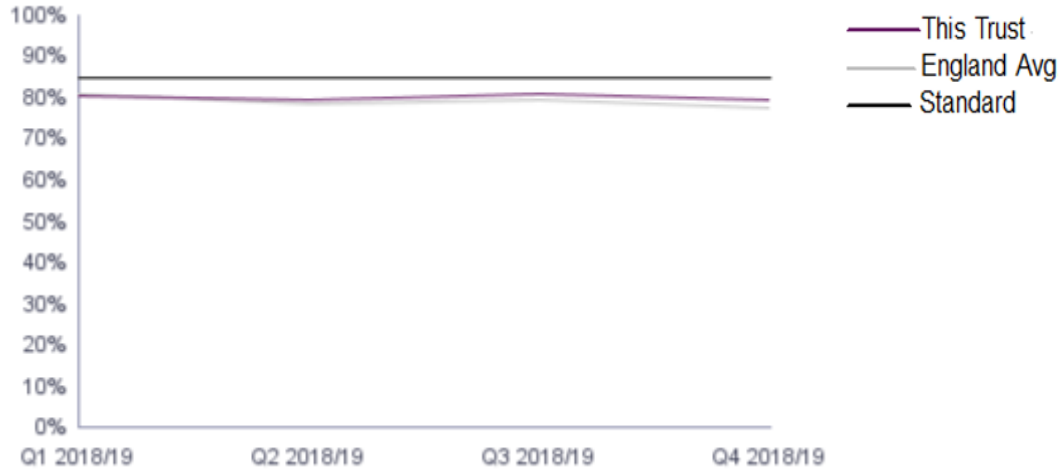

*(Source: NHS England – Cancer Waits)*

**Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment**

The trust is performing worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

However, cancer provisional performance for April-19 was 82.1 % of patients treated within 62 days from referral as per the Trust's recovery plan and in the context of continued significant increased demand, compared to 79.75 National Average (March).

**Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Western Sussex Hospitals NHS Foundation Trust**




*(Source: NHS England – Cancer Waits)*

Diagnostic performance was compliant with the national target for the full 12 months of 2018/2019 and continues to be compliant in April 2019. This is despite demand increases, which have been matched through increased activity and productivity

The Patient Experience and Feedback Committee met on behalf of the trust board four times a year to discuss the PALS enquiries and formal complaints received in detail, reviewing any patterns and themes emerging.

## Learning from complaints and concerns

### Summary of complaints

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

The Customer Relations Team (Patient Advice and Liaison Service and complaints team) provided advice on how and where to complain, investigated matters of concern and helped facilitate a resolution when things had gone wrong. PALS carried out signposting, provided information, advice or reassurance and managed issues that could be resolved quickly, assisting patients/relatives who needed time to discuss concerns and operated a triage service for telephone and face to face enquiries. The complaints team investigated more complex and serious concerns that required a formal investigation about past events.

The trust had a current Complaints & Concerns Policy which made explicit how the trust managed complaints, including the timescales.

Western Sussex Hospitals NHS Foundation Trust had a single point of access via the Patient Advice & Liaison Service (PALS) which triaged all concerns raised by telephone, e-mail and letter. This approach provided service users, relatives, carers and the general public with access to PALS and complaints via an email address or telephone number.

The number of issues around appointments had risen over the recent years, some of which were related to a significant increase in specialties such as ophthalmology, where the criteria for referral had changed and the capacity to see patients had not grown at the same rate. The Kaizen team were facilitating an outpatient improvement project to drive improvements in patient experience themes. In addition, the trust had implemented a number of further improvements as a result of PALS enquiries and formal complaints throughout the year:

- A patient complained that there was a 20-24 week waiting time for urgent spinal triage cases. As a result, additional funding was provided to create an additional clinic.

The number of formal complaints had reduced from an average of 50 per month to 35 per month over the last 12 months. This sustained reduction was thought to be as a direct result of senior managers telephoning the complainant and demonstrating an open approach to providing a quick resolution.

A total of eight complaints were investigated by the PHSO during 2018/19. had not been upheld.

### Trust level

From April 2018 to March 2019 the trust received 98 complaints in relation to outpatients at the trust (24% of total complaints received by the trust). The trust took an average of 31 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be completed in 25 days.

A breakdown of complaints by type is shown below:

| Type of complaint | Number of complaints | Percentage of total |
|---|---|---|
| Patient Care | 69 | 70.4% |
| Values & behaviours (staff) | 11 | 11.2% |
| Appointments | 11 | 11.2% |

| | | |
|---|---|---|
| Communications | 5 | 5.1% |
| Privacy, dignity & well being | 2 | 2.0% |
| **Total** | **98** | **100.0%** |

**Southlands Hospital**

From April 2018 to March 2019 there were 10 complaints about outpatients at Southlands Hospital. The trust took an average of 20 days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be closed within 25 days.

A breakdown of complaints by type is below:

| Type of complaint | Number of complaints | Percentage of total |
|---|---|---|
| Patient Care | 7 | 0.7% |
| Appointments | 2 | 0.2% |
| Values & behaviours (staff) | 1 | 0.1% |
| **Total** | **10** | **100.0%** |

**St Richard's Hospital**

From April 2018 to March 2019 there were 47 complaints about outpatients at St Richard's Hospital. The trust took an average of 36 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed within 25 days.

A breakdown of complaints by type is below:

| Type of complaint | Number of complaints | Percentage of total |
|---|---|---|
| Patient Care | 32 | 68.1% |
| Values & behaviours (staff) | 7 | 14.9% |
| Appointments | 4 | 8.5% |
| Communications | 4 | 8.5% |
| **Total** | **47** | **100.0%** |

**Worthing Hospital**

From April 2018 to March 2019 there were 41 complaints about outpatients at Worthing Hospital. The trust took an average of 34 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed within 25 days.

A breakdown of complaints by type is below:

| Type of complaint | Number of complaints | Percentage of total |
|---|---|---|
| Patient Care | 30 | 73.2% |
| Appointments | 5 | 12.2% |
| Values & behaviours (staff) | 3 | 7.3% |
| Privacy, dignity & well being | 2 | 4.9% |
| Communications | 1 | 2.4% |
| **Total** | **41** | **100.0%** |

*(Source: Routine Provider Information Request (RPIR) – Complaints tab)*

**Number of compliments made to the trust**

From April 2018 to March 2019 there were 653 compliments about outpatients at the trust. A breakdown of compliments by site is below:

| Site | Number of compliments | Percentage of total |
|---|---|---|
| Southlands Hospital | 26 | 4.0% |
| St Richards Hospital | 144 | 22.1% |
| Worthing Hospital | 483 | 74.0% |
| **Total** | **653** | **100.0%** |

*(Source: Routine Provider Information Request (RPIR) – Compliments tab)*

# Acute services

## St Richards

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West Sussex
PO19 6SE

Tel: 01243 788122

www.westernsussexhospitals.nhs.uk

## Critical care

### Facts and data about this service

Trust wide there are 22 critical care beds across two sites, St Richards Hospital Chichester and Worthing Hospital Worthing, including 5 enhanced surgical care beds at Worthing hospital.

Critical care sits within Surgery Division which is led by a triumvirate team of Chief of Service, Head of Nursing and Director of Operations.

Critical care is one of five care groups within the surgery division. Each care group is led by a multi-disciplinary triumvirate of clinical director, care group manager and senior nurse.

St Richards is a flexible 10 bedded critical care unit, which is made up of six level 3 beds and four level 2 beds. There were two single rooms at St Richards Hospital.

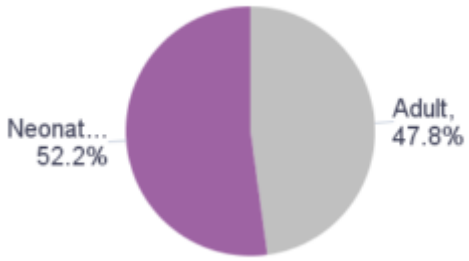
The critical care service was supported by an outreach team who worked across the site supporting ward staff.

The unit had a dedicated family room and a family kitchen. There were also offices and staff changing facilities within the unit.

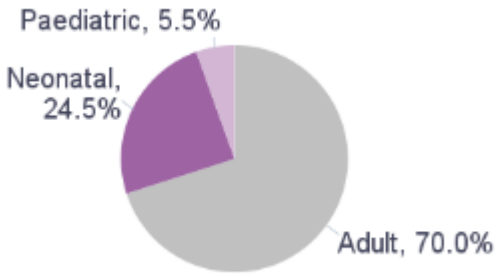
In the period March 2018-March 2019 the critical care unit had 650 admissions.

**Breakdown of critical care beds by type, Western Sussex Hospitals NHS Foundation Trust and England.**

**This trust**




**England**




*(Source: NHS England)*

## Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

### Mandatory training

**The trust provided mandatory training in key skills, including resuscitation training, to all staff and made sure everyone completed it.**

The unit had a designated practice development nurse, who planned training sessions for staff. Staff had classroom based and e-learning sessions which could be remotely accessed from home.

Mandatory training sessions included information governance, equality and diversity, fire safety, health and safety, moving and handling and conflict resolution and resuscitation. The trust target for annual staff completion of mandatory training was 90%. We saw evidence that over 95% of nursing staff were up to date with their mandatory training.

Further training was provided for clinical staff on recognising and responding to patients with mental health needs, learning, disabilities, autism and dementia.

Staff received training in recognising and managing deteriorating patients including those with confirmed or suspected sepsis. This was in line with National Institute for Health and Care Excellence, guidance (NG) 51, recommendation 1.12, training and education.

There was an up to date sepsis policy and all staff knew how to access it. All new nurses working on the critical care unit undertook a respiratory and cardiovascular study day as part of their induction, which included a dedicated session on sepsis.

All nurses we spoke with told us that they are given time to complete their mandatory training either in a classroom setting or via the learning modules. We heard comments that included 'our managers are really supportive and make sure we have time to complete our training' 'We are encouraged and supported to develop our skills and knowledge'.

Band 5 nurses undertook a year preceptorship course to make sure they had the key skills needed. We were told that all new nurses were supernumerary for the first four weeks of their employment in the critical care unit which allowed new starters to safely orientate to the unit. During orientation patient care was assessed.

The unit organised simulated learning for all staff and we found evidence of training equipment including a model used for simulated training events.

Mandatory training for doctors was comprehensive and covered all aspects of critical care, including, sepsis management, basic life support, safeguarding, mental capacity, deprivation of liberty (DoLs) and infection control.

Medical staff new to the unit had sepsis training as part of their induction. This included three morning sessions a week for the first three months of their rotation into critical care. Additional training was given by the outreach team at the monthly critical care mortality and morbidity meetings.

The doctors ran weekly teaching sessions for all staff to attend and receive updates on all aspects of care.

**Mandatory training completion rates are as follows:**

The Trust set a target of 90% for completion of mandatory training.

**St Richard's Hospital critical care department**

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for qualified nursing staff in the critical care department at St Richard's Hospital is shown below:

| Training module name | April 2018 to March 2019 | | | | |
|---|---|---|---|---|---|
| | Staff trained | Eligible staff | Completion rate | Trust target | Met (Yes/No) |
| Equality and Diversity | 52 | 52 | 100.0% | 90% | Yes |
| Fire Training | 52 | 52 | 100.0% | 90% | Yes |
| Health and Safety | 52 | 52 | 100.0% | 90% | Yes |
| Infection Control | 52 | 52 | 100.0% | 90% | Yes |
| Information Governance | 51 | 52 | 98.1% | 90% | Yes |
| Resuscitation | 50 | 52 | 96.2% | 90% | Yes |
| Manual Handling - People | 49 | 52 | 94.2% | 90% | Yes |

At St Richard's Hospital critical care department, the 90% target was met for all seven of the mandatory training modules for which qualified nursing staff were eligible.

*(Source: Routine Provider Information Request (RPIR) – Training tab)*

## Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had up-to-date training on how to recognise and report abuse, and**

**they knew how to apply it. Data provided after the inspection showed five out of six safeguarding training modules were above the trust target of 90% for nursing staff, and four out of six were above the trust target of 90% for medical staff.**

There were clearly defined and embedded standard operating procedures in place that kept people safe and safeguarded them from abuse. These systems were reliable and designed to minimise error.

The trust safeguarding policy had been recently reviewed and we saw evidence of this. The policy was evidence based and followed the national intercolleguiate document 'Adult Safeguarding: Roles and competencies for healthcare staff' (2018). It was electronically available for all staff and included contact numbers for the safeguarding leads and trust-wide safeguarding services.

The trust had effective systems and processes for protecting vulnerable people from harm and abuse. There was a well-integrated safeguarding team that were passionate about their work and committed to ensuring people remained safe. The key message from the trust to their staff was that safeguarding was everyone's business.

The safeguarding team was led by the chief nurse and included a senior safeguarding lead, a safeguarding nurse and a mental capacity act lead, with a team administrator to support them.

The trust made sure that safeguarding was monitored and reviewed across the trust. The trust board met annually to review and publish annual safeguarding reports for safeguarding adults and children. These reports work in partnership with the local authority monitor safeguarding issues across the hospital including critical care. Reports are available for the public domain on the internet, the last reports were published June 2018.

There was good triangulation of safeguarding risks through reviews of complaints, incidents and safeguarding referrals. Future risks were identified and addressed proactively through horizon scanning.

Compliance with safeguarding training was generally good but for child safeguarding the medical staff completion of level 2 training was below target. This was attributed to the recent recruitment of new consultants to increase the critical care establishment and a plan was in place to address this.

Adult protection training compliance rates for level 2 training were below the trust target but were not out with the current guidance. The Intercollegiate document Adult Safeguarding; Roles and Responsibilities for Healthcare Staff (August 2018) states that, "It is expected by the next iteration in 2021 all staff will have received training to attain the appropriate competencies". There was acknowledgement that these levels were not meeting the planned level but explained by both newly appointed staff and a challenge delivering some planned training because of the sudden and unexpected loss of one key member of safeguarding staff. There were plans in place to ensure all staff were trained to the required level.

Training included a module on female genital mutilation (FGM) in line with current government legislation created under the Female Genital Mutilation Act 2003 and found in the Statutory guidance on Female Genital Mutilation 2016 which requires all care providers to provide awareness training to all staff working with women and girls at risk of FGM.

People were protected from discrimination that might amount to abuse, discrimination, harassment or cause psychological harm. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the

Equality Act 2010.

Safeguarding assessment were routinely carried out for all patients admitted to critical care as part of their initial plan of care.

All staff we spoke to understood how to report concerns about neglect abuse and harm and escalate these to the relevant agencies. Staff accessed safeguarding referral forms via the critical care digital patient records. The patient records held safeguarding policy information on the referral pathways and staff had access to the contact details of the duty social workers.

One example given by the consultant was a couple who had been admitted to the ward for substance misuse that led to a drug overdose. On arrival to the unit two patients were unconscious. When they were becoming conscious and physically well, one of the patients advised staff that they had intended to take their own life. The psychiatric liaison team were called to assess the patient and a safeguarding referral was written. The team devised a care plan that helped this client get safe mental health support in the right environment.

Patients on the unit at risk of self-harm this could be flagged on their patient records, and referrals made to the mental health team.

Prevent is part of the government counter-terrorism strategy called CONTEST, it is designed to tackle the problem of terrorism at its roots by preventing people from supporting terrorism or becoming involved in terrorism themselves. (NHS England 2019).

Prevent training was included in the mandatory safeguarding training and available as an e-learning module which provided basic awareness of Prevent. If staff trained at level 3 safeguarding also received level 3 Prevent training.

**Safeguarding training completion rates**

The trust set a target of 90% for completion of safeguarding training.

**St Richard's Hospital critical care department**

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for qualified nursing staff in the critical care department at St Richard's Hospital is shown below:

At St Richards hospital critical care department, the 90% target was met in five out of six

safeguarding training modules for which qualified nursing staff.

The critical care unit rarely took children under sixteen years of age. They did accept young people aged between sixteen and eighteen years of age who were classified as children for safeguarding purposes. The trust target was a stretch target, as they are only required to have safeguarding children level 3 trained staff where the staff are likely to contribute to ongoing safeguarding assessments.

## Cleanliness, infection control and hygiene

**The service-controlled infection risk in line with best practice. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

The unit ensured there were reliable systems in place to prevent and protect people from healthcare associated infections.

The trust had an up-to-date infection control policy and staff knew how to access it. The service had a designated infection control nurse lead, who worked with the unit and microbiologist joined daily ward rounds. All staff were involved in infection prevention and reducing the transfer of hospital born viruses.

All ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up to date and showed that all areas were cleaned regularly. All computers had easy to wipe keyboard covers.

Staff followed infection control principles including the use of personal protective equipment (PPE), and we saw aseptic techniques used for invasive clinical procedures.

Staff were allocated dedicated cleaning responsibilities at shift handovers. Each bedside had a daily cleaning and equipment checklist. Areas were cleaned according to trust guidelines using standard infection control antimicrobial wipes, gels and correct waste disposal bins.

Staff showed us new equipment, that could cover up-to 8 intravenous pumps at any one time. The equipment was run off one main plug. The casing helped protected the equipment from dust and dirt and was easier to clean.

Staff routinely cleaned equipment after patient contact and the bed space was thoroughly cleaned after patients were discharged and equipment labelled with green ‘I am Clean’ sticker ready for the next patient.

Staff cleaned their hands prior to patient care and we observed this. Enough sinks were available clean and soap dispensers and paper towels were stocked up. Alcohol gel was available at the bedsides. Hand hygiene signs were also on display in the staff and patient toilets.

There were dedicated housekeeping staff responsible for cleaning the unit. The whole area was tidy, well maintained and free from clutter.

The Intensive Care National Audit Research Centre (ICNARC) data for April 2018 to March 2019 showed there had been no cases of unit acquired Meticillin-resistant *Staphylococcus aureus* (MRSA) on the unit. However, there were two reported cases of *Clostridium* difficile (C-diff) in the same period although root cause analysis had found no evidence of lapses in care. The trust investigated each individual case to identify any specific themes. In addition, NHS Improvement requires, all Clostridium difficile infections are looked at to see if the case was associated with a ‘lapse of care’. A lapse of care indicates that policies and procedures were not followed.

On the day of our visit we learnt that all patients with raised temperatures and abnormal blood results were reviewed by a consultant microbiologist seven days a week. The consultants and microbiologist followed the correct procedures of Gold Standard Stewardship of antimicrobial therapy which aimed to educate, identify, screen, track and prevent infection (Practical guide to antimicrobial stewardship in hospitals).

All patients admitted to the unit have admission Meticillin-resistant *Staphylococcus aureus* (MRSA) swabs taken. The unit policy was to swab patients weekly if they were receiving long term care, for the bacteria from the admission date.

Critical care blood results where processed in line with national standards as follows: flu results could be obtained within 24hrs, while *Clostridium difficile* (C-diff) and Methicillin-resistant *Staphylococcus aureus* (MRSA) results took two to three days. Blood cultures produced initial results in 24hours and full results in three to five days.

All computers had access to blood results and the. The staff had access to mobile computers during ward rounds and admissions' which ensured timely reporting of abnormal blood results.

We were shown audit results for Infection control rates for St Richards for the period March 2018-19 out of 650 admissions the outcomes were as follows:

| MRSA on Admission | C-Diff on Admission | E-Coli |
|---|---|---|
| 3 | 1 | 2 |
| MRSA unit acquired | C-Diff Unit acquired | |
| 0 | 2 | |
| No Samples = 18 | No C-diff = 91 | |

Staff told us that when infection was thought to have been unit acquired, full deep cleaning was done, swabs of the area's sent to the lab and root cause analysis (RCA) were carried out to find gaps in care if any. The review of the two *Escherichia* coli (E-coli) cases no care issues could be found in the RCA's.

## Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use all equipment. Staff managed clinical waste well. However the unit did not meet recommended guidelines for available side/isolation rooms.**

The hospital was built between 1938-39 and the estate had been progressively extended over the years. The unit was recently redecorated to follow recommendations set out in the Guidelines for Provision of Intensive Care Services 2015. There was space around each bed for nursing staff and doctors to safely care for patients and allow for emergency equipment to be used by the patient's bedside.

The department kept people safe, there was an entry buzzer system to the ward. The nursing station was positioned so the band 7 clinical co-ordinator and medical staff had a clear view of all level three beds on the unit. However, national Intensive Care Guidelines recommend that critical care units provide at least 20% of their bed capacity as single isolation rooms. Although there were two single rooms which amounts to 20%, this limited the unit's ability to provide care where patients required isolation. This had been reported on the trust risk register and plans were in place to increase single rooms in the future.

The unit maintained and used equipment correctly so that people were kept safe. A technician handled cleaning and maintenance of the equipment on the unit. All equipment conformed with national safety standards and was in working order.

We were shown the equipment tracker log which was created to keep track of equipment that had been used to transfer patients from the unit.

Emergency equipment was available, safe and fit for purpose. We checked the resuscitation trolley and difficult intubation trolley. All equipment and drugs were within their use-by dates. We also saw checklists for all trolleys showing evidence staff checked the trolleys daily.

If a patient needed an emergency transfer to theatre the team were fully equipped to transfer them safely, theatres were situated on the same floor of the hospital.

Staff had training on equipment and a log was kept of this. On the day of inspection an engineer was maintaining critical care ventilators and respiration equipment.

Clinical rooms used to store and make up medicines, was clean and free of clutter. Signs were laminated, and fridge temperatures monitored daily.

Staff disposed of clinical waste safely. Nationally recognised colour codes were used to separate normal waste from clinical waste, sharps bins and bed linen. Bins were not over flowing and sharps bins were clearly labelled and stored safely. This was in line with, Health Technical Memorandum (HTM): Safe Management of Healthcare Waste, control of substances hazardous to health (COSHH), and health and safety at work regulations.

## Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and minimised or removed risks. Staff quickly identified and acted upon patients at risk of deterioration.**

Staff completed risk assessments for each patient on admission and throughout their stay to minimise risks. Access to the patient records was readily available and plans of care and treatment was actioned quickly; particularly when people where referred or when they transitioned between services.

Different digital systems used to store or manage care records, were coordinated. People understood the information that was shared about them and were provided with a copy of this when appropriate. All staff have access to e-obs and national early warning scores (NEWS) via the electronic patient monitoring system. We were shown how the digital patient software systems communicate with each other effectively.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. In line with National Institute for Health and Care Excellence (NICE), guideline (NG), 51, sepsis: recognition, diagnosis and management, the service used an adapted version of the National Early Warning System (NEWS) track and trigger flow chart. NEWS is a simple scoring system of physiological measurements (for example, blood pressure, temperature and pulse) for patient monitoring.

The trust made sure that all staff had the support, training, technology and equipment to identify and respond to changing conditions of people who used the services. The training included, medical emergencies, deteriorating health and wellbeing, or challenging behaviour. Staff were always supported by senior team members in these situations.

Staff used a virtual ward, which they had recently created on their critical care electronic patient records the system. This mirrored nationally recognised National Early Warning Score (NEWS) observation charts and highlighted deteriorating patients and escalated them appropriately. The virtual ward was used for risk assessments patients on admission and staff updated them when necessary and used recognised care pathways. Patients were continually monitored and accessed. High tech patient monitoring IT equipment was on display at the nursing station, so medics and nurses were quickly alerted changes in patients' conditions.

A designated outreach team were available between 8am and 8pm, seven days a week. The team provided rapid response and could be contacted directly. The team comprised of five band 7 nurses and one band 6. All staff had a background of working in critical care. There were two nurses available between 7.30 am to 8 pm, seven days a week. Although national intensive care guidelines recommended round the clock cover, the trust managed out of our critical care via the site clinical practitioners who then handover care back to the team at the start of their shifts.

The team accessed a patient register on the critical care virtual ward electronic patient records, or their smart phones. They attended a standardised handover and continually liaised with critical care staff about patient conditions, on the unit and other wards.

The critical outreach team led on a sepsis awareness programmes across the trust. Their work and the work of staff across the trust had seen the Dr Foster standardised mortality ratio on this measure decreased from 112 to 98.

All staff knew about and dealt with any specific risk issues which included pressure sores, sepsis and safeguarding, and managing invasive procedures. The outreach team were involved in managing and treating sepsis on the wards. The trust used the acronym of BUFALO (Blood cultures, measure accurate urine output, administer Intravenous fluids, administer broad spectrum antibiotic, measure serum lactate, administer high flow oxygen) to highlight the deteriating.

All band 6 nurses had completed the critical care course which covered sepsis in detail and sepsis training was available on mandatory study days. Sepsis was audited, and data drawn from the patient record. The data was discussed at the monthly morbidity and mortality meetings.

We were told that management of patients with sepsis was a key theme discussed at critical care monthly mortality and morbidity meetings, and that the outreach teams on both sites have a dedicated sepsis nurse lead who updates the unit sepsis champions. The champions are both trained nurses and healthcare assistants.

The service had round-the-clock access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health) (AMSAT). Staff told us that their mental health specialist teams were supportive and would assess patients as soon as they were medically fit.

The critical care medical team looked for new evidence based clinical practices that would improve common chronic health conditions. One example of this was the unit now used a 'safer scan' to exclude punctured lungs and recognise leakages or infections in the lungs, so they could start treatment quickly. A physiotherapist had been trained to perform lung ultrasounds and was accredited with CUISIC (ultrasound in critical care). This practice speeds up diagnosis, reduces exposure to radiation, and saves money.

## Nurse staffing

**The service had enough nurses and allied healthcare professional staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.**

Managers regularly reviewed and adjusted staffing levels and skill mix. Bank and agency staff were provided with a full induction. Systems and processes were in place to assess, plan and review staffing levels on the critical care unit, including skill mix. Rotas were planned, which allowed for adjustments to be made to make sure the correct skill mix was in place to ensure safe patient care.

Staffing levels compared well with the national standard laid out in the Guidelines for the Provision of intensive care Services 2015. Nurse staffing provided, one to one care by a registered band 6 critical care nurse for level 3 patients. One to two care by a registered band 5 and 6 nurses to patients for level 2 patients.

The team is made up of 60 staff at St Richard's Hospital, this included nine intensivist consultant, two junior doctors, two band 7 nurses, and 46 band 5 and band 6 nurses, who were supported by healthcare assistants, a technician and one clerk. Two outreach team nurses acted as daily support for the team between 7.30am to 8pm.

The annual vacancy rate was currently 6%. Shortfalls in the staffing levels were covered by hospital bank staff. In line with the Guidelines for the Provision of Intensive Care Services 2015, the critical care unit used their own staff to fill gaps in the roster. The unit did not use more than 3% of registered nurse from bank/agency staff on any one shift when they were not their own staff.

There were systems in place to plan and review staffing. Managers used digital rostering software to create duty rotas, with the right skills mix to cover shifts over a twenty-four-hour period. The digital roster system could collect data, allocate annual leave to make sure that the service was always covered.

The rostering system made sure staff took annual leave at least quarterly. Managers could look at sickness levels, annual leave and extra hours worked, this allowed managers to ensure safe staffing.

On the day of our inspection we saw seven registered nurses, one band 7 supernumerary clinical co-ordinator, one student nurse, one technician and one healthcare assistant on duty.

Each shift was twelve and a half hours either, 7.30 am to 8 pm or 7.30 pm to 8 am. We were shown the duty roster which was designed to offer a safe competent skill mix. Daily cover consisted of one band 7 Clinical co-ordinator, two band 6 critical care accredited nurses, seven band 5 nurses supported by one health care assistant (HCA) and one technician.

The unit has six flexible level 3 beds, and four flexible level 2 beds. On the day of our visit level 3 patients had one to one care by their designated nurse which is in line with national intensive care standards.

At the beginning of each shift staff attended a standardised handover, which included discussions over staffing levels for the day, current patient admissions, allocation of equipment and cleaning checks, capacity and acuity of the unit. Staff were assigned their patients and then a more detailed handover happened at the bedside from the previous shift nursing staff.

Arrangements for using bank or agency staff were always effective and keep people safe. Nurses told us that they covered outstanding shifts via a secure staff social media app, all staff on the unit who wanted to work bank shifts joined the secure group to ensure that staff working bank were familiar with the environment and have the necessary skills to assess and treat patients. The unit ran smoothly with this system and we were told that the unit did not need external bank staff. Agency staff were only used if they needed a mental health nurse for a vulnerable patient.

Cross site there was a dedicated physiotherapist for each critical care unit, with additional training in respiratory management. All staff we spoke with confirmed physiotherapy staffing was adequate to provide the respiratory management and rehabilitation components of care.

**Trust level**

The table below shows a summary of the nursing staffing metrics in medicine at trust level compared to the trust's targets, where applicable:

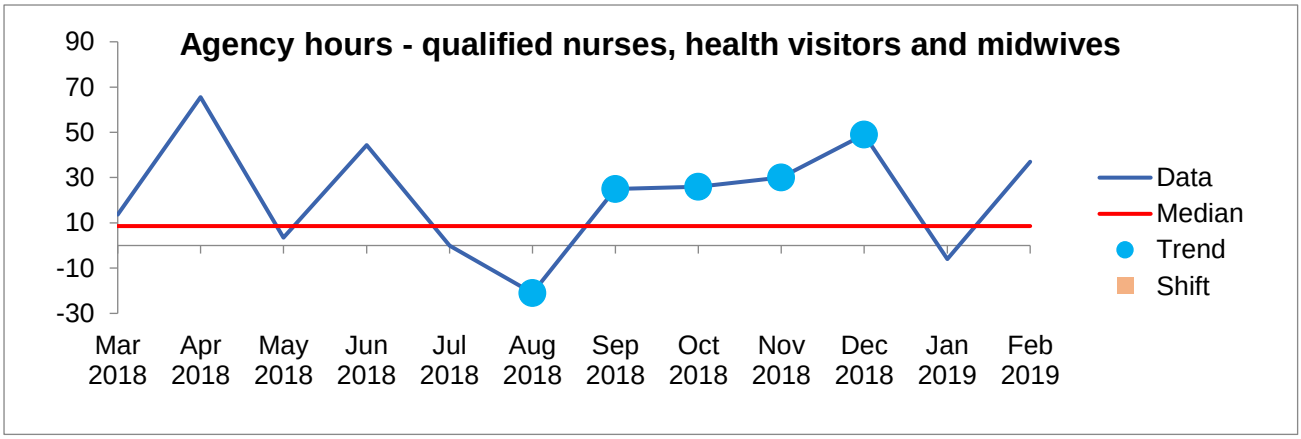
| **Core service annual staffing metrics** |
| --- |
| April 2018 – March 2019 |

| Staff Group | Annual average establishment | Annual vacancy rate | Annual turnover rate | Annual sickness rate | Annual bank hours (% of available hours) | Annual agency hours (% of available hours) | Annual unfilled hours (% of available hours) |
|---|---|---|---|---|---|---|---|
| **All Staff** | 116.1 | 1% | 5% | 4.9% | | | |
| **Qualified Nurses** | 104.0 | 0% | 4% | 4.3% | 6,763 (3%) | 267 (<1%) | 20,604 (9%) |

*(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)*

Nurse staffing rates within this core service were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness and bank use.

**Trust bank and agency staff usage**




| | Core service annual staffing metrics | | | | | | |
|---|---|---|---|---|---|---|---|
| | April 2018 – March 2019 | | | | | | |
| **Staff Group** | **Annual average establishment** | **Annual vacancy rate** | **Annual turnover rate** | **Annual sickness rate** | **Annual bank hours (% of available hours)** | **Annual agency hours (% of available hours)** | **Annual unfilled hours (% of available hours)** |
| **All Staff** | 53.4 | -2%* | 7% | 4.0% | | | |
| **Qualified Nurses** | 48.0 | -3%* | 4% | 3.7% | 3,627 (3%) | 30 (<1%) | 6,120 (6%) |

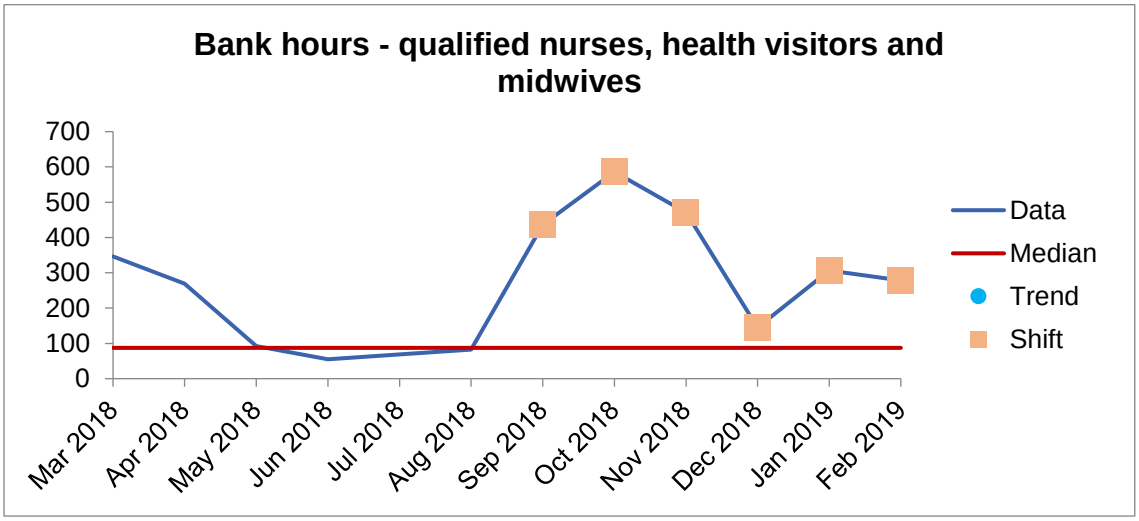
**St Richard's Hospital**

The table below shows a summary of the nursing staffing metrics in medicine at trust level compared to the trust's targets, where applicable:

* The negative vacancy rate may be a sign of an over-establishment of staff.

Nurse staffing rates within this core service at St Richard's Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were found in monthly rates for vacancy, turnover, sickness, bank use and agency use.

**Bank and agency staff usage Trust wide**




Monthly 'bank hours' over the last 12 months for qualified nurses, health visitors and midwives show a shift from September 2018 to February 2019.

*(Source: Routine Provider Information Request (RPIR) - Nursing – Bank and Agency tab)*

## Medical staffing

**The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to give the right care and treatment.**

Critical care was consultant led. Intensivist consultants led twice daily ward rounds seven days a week. The unit currently employed nine consultants, eight middle grade doctors and 11 senior middle grade doctors. Rosters were planned, and cover was organised for the full twenty-hour-period seven days a week. Locum cover was not used on the unit.

Staffing levels and the skill mix compared well with planned levels and cover was provided for staff absence. Since our last inspection consultant care has increased. At both sites, one consultant was always available to the unit from 8am to 6.30pm.

The consultants work a one in nine on call rota and were able to access patient records from home. Their contracts required them to be no more than 30 minutes from the hospitals. The distance they lived from the hospital was recorded in their appraisals. The on-call consultants had remote access to all patient information.

The middle grades rotated through critical care according to their rota pattern; during core hours Monday to Friday there were a minimum of two middle grade doctors working on each unit. Out of hours and at weekends there was a minimum of one middle grade doctor working on each unit.

Consultants responsible for patients on the unit were free from other clinical commitments, when covering the critical care unit.

Patients in critical care were reviewed by a consultant within 12 hours of admission. We looked in five patient records and all five showed evidence of a review. This is in line with national guidance.

Current arrangements for using bank, agency and locum staff work well, they were economical and kept people safe.

Medical staff told us that they planned and managed cover well between the medical team within the trust. Most shifts were covered in house and agency and locum staff were rarely used and we were shown evidence of this.

## Records

**Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**

Patient care records including clinical data were written and managed via an electronic patient record and kept people safe. All medical staff, including members of the multidisciplinary teams (MDT) kept detailed notes on patient records.

The trust had developed a virtual ward module on the critical care electronic patient records. Which contained detailed appropriate individual patient information including mental health history. The patient record system had all the information needed to carry out safe, immediate care.

Medical records were completed in line professional standards. Patients were reviewed by a consultant on admission to critical care and there was daily multidisciplinary team (MDT) input. We also saw there was clear documentation of the time and decision to admit to the critical care unit. This was in line with National Institute for Health and Care Excellence (NICE), clinical guidance 50; acutely ill adults in hospital: recognition and response to acute illness in adults in hospital.

Staff had all the information needed to deliver safe care and treatment in a timely and accessible way. The lead IT nurse told us that the unit had recently rolled out a new discharge notification for GP's and MDT's.

The specialist Information Technology (IT) nurse told us that one of the team's doctors recognised that the discharge notification required improvement. Questionnaires were sent to GP's and other community health care professionals in the local area, asking them what information they would like to see on the notification. Data was then collected and analysed. The information gathered from the results helped produce a methodical detailed safe discharge notification, that was introduced on the week of our inspection. The notification showed the patient diagnosis in bold. Detailed plans of care, imaging, blood results and medication were clearly documented.

When people moved between teams, services and organisations all the information (including referrals and discharges) needed for their ongoing care was shared appropriately and easily accessible, in line with the relevant protocols.

The outreach team used the same virtual ward electronic records and had their own patient register which showed details of all patients being cared for by the team across the whole hospital.

This helped doctors, nurses and other members of the multi-disciplinary team to make quick informed decisions about care and flow, by discussing levels of care for patients on the unit.

The on-call consultants and the critical care team had remote access to patient records when off site of the unit, to carry out risk assessments in a timely way.

The critical care electronic patient records merged efficiently and managed information about people, carers and partner agency's safely in line with current general data protection regulations.

For example blood and imaging results are accessible from the critical care patient records, the trust was working towards a paperless process and currently merging paper records with digital notes.

## Medicines

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Medicines were stored securely behind locked doors with access restricted to appropriate staff. Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored securely. Two nurses checked the quantities daily and any discrepancies were reported. Medicines administration was recorded electronically, and we saw medicines were given as prescribed.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines**.** There was good clinical pharmacy support with a pharmacist who visited the unit daily. They were able to provide advice to patients and carers if needed

Staff stored and managed all medicines and prescribing documents in line with the provider's policy**.** Room and fridge temperatures were recorded daily to ensure medicines were stored at appropriate temperatures, however we did see the maximum fridge temperature had been outside the recommended range over the previous two months and there was no evidence action had been taken. It was unclear if staff had been resetting the thermometer after each check.

Staff followed current national practice to check patients had the correct medicines. Policies and protocols were available for all staff on the intranet. The pharmacist was also contactable when they were not on the unit. Checks were completed when patients came to the unit to ensure they were prescribed their regular medication.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Medicine related alerts and recalls were communicated to the nurse in charge of the ward and cascaded to all ward staff. Medicines incidents were recorded on a nationally used electronic database. Examples were given to show how improvements have been made following recent incidents to prevent them from re-occurring.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff explained how they would support patients who lacked capacity to make informed decisions about their medicines. Staff knew when it was appropriate to administer medicines which were prescribed to be taken when required.

## Incidents

**The service monitored and reviewed patient safety incidents well. Staff recognised and reported incidents and near misses.**

Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Policies and procedures were in place to ensure there was a methodical approach to investigating safety issues. The trust patient safety team would monitor and review the unit's performance in dealing with investigations.

There were effective systems in place to report incidents. Incidents are graded by their severity from no harm, to harm including injury, suffering, disability or death. The incidents are rag rated and assigned to the clinical staff and governance leads to investigate.

Incidents were monitored and reviewed, and staff gave examples of learning as a result. Staff understood the principles of Duty of Candour regulations, were confident in applying the practical elements of the legislation. The team had noticed that one patient had been given a dose of antibiotics too soon due to changes in the prescribing guidelines. A risk alert was raised and investigated. The family received an apology, the patient did not suffer harm, however the department placed a digital bulletin notice board in the clinical room with current alerts to remind staff of any policy or prescribing changes.

Staff understood their roles and responsibilities for raising concerns, recording concerns, safety incidents, and near misses and where to report them both internally and externally.

The service made sure that actions from patient's safety alerts were implemented and monitored. the unit safety performance is in line with national standards and the trust performed in line with similar services.

Data given to us for the year July 2018- July 2019, showed there were a total of 123 reported incidents, 74 resulted in no harm, 49 caused minimal harm. Themes included, abusive or disruptive behaviour, access appointments or delayed discharges, clinical assessments including imaging and blood samples and consent and confidentiality.

The service reported no moderate/severe harm or death in the last 12 months.

There were standardised arrangements in place for investigating safeguarding and safety events and incidents, when things went wrong. All relevant staff, services and service users were involved in reviews and investigations.

Staff participated in and, learnt from reviews and investigations carried out by all services and agencies involved in critical care. Learning was shared well, and actions were taken to make improvements

Medical staff and nurses would review internal incidents using a root cause analysis approach. Any themes were discussed at MDT and the monthly morbidity and Mortality meetings and we were shown minutes of these meetings, which covered all aspects of patient care.

There were effective arrangements in place to respond to relevant external safety alerts, recalls, enquiries, reviews and investigations.

Staff were aware of policies and procedures about major incidents and had immediate access to major incidents guidelines and flow charts. Staff told us they had undertaken a major incident role play scenario and felt competent in dealing with external safety alerts.

The unit held multi professional clinical governance meetings quarterly, where senior staff analyse morbidity and mortality and liaise with external services to improve patient outcomes.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

- From June 2018 to May 2019, the trust reported no never events for critical care at St Richards.

**Breakdown of serious incidents reported to STEIS**

We were shown evidence that in line with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from June 2018 to May 2019.

### Safety thermometer

**The service used monitored results well to improve safety. However it was not displayed for staff, patients or visitors to see.**

Safety thermometer data was not available during our inspection, however the trust monitors safety by using the Intensive Care National Audit Research Centre (ICNARC) model of critical care data collection.

Risk assessments for pressure ulcers and falls were part of the nursing assessment documentation and we saw these were up to date, completed and regularly reviewed. In records which identified patients who were at risk of developing pressure ulcers, we saw actions were appropriately followed up, such as use of a pressure care relieving mattress.

## Is the service effective?

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patient's subject to the Mental Health Act 1983.**

There was a truly integrated approach to assessing, planning and providing care and treatment based on national guidance and evidence-based practice.

The service care package included addressing, where relevant, their nutrition, hydration and pain relief needs. The safe use of innovative and pioneering approaches to care and how it was delivered were actively encouraged. New evidence-based techniques and technologies were used to support the delivery of high-quality care.

Staff followed clear and up-to-date policies and procedures. Peoples physical, mental health and social needs were routinely assessed. Care was adapted to meet individual needs, treatment was given in line with current legislation.

The unit's medical staff actively sought involvement in research and development, based on

current data of outcomes. In 2018/2019 the critical care team participated in several international research trials including;

- VIP 2 stand for the Very Old Intensive Care Patients study 2 (POETICS2 in the UK). The VIP2 study is an international, multicentre study of the critically ill and old intensive care unit population. The study gathers data from across the world about a patient's frailty, cognitive function, activity in daily life and co-morbidity. The aim is development and validation of a mortality risk scoring for old intensive care patients.
- Standard versus accelerated initiation of renal replacement therapy (STARRT) in Acute Kidney Injury (AKI) and nationally known as STARRT AKI which is a research programme that compares Acute kidney injury is a common and devastating complication of critical illness. Once AKI is established, treatment is supportive, and no intervention has been found to restore kidney function or improve overall survival. Renal replacement therapy (RRT), usually in the form of haemodialysis, is frequently needed to manage patients with severe AKI. Such patients have an in-hospital mortality that consistently exceeds 50% with delays in RRT initiation implicated as a contributor.
- The '65'Trial which is a programme evaluating the clinical and cost-effectiveness of permissive hypotension in critically ill patients aged 65 years or over with vasodilatory hypotension.

The trust won the national safety prize for the Annual Association of Anaesthetists twice in the last six years. One of these was for a doctor who had developed a new gel to enable the creation of simulation models for training clinical staff in the management of patients with different body shapes or anomalies.

The St Richards Hospital critical care unit uses the patient first quality improvement system which includes a standardised handover at the start of each shift. Patient First is a long-term approach to transforming hospital services for the better. The trust had seen marked improvements in care, the introduction of safety huddles strengthened communication, team working and raised standards of care, we saw evidence of this throughout our inspection. This standardised handover procedure, included all staff on the unit at the beginning of each shift and discussed staffing, capacity and acuity and news.

Staff protected the rights of patient's subject to the Mental Health Act (1983) and followed the code of practice**.** At patient handover's, staff routinely referred to the psychological and emotional needs of the patients, their relatives and carers (AMSAT) and the trust recently obtained funding to recruit a clinical psychologist for the unit to have counselling access readily available. The trust safeguarding team included a mental capacity act specialist lead.

A detailed individual handover took place at a patient bedside. On discharge, when a ward bed was allocated to a patient, nursing and medical staff contacted the speciality teams to give a handover and we saw evidence of this.

There were processes in place to protect against discrimination, when making decisions about peoples care and treatment. The trusts equality, diversity and inclusion policy supported the Equality Act 2010, and the Human Rights Act 1998. The guidelines had recently been reviewed and included an 'equality analysis template' used to analyse the effectiveness of the policy on protected groups. Staff had equality and diversity training which they accessed online, 90% of staff had completed this, and this was checked by the Nurse educator. Staff worked closely with the learning disability specialist nurse, the mental health team and the end of life team.

Trust investment in technology and equipment had improved patient care and treatment and made a positive influence on people's independence**.** The critical care electronic patient records that we were shown included a large patient NEWS observation chart. The digital chart highlighted abnormal observations in yellow. On the day of our visit staff were able to show us how quickly they could access policies and guidelines to make sure they worked within current guidelines to provide effective care.

Digital television screens had been introduced to highlight specific safety information to staff in a simple way. These were small computers that could be attached directly to large screens in prominent places to remind staff about specific things. We saw a screen that reminded staff about their responsibilities and the requirements of the Mental Capacity Act 2005.

Patients receiving intravenous (IV) medication and fluids were cared for by healthcare professionals competent in administering and assessing fluids and medications. The unit had invested in new pump portals that could house up to eight intravenous pumps, the devices were at a safe height and were always accessible to staff. Patients had the site of their IV medication checked daily and this was documented on the virtual ward observation chart, which followed the National Institute of Health and Care Excellence (NICE) quality statement 66 Version two.

Staff explained that they were able to document, fluid, nutrition and Thrombus Venous Embolism (VTE) assessments electronically when needed. Charts within the electronic patient records highlighted trends and flagged abnormal results.

There was an up-to-date on call list for doctors and pharmacists that had phone and bleep numbers. This meant nursing staff and quick and easy access for advice and escalating concerns.

The rights of people subject to the Mental Health Act (MHA) 1983 are protected and staff respect the guidance of the MHA code of practice. The trust has a dedicated mental capacity act lead who is part of the safeguarding team, all staff have mental capacity act and deprivation of liberty mandatory training.

The unit provided patients and families with information around accessing external services once they are discharged from the unit and makes the right referrals when needed.

The Guidelines for the Provision of Intensive Care Services 2015, states that patients discharged from an intensive care unit must have access to an intensive care follow up clinic. Patients who had been an inpatient in the critical care unit for more than 72 hours, were offered to attend a follow up clinic.

Staff were actively involved in audits research and data collection, and in certain cases could be asked to review reported incidents and create a route cause analysis to identify trends. Outcomes of audits are discussed at monthly meetings.

## Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service adjusted diets for patients' religious, cultural and other needs.**

Staff used alternative feeding and hydration methods when necessary. The service adjusted care to ensure that the patients' religious, cultural and other needs were met.

There was a dietician assigned to the unit and they joined the ward round in the morning and liaised with the MDT assessed and addressed nutrition and hydration. The dietician supported

staff, patients and families and ensured seriously ill patients were given the correct diet during their stay on the unit.

In the case of patients restricted from food, the dietician would review and discuss nasal gastric (NG) feeding and food supplementation with patients and families.

We looked at the critical care digital patient records and saw that fluid balance and nutrition charts were accurately completed.

## Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way**. **They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

Acute pain management was discussed with the consultants and pharmacists, who joined ward rounds and reviewed pain medication.

The service supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain when needed.

Staff had electronic access to pain assessment tools and knew how to assess pain levels in non-verbal patients.

Pain scores were measured using standardised scoring methods. All patients with acute pain were given individualised analgesia which was suitable for their condition, safe and effective.

Links to drug charts were available via the digital patient records and pain assessments were routinely carried out.

## Patient outcomes

**All staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. Opportunities to participate in benchmarking and peer review were proactively pursued, including participation in approved accreditation schemes. High performance was recognised by credible external bodies. Outcomes for people who used the service were positive, consistent and on occasions exceeded expectations.**

The outreach team supported nursing staff on wards to stabilise patients outside of the unit. The team were actively involved in resuscitation, including decisions about patients who have a ‘do not resuscitate requests (DNR)’ documented on their patient records. Since the introduction of the extended cover there had been a decrease in cardiac arrest events, as the deteriorating patient had been identified early, this had also helped with access and flow as they stabilised patients and, in some cases, reduced the need for admission to critical care.

The service participated in national audits, Intensive Care National Audit Research Centre and the NHS Blood and Transplant national potential donor audit. The results were used to benchmark and compare with other trusts nationally. Information provided by the department identified that it audited a range of pathways including those used from the Intensive Care National Audit Research Centre. Action plans were in place to improve areas in the audit that were not at the required level.

Information about the outcomes of peoples care and treatment routinely reviewed by staff. The digital patient care records collected data on, Thrombus Venous Embolism (VTE) assessment, Methicillin-resistant *Staphylococcus aureus* (MRSA) swab checks, and links to medication data was checked weekly by the IT nurse specialist.

The trust organ donation service was rated Gold in 2018/19 by the organ donation service. The trust achieved 100% early referral rates and 100% Specialist nurse for organ donation (SNOD) attendance who along with medical staff that identified potential donors had sensitive conversations with patients and relatives for anyone meeting the referral criteria. Western Sussex facilitated 12 actual solid organ donations resulting in 29 patients receiving a transplant during the standard period.

The hospitals standardised mortality ratio (HSMR) for the critical care units was 0.85 – 0.9. Hospital mortality is defined as death before ultimate discharge from acute hospital. A mortality ratio is calculated by dividing the observed by the expected acute hospital mortality, with the expected estimated by a risk prediction model, a mortality ratio is one (1.0) when the observed and expected acute hospital mortality are equal. Western Sussex hospitals Critical Care units performed much better than expected when compared to other critical care units.

The unit staff worked with the Specialist Palliative Care team. Patients identified as approaching the end of their life could choose to be transferred home direct from the critical care unit. This meant that the data submitted to Intensive Care National Audit Research Centre would look worse for the trust because of the number of patients.

We saw the service participated in the Commissioning for Quality and Innovation (CQUIN) to reduce the delayed discharges from adult critical care to ward level care by 30%. The trust achieved a 75% reduction in their delayed discharges from the critical unit to the ward, which they have maintained.

Doctors held monthly morbidity and mortality meetings to discuss unexpected care events such as sepsis, deaths on the unit, infection risks and routinely reviewed patient records and we saw evidence of these. Outcomes were monitored, and trends discussed, improvements to care were made based on the data collected.

The consultants encouraged doctors to be involved in research projects to improve the morbidity and mortality of patients. Medical staff told us that one example of this related long-term use of breathing apparatus masks. Long term use of the masks can leave sores on the patients face so staff were looking at ways to improve comfort and fit of the masks, this research was ongoing. We reviewed data that proved staff provided high quality care and improved the patients experience.

**ICNARC Participation**

The trust submitted data to the Intensive Care National Audit & Research Centre (ICNARC). he most recent data was only made available during the week preceding the inspection visit. It was not yet available on the Intensive Care National Audit & Research Centre website, but we were provided with it by the trust. They were able to explain and provide details of what the data and annual report were showing for their service. All indicators showed performance about comparator trusts and within two standard deviations from the average. Both sites had performance that was better than expected and better than peers

**ICNARC results**

**St Richard's Hospital**

- The units ICNARC data results March 2018-19 confirmed that critical care is meeting and, in some cases, exceeding national targets.

The table below summarises the performance at St Richard's Hospital Intensive Care Unit in the 2017/18 ICNARC Audit.

| Metrics *(Audit measures)* | Trust performance | Comparison to other Trusts | Meets national standard? |
|---|---|---|---|
| **Crude non-clinical transfers** *(Transfers made for non-clinical reasons often relate to patient flow and capacity issues which may add to patient risk, prolong intensive care unit stay and cause distress to patients and carers)* | 0.0% | Within expected range | ✓ |
| **Crude, non-delayed, out-of-hours discharge to the ward proportion** *(Discharge out-of-hours is associated with increased risk of mortality)* | 1.6% | Within expected range | ✓ |
| **Crude delayed discharge (% bed-days occupied by patients with discharge delayed more than 8 hours)** *(Discharge from critical care should be within four hours of decision to discharge and occur as early as possible in the day*) | 1.1% | Not in the worst 5% of units | ✓ |
| **Risk-adjusted hospital mortality ratio (all patients)** *(Risk-adjusted measures take into account the differences in the case-mix of patients treated*) | 1.0 | Within expected range | No current standard |
| **Risk-adjusted hospital mortality ratio for patients with predicted risk of death less than 20% ('lower risk' patients)** *(Risk-adjusted measures take into account the differences in the case-mix of patients treated*) | 0.9 | Within expected limits | No current standard |

## Competent staff

**The continuing development of the staff skills, competence and knowledge was recognised as being integral to high quality care. Staff were proactively supported and encouraged to develop new skills, use their transferable skills and share best practice. Managers made sure staff received any specialist training for their role.**

Managers identified the training needs of staff and gave them opportunities and times to develop their knowledge and skills. Staff were competent, experienced, qualified and had the right skills and knowledge to meet the needs of the patients. The critical care unit had a dedicated clinical nurse educator at band 7 level who was responsible for organising mandatory training, liaising with

local university links, supporting preceptorships, promoting staff development and continual professional development.

There was an induction process for all new starters. Nurses were given supernumerary status for four weeks before working independently**.** Junior nurses were given a one-year preceptorship programme, gain competencies under supervision and with full support of senior staff. Band 6 nurses were encouraged to manage shifts to help develop their managerial involvement. Staff told us they felt supported to develop their knowledge and skills.

We looked at five staff appraisals which were fully completed and showed staff were compliant. The unit exceeded trust targets for appraisals currently over 95% have had their annual appraisal. Staff told us they received feedback from their team leaders and understood their performance targets, aims and development pathways. Management were keen to 'grow their own' we learnt that one health care assistants (HCA) was currently working on the unit as an apprentice.

Individual members of the multidisciplinary team had designed complex teaching aids that allowed other staff to become familiar with and competent in key skills such as managing complex airways. The unit had a training simulator and offered high fidelity simulated training to all members of the multidisciplinary team.

Doctors ran weekly training sessions which at times included, simulated learning using mannequins and equipment.

The unit had a competent team of support staff who were appropriately trained, competent and familiar with the unit's equipment. The team were used to with providing emotional support to families and friend. The unit held a health care assistant development day, and staff were taught basic observations and life support methods.

The physiotherapy team told us they offer shadowing to junior staff to improve kills.

Schwartz Rounds provide a structured forum where staff, come together regularly to discuss the emotional and social aspects of working in healthcare. The trust held an open Schwartz Round for consultants because they recognised that the consultant body was less likely to access other support systems but had the added pressure of supporting junior staff with their wellbeing. The purpose of rounds was to understand the challenges and rewards that are intrinsic to providing care. Rounds can help staff feel more supported in their jobs, allowing them the time and space to reflect on their roles.

The medical staff on the critical care unit were comfortable having difficult conversations about a patient's prognosis. This was consultant led but often supported by the hospital chaplain.

**Appraisal rates**

From 17 April 2018 to 16 April 2019, 96.4% of staff within the critical care department at St Richard's Hospital received an appraisal compared to a trust target of 90%. The appraisal target was met by all staff groups.

**St Richard's Hospital**

| Staff group | 17 April 2018 to 16 April 2019 | | | | |
|---|---|---|---|---|---|
| | Staff who received an appraisal | Eligible staff | Completion rate | Trust target | Met (Yes/ No) |
| Additional Clinical Services | 3 | 3 | 100.0% | 90% | Yes |
| Administrative and Clerical | 1 | 1 | 100.0% | 90% | Yes |

| | | | | | |
|---|---|---|---|---|---|
| Estates and Ancillary | 1 | 1 | 100.0% | 90% | Yes |
| Nursing and Midwifery Registered | 49 | 51 | 96.1% | 90% | Yes |
| **Total** | **54** | **56** | **96.4%** | **90%** | **Yes** |

From 17 April 2018 to 16 April 2019, 95.6% of staff within the critical care department at Worthing Hospital received an appraisal compared to a trust target of 90%. The appraisal target was met by all staff groups.

*(Source: Routine Provider Information Request (RPIR) – Appraisal tab)*

**Qualified nursing staff**

As of 17 April 2019, the trust reported that 56 nursing staff had a post registration award in critical care nursing.

Site breakdown can be seen below:

| Site/Location/Unit | Total number of nursing staff in unit (qualified) | Total number of nursing staff with post registration award |
|---|---|---|
| Worthing Hospital Critical Care Unit | 59 | 31 |
| St. Richard's Hospital Critical Care Unit | 54 | 25 |

There were also 113 staff with training in specialised equipment.

Site breakdown can be seen below:

| Site/Location/Unit | Total number of staff (qualified and unqualified) | Total staff with up to date training in specialised unit equipment |
|---|---|---|
| Worthing Hospital Critical Care Unit | 66 | 59 |
| St. Richard's Hospital Critical Care Unit | 58 | 54 |

*(Source: Acute Routine Provider Information Request (RPIR) – CC-staffing tab)*

## Multidisciplinary working

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. Services were committed to working collaboratively and found innovative and efficient ways to improve and deliver joined-up care to people who used the service.**

There was a rich culture of multidisciplinary working. The ward round consisted of doctors, nurses, physiotherapists, pharmacists, radiologists and dietician. The microbiologist attended the ward at noon every day to review patient care, lab results and current medication.

All health care professionals had input into the planning, assessing and delivering of patients' care and treatment. Staff told us they were proud of good multidisciplinary team working, and we saw this in practice. Staff were considerate and helpful to one another. For example, the unit staff worked with the Specialist Palliative Care team to enable relatives to take home their son at the

end of his life, direct from the critical care unit with the appropriate support, equipment and medication.

Referrals to the end of life care team could be made by telephone or using a webform that was checked twice daily. The team responded in the same day that the referral was made.

One patient who was in acute renal failure but who insisted they were quite well and wanted to go home. They were discharged from the unit having agreed to accept support from the community team from the local hospice.

When an acutely unwell patient was admitted to the hospital via the emergency floor or medical assessment units, consultants and outreach staff were said to 'walk side by side, with the palliative care team staff and emergency department staff until the best decision for the patient's ongoing care and treatment was made. The decision was usually based on what a patient wanted. The consultants involved in the care agreed who would have the discussion around the patient's wishes, the ceiling of care and what was appropriate.

Specialist palliative care consultants sat alongside critical care consultants as part of the combined Mortality and Morbidity and End of Life Care board.

Critical care nurses are not involved in discussions around organ donation, as that would be a potential conflict of interest the discussions are done by a doctor or end of life nurse. Nursing staff continued to support families where patients were going through a donation process but were not involved in the decision making nor offered advice on the whether to donate.

## Seven-day services

Consultants were on site every day from 08.00pm until 6.30 pm. All on-call consultants were available over the phone and available to attend within 30 minutes from their place of residents. Senior doctors provided round-the-clock cover on the unit with the support of junior doctors.

Key services were available seven days a week to support prompt patient care.

However, the critical care outreach team covered the hospital 7 days a week 8am-8pm. There were arrangements in place to mitigate this and site managers who were very experienced nurses were able to advise on the management of deteriorating patients.

## Health promotion

**Staff were consistent in supporting people to live healthier lives, including targeting those who needed extra support, through a proactive approach to health promotion and improving ill-health, they used every contact with people to do so.**

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. There were guidelines in place to support patients withdrawing from drugs or alcohol. Consultants would provide advice and support. If patients smoked, nicotine patches could also be prescribed and provided to patients.

They referred patients to specialist teams as needed, for example the diabetes team, physiotherapists and pain team.

Follow up clinics took place once a month. This meant that the service made sure they had opportunities for ongoing assessment and providing advice on rehabilitation and health promotion.

A range of patient information leaflets were available for patients and families. This included information such smoking cessation.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Practices around consent, and records were actively monitored and reviewed to improve how people were involved in decisions making regarding their treatment and care.**

**Mental Capacity Act and Deprivation of Liberty training completion**

Staff demonstrated a good understanding of the Mental Capacity Act. Staff we spoke with were clear about how to assess a patient who lacked capacity. There was a designated mental capacity nurse lead Specialist teams, such as dementia or learning disabilities were available to give guidance on the Mental Capacity Act and Deprivation of Liberty Safeguards if required. Staff told us they worked with family members at best interests' meetings where patients lacked capacity, to get the best outcomes for patients.

The trust had a Mental Capacity Act and Policy on Reducing the need for Physical

Interventions policy. There policies referred to the Mental Capacity Act Code of Practice and the Deprivation of liberty code of practice and were in line with current national guidance.

The Trust data for Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training, are included within the safeguarding level 2 training module. There is also a separate MCA e-learning module available to staff.

A breakdown of compliance for MCA/DOLS training courses (as part of the safeguarding level 2 training modules) from April 2018 to March 2019 at trust level for qualified nursing staff in critical care is shown below:

**St Richard's Hospital critical care department**

A breakdown of compliance for MCA/DOLS training courses (as part of the safeguarding level 2 training modules) from April 2018 to March 2019 at St Richard's Hospital for qualified nursing staff in critical care is shown below:

| Training module name | April 2018 to March 2019 | | | | |
|---|---|---|---|---|---|
| | Staff trained | Eligible staff | Completion rate | Trust target | Met (Yes/No) |
| Safeguarding Adults (Level 2) | 44 | 52 | 84.6% | 90% | No |
| Safeguarding Children (Level 2) | 15 | 52 | 28.8% | 90% | No |

At St Richard's Hospital critical care department, the 90% target was met for none of the two safeguarding level 2 training modules for which qualified nursing staff were eligible. Data provided after the inspection showed the department met the 90% target in one of the two safeguarding level 2 training.

*(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)*

# Is the service caring?

## Compassionate care

**There was a strong visible person-centred culture to providing care of the unit. Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**

During our inspection we saw a highly motivated and passionate team, offering care that was kind and protected people's dignity. Relationships between patients, those close to them and staff were strong, compassionate, supportive, and respectful.

Staff took time to truly interact with people. The National Institute of Clinical Excellence (NICE 2012) Patient experience in adult NHS service Quality statement 15 (1) recommends, that staff get to know their patients as individuals, we could clearly see this on the critical care unit. Staff treated patients holistically and care was personalised.

There was a strong and visible person-centred culture of care on the unit. Staff were highly motivated, sensitive to the needs of their patients and relatives. They promoted compassion and dignity and all time and spoke to patients in language they could understand.

People had access to a host of health care professionals which included, learning disabilities specialist nurses, the mental health team, dementia nurse and the end of life specialist nursing team.

Whilst on the unit we saw a patient being admitted. The allocated nurse undertook equipment checks before the patient arrived and made sure the bed and area were fit for admission. The outreach team had escorted the patient to the unit and a full and safe handover was given. The patient was attached to 24 hour monitoring equipment, which was viewable at the staff work station. The assigned nurse used digital care records to document vital observations of the patient. Care was explained to the relatives once the patient was settled. The consultant supported staff by speaking to relatives and documented a plan of care in the digital patient records.

The trust had policies for challenging behaviour and we saw evidence of this. The mental health policy had a section on dealing with delirium and distressing behaviour. Staff told us they had conflict resolution training via an e-learning module, to help them deal with distressed and abusive people.

Staff ensured that people's dignity and privacy were respected when during examinations and intimate care. Privacy was always considered and maintained on the unit.

One example of compassionate care was that staff raised funds to buy sound monitoring equipment, called the 'sound ear' to make sure noise levels were kept to a minimum. This was placed centrally when a patient and family were going through a difficult time to make sure all staff kept noise to a minimum.

Staff told us they were aware of communication and cultural differences that arise. They provided examples of how they adapted communication styles to make sure the service provided the right support to people. For example, staff told us about a patient who was admitted with learning difficulties, who had trouble communicating. Staff learnt Makaton, the sign and symbols language speak with him.

We observed staff responding in a compassionate, appropriate and timely way when people were experiencing pain, discomfort or emotional distress.

Patients we spoke to gave positive feedback about the care they received. Examples included comments like "Staff are kind, courteous and compassionate", "Pain relief is provided when needed, and I feel included in the care and treatment I am receiving", "doctors are kind and explain everything", and finally "staff always introduce themselves and quickly answer the call bell'.

## Emotional support

**Staff recognised and respected the entirety of people's needs. They understood the impact that a person's care, treatment or condition had on their wellbeing and on those close to them, both emotionally and socially.**

Staff were always considerate of people personal, cultural, social and religious requests and found innovative ways to meet them. Peoples emotional and cultural needs were known to be as being as important as their physical needs.

The Critical care unit devised services that allowed people to express their views and be actively involved in decisions about their care, support and treatment wherever possible.

Our team observed that end of life care was embedded into practice amongst the team, staff told there was lots of support for families and patients facing difficult decisions. The unit had access to a dedicated end of life and bereavement team and all staff provided support for people involved in end of life diagnosis. The trust Chaplin was also available to offer support to relatives and carers and was present on the day of our inspection. A family room and kitchen for relatives was available for those who needed it.

Appropriate and timely support and information were given, to help people cope with their condition. All staff on the unit understood the impact that critical care, disability and treatment had on patients and families emotional and cultural wellbeing. Patients who were given life changing diagnosis were always given the appropriate emotional support and access to other support services.

Patient diaries were provided used for people who needed to stay longer than 72hrs, to document care and activities daily on the unit. Visitors could write comments and nursing staff would write a short summary of the patient's condition. This helped patients recovering from unconsciousness to understand the treatment they received whilst on the unit. NICE quality statement 15 (2) states 'patients experience effective interactions with staff who have demonstrated competency in relevant communication skills.

One entry by a family member wrote about the patient's condition and how it had improved, the comment was "you are looking so much better" and "looking forward to having you closer to home".

The team excelled in providing emotional support for patients suffering from life changing conditions, bariatric surgery or terminal illness. An example given to us was regarding a young man developed a condition that left him paralysed for a long stay, on critical care. His mood became low and despite daily intensive physio, speech, language and occupation therapy his recovery progress was slow. The physiotherapists decided to try hydrotherapy. The team researched and planned ways to transfer this high-risk patient to the hydropool outside critical care. They developed a guideline and preparation checklist to make sure his safety in water with a complex breathing apparatus (tracheostomy). Following several sessions in the pool the patient's mood rapidly improved and he made significant progress with strength and mobility. Being able to move in water was a huge boost for him. This patient now runs marathons raising money for critical care and last year returned to the unit to thank the team for all their hard work and care.

Patients we spoke to felt emotionally supported, comments included, "Thank you all so much for your incredible care, patience, support and cheeriness" and "staff made this appalling time more

bearable because they individually and collectively had that ‘special indefinable magic’ (something that can’t be made or instilled – it’s either there or it isn’t!!)”.

## Understanding and involvement of patients and those close to them

**Staff involved patients and those close to them in decisions about their care and treatment. Relatives of patients told us they felt involved in decisions. We saw staff communicate with patients and their relatives in a way which they could understand, and they asked patients if they understood what had been discussed.**

People who used the service and those close to them were active partners in their care. Staff showed total commitment to working in partnership with people.

Staff always empowered people who used the service to have a voice and to realise their potential. They showed determination and creativity to overcome obstacles in care delivery. Peoples preferences and desires was always tailored to meet their individual needs.

Staff made sure peoples communication needs were met by linking with best practice and learning from it. Communication aids were used to help people become partners in their care and treatment. For example staff raised money to buy orientation boards white boards which are placed the end of the bed to help with communication. Learning disability and dementia link nurses accepted referrals and visited the unit to support patients with communication problems and interpreting services were available when needed. Staff had also had access to pictorial and visual aids.

To overcome language barriers, staff told us they would use their families to communicate normal procedures or contact language line or book interpreters for more complex care.

Families of patients who donated their organs, were given the opportunity to follow up on a donation which for many acted as a comfort in their time of loss. The ‘Join the NHS Organ Donation Register’ leaflet was available on the unit to raise awareness for this national cause.

Patients and families were given a guide to intensive care whilst on the unit. The trust published a patient handbook which contained information regarding the value of hospital radio broadcasting for patients. Included in both leaflets were contact details of the patient advice and liaison service and external support networks. The trust gave all patients contact details for the ‘time to talk’ counselling service, which helped people who may have been traumatised by a life changing medical condition or diagnosis.

The multidisciplinary team supported patients and families to understand the relevant treatment options relating to their care, which included, risk, benefits and potential consequences. Staff acknowledged that people needed to have links with their support and advocacy networks in the community and made sure external links were established. People were truly empowered to link and use support networks and advocacy.

National Institute of Health and Care Excellence, quality standard 15, statement 4 states that patients and families should always been involved the decision-making process. People told us they felt like partners in their care, staff routinely involved people and those close to them in planning and decisions about their care and treatment. Family members told us that staff they felt included in the care of their relatives we heard comments like “I feel involved in his treatment and decisions about his care” “each time we visited we are greeted with a happy face and we are on first name terms with staff” and finally “overall staff provided outstanding care”.

People were encouraged to give feedback about the service via the friends and family test. St Richards critical care unit received positive feedback. In June 2019 50 people provided feedback about the service, and 90% of these said they were extremely likely to recommend the service, with 6% likely. Nobody said they were unlikely to recommend the critical care unit to provide care.

## Is the service responsive?

### Service delivery to meet the needs of local people

**The service planning and delivery of care truly met the needs of local people and the communities it served. It worked well with others in the wider system and local organisations to plan care.**

The intensive care unit was a ten-bedded unit that provided care for patients needing advanced respiratory support (ventilation), advanced renal support (hemofiltration) and other complex therapies. Patients received one to one or one to two nursing, depending on their needs. A doctor was always available, and patients were seen regularly throughout the day.

The Intensive care society set out guidelines for the Provision of Intensive Care Services (2015) states the ‘art’ of intensive care lies more in integrating multi-professional care and complex interventions over time, across locations and between teams, than in the delivery of any single treatment (Julian Bion 2015). We were shown examples of integrated multidisciplinary work throughout our inspection. Care, and services were designed to meet the needs of patients with complex health needs. Managers reviewed, planned and organised services on a regular basis, so they met the needs of the local population, at St Richards we saw examples of this.

Staff made sure that people were told when they may need to seek further help and advice and what to do if their condition deteriorated. People were regularly referred to occupational therapists, physiotherapists, end of life nurses and community care links. The unit provided patients and relatives with information leaflets which contained detailed information on their care and resources available during and after admission.

The service made sure that patients were followed up after discharge, follow up clinics were in place in line with recommendations from the Guidance for the Provision of Intensive care (2015). A band 6 outreach nurse runs the clinic. Patients were offered an appointment a month after discharge. Staff could refer patients or patients can request to be seen.

The outpatient clinic ran with no time limit for patients, to allow for a review of their stay. Their patient diary acted as a valuable tool, some patients chose to take a tour of the critical care unit, so they could understand their care. The service supported the children of patients and gave patients links to national support services. However there is a risk associated with only having one staff member covering this valuable clinic, in case of sickness or annual leave or support. The trust aimed to increase staffing in the future.

The facilities and premises were suitable for the services being delivered. On the day of our visit we were told that the unit had recently been redecorated and thought had gone into the lighting and the space around the beds. However there were only two isolation rooms. The Trust had reported this fact to the risk register and had written a business plan to extend its estates and facilities and currently funding was awarded to draw up plans to rebuild the Worthing Critical care site.

A staff member told us that there was a standard procedure for preparing patients being transferred to the wards. This included optimising the patient's ventilation for transfer, liaising with the ward about special needs and equipment and setting goals for rehabilitation. The service did not have access to regional home ventilation weaning unit, all patients with complex weaning problems were referred to the respiratory team.

There were innovative approaches to providing integrated person-centred pathways with other care providers and local organisations to plan and deliver holistic care particularly for people with multiple and complex needs. For example, a senior physiotherapist was trained to perform lung ultrasound and accredited with a Core Ultrasound in Intensive Care (CUSIC). The medical team supported the physiotherapist to use safer scan equipment to promptly identify lung infection and exclude pneumothorax; which speeded up diagnosis and reduced exposure to radiation.

## Meeting people's individual needs

**The service was inclusive and took account of patients' individual needs and preferences. There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that meets these needs, which is accessible and promotes equality. This included people with protected characteristics under the Equality Act, people who may be approaching the end of their life, and people who are in vulnerable circumstances or who have complex needs.**

Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. People were treated as individuals and their care was designed to take all their needs into account.

Staff had a good awareness of the possibility of patients suffering from delirium because of complex treatment. The department was committed to making patients feel safe and secure, and keeping noise levels to a minimum.

Physiotherapists told us that they ran twice weekly rehabilitation goal setting for patients, the first assessment was done within four days of admission and involved various members of the multidisciplinary team. The lead physiotherapist follows patients through their hospital stay and after discharge and links with the community follow up nurse.

The unit made sure that it had beds to accommodate bariatric patients' beds were designed to sleep patients weighing up to 195kg.

People were supported by a dedicated end of life team who were advocates to people and relatives facing end of life decisions. Families were supported in their decisions and on how to make practical arrangements, staff went above and beyond to meet the needs of service users and we saw examples of extensive multi-disciplinary working.

One example of this was a young 17-year-old man who had been born with a degenerative condition. The family cared for him at home and when care had reached the point where it needed to be palliative the family asked if he could be sent back home. The staff held an MDT meeting and the families wishes were granted and they took their son home with community support to end his life in a dignified manner.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs in line with the Mental Health Act 1983. On the day of our visit staff showed a deep understanding of issues relating to mental capacity including

to dementia, learning disabilities and mental health patients. The trust had a designated mental capacity specialist nurse who supported the unit. Consultants and nurses told us that they had good relationships with their mental health colleagues, they could tell us how and where to make the proper referrals to the psychiatric team when needed.

The trust had a Mental Health Strategy that was known to the staff on the critical care units. Staff recognised the short- and longer-term impact of critical illness on patients and their families and had developed ways to assist them in dealing with this. A Business Case for the unit to employ a senior clinical psychologist was awaiting sign off. The psychologist would be available part-time to support the emotional needs of the patients and run follow up clinics, so patients can debrief after being discharged.

We were given good examples of innovative practice by staff to enhance the patient experience. Staff raised £12,000 for the unit through a cake sale, charitable ball, a 10k run and a triathlon. Staff purchased orientation white-boards and a sound monitoring unit called the 'sound ear'. The sound ear could be set at different levels throughout the day and night and was colour coded and lit up when sound reached certain levels. This ensured that staff and relatives were mindful of the noise levels within the unit

The orientation white-boards were used for patients who were unable to communicate, for example patients with learning difficulties, dementia and unconscious. Families could add information including photos to the board, so everybody involved in their care understood and conversed with them with a deeper understanding. The boards included information such as, patients first language, religious or spiritual beliefs, a list of names of close relatives and friends, pets, mobility information, daily routine, hobbies, and favourite food and music.

Staff told us that if they received patients who could not speak English, they would attempt to book a face to face interpreter for as soon as possible for the conscious patients for medical consent and diagnosis. Family was used for 'how are you feeling' conversations. The staff had access to language line. The staff could access a sign language interpreter via LD CND and used visual/pictorial aids.

Staff could access all clinical nurse specialists the list included, learning difficulties, dementia link nurse, stoma nurse, palliative care nurses and pain control every effort was made by staff to ensure it was accessible to the needs of vulnerable people with complex needs.

Patients were given a choice of food and drink to meet their cultural and religious preferences. On the day of our inspection, the unit made every effort to ensure people's needs and choices were met. The dietician works closely with the team to manage patients who are being fed via a tube or are being weaned back to solid food.

## Access and flow

**People could access the service when they needed it and received the right care promptly. There was innovative use of technology which ensured people had the right access to care and treatment.**

From May 2018 to April 2019, Western Sussex Hospitals NHS Foundation Trust has seen adult bed occupancy that has shown some variation for the last six months of the period. Overall the trust's performance is in line with NHS national averages, though it has been better than the average for the last two months of the period.

The Royal College of Anaesthetists recommends 70% occupancy for critical care services, to allow capacity for emergency admissions. The unit had seen 650 admissions in the year March 2018-19, we saw data that showed average daily bed occupancy and patients per consultant was between 6.5 to 7.5%. Consultant to patient ratio averaged 1.7.

Consultants told us that they aim to assess all patients within half hour of admission to the unit either face to face or remotely via telephone with their registrar when they are on call.

Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards**.** Managers monitored length of stay and acuity and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

Staff had access to brand new technology, a lung density scanner was used to diagnose lung conditions accurately and quickly. Diagnostic digital software was on display throughout the unit, staff could view patient conditions at the nursing station.

Staff had been involved in the design of their virtual ward digital patient records, which allowed clear and quick access to patient records. For example critical care and the outreach team could view each other's patient register via the system. The outreach team and consultants also had remote access the patient records, which allows patients to be reviewed quickly and carefully.

Staff were mindful of the complex needs of their patients and endeavoured to make sure patients were assigned to the right level of care. Although this was a mixed sex area, staff knew about and understood the standards for mixed sex accommodation and knew how and when to report any potential breaches. Space between beds was adequate and curtains could be drawn for personal care.

Mental health patients referred to the psychiatric team, need to be medically stable and pain free before assessment. Patients who had been sectioned under the mental health act section 47 were medically stabilised before having a psychiatric review. Staff reported that the mental health team could be contacted round the clock and were incredibly supportive, wherever possible. However the staff were unable to say how quickly and there was no audit for this.

At shift handovers staff discussed bed capacity. Patients were prioritised by need staff were assigned to patients. Concerns about staffing, equipment or the unit were highlighted and trust wide or local health concerns can be reported. On the day of our visit the UK was experiencing high temperatures and the possible increase in demand on the service was discussed, as well as keeping patients and staff hydrated and cool.

The service managed beds for elective colorectal surgery which needed post elective level 2 care well. In periods of high demand critical care outliers were managed by the outreach team in Emergency Department a designated area of the recovery unit. Beds were triaged according to need, and the outreach team attended the huddles and liaised with the unit on any patients who qualified for outreach care, to avoid admissions to the unit. Staff told us that in many instances the outreach care had a positive effect on patient care and flow.

To help make sure that patients with infections recovered well, the microbiologist visited daily at noon to review patients, discuss lab results, medication and support staff with any ongoing concerns.

We were told by the consultants that it is rare to transport a patient to another critical care for a non-clinical reason. There was one incident during the winter pressure months, where a patient was transferred to Worthing. Ambulance staff were used along with a critical care nurse. There

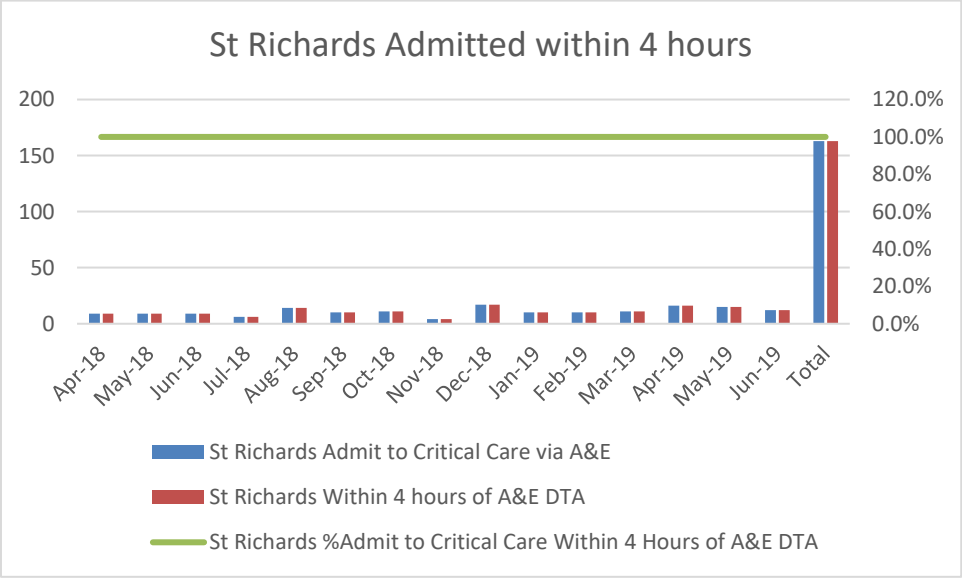
have also been incidents where they have taken a patient to Worthing and bought one back to St Richards. This was to manage level 2 and 3 bed needs within the whole trust. In the last 12 months St Richards critical care had no non-medical transfers.

Transfers during 10pm and 7am where avoided where possible and there would be a pre-discharge meeting to discuss these.

Staff acknowledged that access and flow were vital to help run a good service and they make every effort to ensure patients were discharged home within recognised time frames. However caring for patients individualised needs are prioritised, and delays may occur for a patient with complex needs who requires a care package within the community.

**Percentage of patients admitted to critical care within four hours of decision to admit**

The trust made sure that people with the most urgent need have their care and treatment prioritised. Data supplied to us by the trust showed that the average percentage of patients admitted to critical within four hours of decision to admit was 100%.

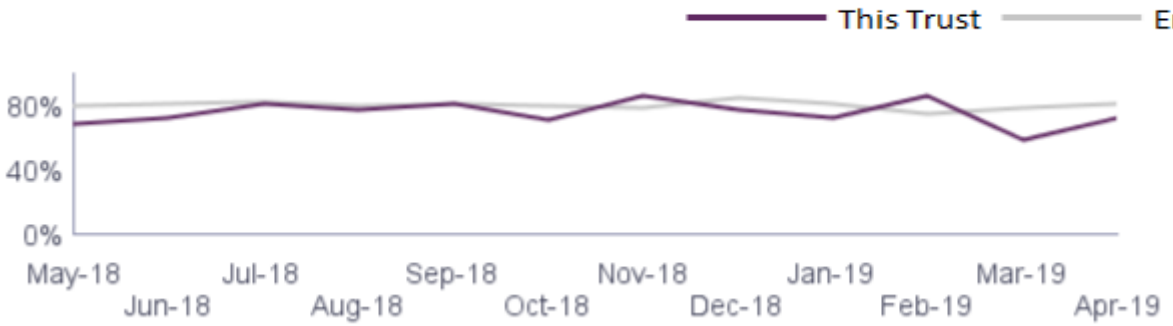



**(***Source ADR RYR16*)

**Bed occupancy**

From May 2018 to April 2019, Western Sussex Hospitals NHS Foundation Trust has seen adult bed occupancy that has shown some variation for the last six months of the period. Overall the trust's performance is in line with the England average, though it has been better than the average for the last two months of the period.

**Adult critical care Bed occupancy rates, Western Sussex Hospitals NHS Foundation Trust.**




Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

*(Source: NHS England)*

## Learning from complaints and concerns

**It was easy for people to give feedback and raise concerned about their care and treatment. The service treated concerns and complaints seriously, investigated them and shared lessons learnt with all staff. It was clear what improvements had been made because of learning from reviews and feedback.**

The unit displayed patient information boards in the corridors, with lots of information for patients. The information included, accessing support groups, local community support, patient information and the contact details for the patient advice and liaison service (PALS).

Discharged patients were made follow up outpatient appointments and given a critical care discharge leaflet. The discharge notification included details of what to do if you have concerns and contact information. The trust website had a dedicated 'give us feedback' and 'make a complaint' tab on its home page.

We were shown the only two complaints over the last year, and the responses from staff. The unit responded on time, conducted full investigations and shared as much information as possible within the confines of the general data protection regulation (GDPR)

The trust confirmed that there have been nil complaints referred to the Parliamentary and Health Service Ombudsman in the last 12 months.

(*Source: St Richards site complaint references 58371/62252*)

**Summary of complaints**

**Trust level**

There had not been any complaints about the critical units on either site that would trigger a formal response under the duty of candour regulation. The duty of candour is enforced by regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which states that, Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

From April 2018 to March 2019 the trust received one complaint in relation to critical care at St Richard's Hospital. The trust took an average of 13 days to close this complaint, which is in line with their complaints policy, which says complaints should be closed with 25 days. The topic of the complaint was about the attitude of nursing staff.

*(Source: Routine Provider Information Request (RPIR) – Complaints tab)*

**Number of compliments made to the trust**

From April 2018 to March 2019 there were 95 compliments about critical care at the trust. A breakdown of compliments by site is below:

| Site | Number of compliments | Percentage of total |
|---|---|---|
| St Richards Hospital | 91 | 96% |
| Worthing Hospital | 4 | 4% |
| **Total** | **95** | **100%** |

*(Source: Routine Provider Information Request (RPIR) – Compliments tab)*

## Is the service well-led?

### Leadership

**There was an inclusive, effective and compassionate leadership structure. Leaders at all levels had high levels of experience, and continually demonstrated the capability and capacity to provide excellent and sustainable care. Deeply embedded systems of leadership and succession planning aimed at ensuring leadership represented the diversity of the workforce was evident.**

There was noticeably clear leadership of the service with a structure that was mirrored on both acute sites. Critical care services sat within the Surgery Division under a triumvirate leadership of a Director of Operations, a Chief of Service and a Head of Nursing.

Below this tier of leadership sat the Critical Care, Theatres, Anaesthetics and Pain Management Care Group. The cross-site leadership of this service was also a triumvirate structure with a Clinical Director, a Care Group Manager and a Matron. The triumvirate was supported on each site by a Clinical Site Lead.

Since the last inspection in 2015, there had been improvement in the consultant level cover at each site. There was now consultant level leadership of patient care 24 hours a day seven days a week.

The trust had invested in a split consultant intensivist rota allowing for cover and specialist review of admissions on the unit or via remote access when the consultants are on call. All newly appointed consultants were both anaesthetic and intensivist trained and all longer serving intensivists were appropriately qualified anaesthetist with additional intensivist recognition through significant experience. This meant there was always appropriately qualified expertise and leadership available to unit staff.

Since the last inspection, the trust had reviewed their nursing model and increased the establishment to provide a supernumerary nurse in charge on all shifts.

The Care Group and Surgical Division leaders supported staff to develop innovative ways of reinforcing staff learning and competency. Individuals and teams of staff had designed complex teaching tools that enabled other staff to become familiar with and competent in key skills such as managing complex airways.

The leaders, at all levels from trust board to site level leaders were visible, respected and approachable. The leaders knew their service well and understood where the strengths and challenges lay. Clinical and non-clinical leaders at all levels were well informed about the performance data and risks but could also provide detail about the narrative that supported and underpinned that data. They understood their service exceptionally well and used data as a tool to benchmark and improve their service performance rather than just as a comparator.

The Chief of Surgery, for example, was able to provide us with the details of every case that counted as a discharge direct from the critical care unit and could explain how this impacted on the ICNARC scores. The trust Chief Nurse was able to recount stories of particularly compassionate care of patients who had been admitted to the critical care units. The leaders knew the fine detail of the quality of care they were providing.

There was an established leadership development programme for different grades of staff. Staff that were in senior posts had been 'home grown' with site level nursing leads and the matron having been employed in other roles within the trust previously.

The leadership team were always visible during our visit and staff morale was high. Staff told us that the leadership team were always approachable and supportive.

The trust had an objective of achieving the best staff engagement score in country by 2020 and had a Best Place to Work project in progress. The True North Objective update provided data that the trust was on track to achieve this.

The trust had developed a Clinical Improvement Scholarship programme in collaboration with Health Education England Kent Surrey and Sussex. The programme aimed to support practitioners in combining their everyday clinical role alongside development of their research, leadership and continuous improvement.

## Vision and strategy

**The service had a vision for what it wanted to achieve and turned innovative strategies into actions, which were achievable and developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and fully aligned to local plans within the wider health economy. These was a demonstrated commitment to system-wide collaboration and leadership.**

The trust had a noticeably clear vision and strategy that all Divisional visions and strategies underpinned. The trust employed the Patient First strategy which is the long-term approach to transforming the way services were delivered.

Patient First is based on proven improvement methodologies, most notably the principles of 'kaizen' (or 'continuous improvement') and the Lean approach to management developed by the Toyota Motor Company and adapted successfully for use in healthcare by organisations such as the Virginia Mason Medical Centre and Theda care.

Patient First is based on standardisation, system redesign and ongoing development of patient care pathways built on incremental and continuous improvement. The trust uses 6 key principles:

1. The patient at the heart of every element of change
2. Cultural change across the organisation
3. Continuous improvement of our services through small steps of incremental change
4. Constant testing of the patient pathway to find new opportunities to develop
5. Encouraging front-line staff to lead the redesign processes
6. Equal voices for all.

Patient first is a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care.

The critical care team were strongly aligned to the trust vision and values. Staff talked about the patient being at the apex of a triangle and were encouraged to recognise that whatever they did contributed in some way to improving outcomes and experiences for patients and their families. This was described as the 'True North', the constant towards which the direction of travel was always set. Everything staff did was a contributing factor in reaching True North.

The Divisional Business Plan was aligned to the Trust Site Master Plan. One of the challenges faced by the critical unit was the estate which, whilst not currently having a negative impact on patient care or safety, was less than ideal and was not 'future proof'. The Trust Site Master Plan included steps to enable the expansion and reconfiguration of both critical care units.

## Culture

**Leaders delivery of the shared purpose was inspiring, and motivated people to succeed. Staff are proud of the organisation as a place to work and speak highly of its culture. There were high levels of staff satisfaction across all teams, including staff protected by the characteristics of the Equality Act.**

Organisational commitment and effective action towards ensuring equality and inclusion was obvious within the workforce. Staff were proud of the organisation as a place to work and spoke highly of the leadership and culture. Staff at all levels were encouraged and supported to speak up and raise concerns, all policies and procedures positively supported this process.

The critical care team were committed to a culture centred on the needs and the experience of the people who accessed services. The trust had a clear strategy and used a business model called 'Patient First', a long-term approach to transforming hospital services. Patient first was designed to empower front line staff to contribute to improvements; by providing the training, tools, skills and freedom to seek out opportunities to make sustainable changes happen.

All staff that we spoke with felt that they were well supported and listened to. Staff of all grades and disciplines felt able to influence care and have their ideas and opinions considered.

The unit had introduced annual feedback to individual consultants based on the General Medical Council (GMC) survey. The unit leaders were concerned that three years ago there had been some indicators scoring poorly around the questions of the unit being a supportive environment. An in-house survey was introduced and reported annually with feedback to each consultant. The most recent GMC survey showed all indictors were rated good/green with a narrative that trainees felt it was a supportive learning environment.

One consultant talked to us about their own feedback and how, initially, they had felt it was quite uncomfortable because it was holding a mirror up to their practice and they were found wanting. They had made one small change that involved asking for a short delay when they were woken in the middle of the night by junior doctors. This allowed them to 'come to', gather their thoughts and be more positive in their response. Their personal feedback had improved because of this.

The duty of candour was well embedded, and staff were supported to acknowledge any shortfalls and helped to reduce the impact. Staff were committed to openness and transparency with patients, their loved ones and each other. This was demonstrated when staff talked about having difficult discussions with patients to help them understand their condition and prognosis. Senior staff supported others to enable patients to fully understand the outcomes from treating or not treating their condition.

The trust employed two Freedom to Speak Out Guardians across both sites. Staff we spoke with were aware of how to access them and understood their role. The Guardians listened to individual staff and used their role to share information and highlight any patterns or concerns through attendance at the Triangulation (patient safety) meetings, the Health and Wellbeing group and mental health sub group. They also met quarterly with the CEO and felt that they could approach

her directly, if they had any serious concerns. They also attended the Diversity Matters group that was shared by the CEO.

The trust had held an open Schwartz Round that had a consultant only audience. They had recognised that the consultant body was less likely to access other support systems but had the added pressure of supporting junior staff with their wellbeing. Schwartz Rounds supply a structured forum where staff, come together regularly to discuss the emotional and social aspects of working in healthcare. The purpose of rounds is to understand the challenges and rewards that are intrinsic to providing care, not to solve problems or to focus on the clinical aspects of patient care. Rounds can help staff feel more supported in their jobs, allowing them the time and space to reflect on their roles.

The NHS Staff Survey showed that the staff engagement score for the directorate was better than both the trust average of 7.2 and the national average of 7.00.

During each debrief session held following a particularly difficult situation for staff, there a was a reminder about how to access the trust counselling service.

Interdisciplinary relationships were a strength of the unit. Medical nursing and allied healthcare profession staff worked well together in the best interests of the patients. This extended beyond unit staff, with evidence of strong relationships with the Specialist Palliative Care Team, the Chaplaincy team, paediatrics and maternity staff. We saw a text message from an obstetrician giving positive feedback on the way that the unit staff had shared the cared of a mother who was admitted following the delivery of her baby.

The trust staff had been involved in creating a Behaviour Framework ‘Above and Below the Line’ that had been ratified. The steering group was agreeing wording to support staff in challenging inappropriate behaviour that was out with the trust values.

Staff and unit leaders felt they were supported to manage behaviour and performance fairly and through encouraging learning. Where it was felt behaviour or performance fell too far short of the acceptable standard, formal measures would be instigated.

All staff have annual appraisals. We looked at five files for nursing staff and five for medical staff. All documents were completed accurately and comprehensively.

Nursing appraisals has clear and current goals, a values and attitudes assessment and a health and well-being check in. All included a review of mandatory training and a revalidation date.

The medical staff appraisals included their scope of work, their qualifications and revalidation, quality improvement activities, reflection on any significant events and feedback from colleagues and patients.

As at December 2018, 96.4% compliance for staff attending Equality & Diversity training.

New policies and service changes had been properly scrutinised to make sure no protected characteristics are unfairly affected upon, and any opportunity to advance equality is taken.

The staff networks Celebrating Cultures Network, Disability Forum, LGBT Network and Employee Partnership Forum reviewed policies to provide opinion on proposed policies and decisions.

The CEO and executive team along with those involved in cultural development such as the Freedom to Speak Up Guardian were committed to and explicitly stated their belief that, “To permit is to promote”. This was about staff not standing by and accepting minor infringements of the trust values and behaviour framework. The trust was working with staff groups to develop safe, non-confrontational and non-accusatory simple words that staff could use when someone spoke of

behaved in a way that made others feel uncomfortable. The suggestion would be that a phrase such as, “That’s not OK”, made the point and addressed the behaviour without it escalating and becoming more hostile; it could enable more junior staff to address behaviours and comments made by senior staff or allow staff to comment about unacceptable behaviour exhibited in clinical areas.

## Governance

**Governance arrangements were proactively reviewed and reflected best practice. A systematic approach was taken to working with other organisations to improve care outcomes.**

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The trust had an effective governance structure that the Surgical Division and care Group fed in to. The surgical division held bi-monthly strategy meetings which involved the multidisciplinary team. The care group leaders. sat as part of the multi-disciplinary surgical board and were able to bring another member of staff with them to the meetings. This meant that the clinical site leaders but often attended but it also offered opportunities to more junior staff and to staff from different disciplines. The Surgical Divisional Chief of Service and the Care Group Director met frequently with the clinical site leaders to ensure that everyone was cited on operational and clinical risk and performance.

There was also a Surgical Governance Forum held monthly which clinical directors, site leaders and clinical governance leads were encouraged to attend.

The division had recently held an awayday for the senior team that used an external coach to support teambuilding activity. It was planned to repeat this regularly with a business meeting in the morning and developmental activity in the afternoon.

The Clinical Divisions, including surgery, were represented at the quarterly Clinical Governance Review meetings, These, in turn fed into the Quality Assurance Committee of the Trust Board.

There was also representation from the critical care unit and Surgical Division at groups and committees that fed into the Quality Board, which also fed into the Quality Assurance Committee of the Trust Board. These included a Mortality Steering Group, a Resuscitation Committee, a Research and Innovation Committee and an End of Life Board.

There was a critical care outreach team which meets with the Guidelines for the Provision of Intensive Care Services (2015). The trust had an effective early warning and escalation system to highlight deteriorating patients and patients at risk of deteriorations were closely monitored by the outreach team. The effectiveness of this aspect of their work had reduced the number for cardiac arrests significantly and improved patient outcomes.

## Management of risk, issues and performance

**There was a demonstrated commitment to best practice performance and risk management systems and processes cross-site. The leadership team reviewed how it functioned and ensured that staff at all levels had the knowledge and skills to use all systems and processes effectively. Problems were identified and addressed quickly and openly.**

The service had effective systems for identifying, reducing or eliminating risks. There were comprehensive assurance systems with performance issues escalated appropriately through well understood processes. Regular critical care board and critical care strategy meetings were held, and the effectiveness of the reporting systems were reviewed.

All leaders of the service, the trust clinical leaders and the staff working on the units had an exceptional grasp of performance and could provide detail not only of numerical data but also of trends and patterns identified, changes to improvement trajectories and most importantly the patient stories that underpinned the data.
The unit risk register was current and used as a tool for driving improvement and reducing risks. It fed into the trust risk register with elevated risks being identified through a clear scoring process. All staff and leaders of all levels identified the same risks as their 'top three'; these were reflected on the risk register and had ongoing actions to address the risks.

All who discussed risk mentioned staffing as a priority and their greatest challenge. There was a commitment not only to recruiting and retaining enough staff but of recruiting and retaining staff of the right calibre. Just being qualified was not enough; the staff appointed had to be the right staff in terms of attitudes and commitment. The trust had a recruitment strategy which included drafting staff from the Philippines and supporting them to integrate into the local community.

There was also a strong learning programme that supported the culture of 'growing our own'. Staff could join the trust as apprentices or on lower grades and were encouraged to develop through formal learning programmes to professional registration. Postgraduate study was also supported to develop a strong research base and encourage staff to remain at the trust.

Standardisation of equipment, processes and the IT systems allowed seamless and safe movement between the units for staff. Staff did not move often, but it was occasionally necessary where one unit was much busier than the other. The staff did not have to work with unfamiliar equipment and could provide care of a consistently high standard and with reduced risk because of this.

All efficiency savings were considered by a group which included executive staff and senior clinicians considering progress towards strategic objectives. All changes were subject to a formal quality impact assessment.

There was also a strong culture of 'Good care costs less' and that adequate resources and high-quality care delivery reduced the overall costs through reduced litigation, reduced pressure damage management, reduced falls injuries and reduced costs associated with staff burnout and turnover.

We attended a review meeting of the trust quality improvement objectives with cross discipline and cross directorate attendance. Each True North objective and strategic priority was reviewed and updated. One such priority was the reduction of medical staffing costs by reducing agency use. The trust understood that outcomes were better, patient experience was better and there was better progress towards meeting referral to treatment time targets for more patients if a temporary contract was offered rather than using different locum consultants to address a backlog. It was also cheaper.

The trust had a mental health care policy and staff were aware of this. A newly appointed consultant had authored a dissertation on staff wellbeing and its impact on the quality of patient care and was going to lead on wellbeing across both sites. A business case had been submitted to appoint a senior clinical psychologist to work with both patients and staff. The consultant rota had been split to ensure that junior doctors had better access to support. Debrief sessions were held

following particularly challenging episodes of care and staff were reminded each time about the counselling service.

Staff long absence levels were better than the national average. Staff turnover rates were better than the national average.

There was an Executive Serious Incident Monthly Report and annual report. The reporting process and algorithm made clear at what level incidents were reported via the national reporting systems and what local response was required.

All incidents reported as moderate harm or above (including near misses) were reviewed daily by the Chief Medical Officer and the Chief Nurse.

## Information management

**The service invested in innovative and best practice information systems and processes. Staff had access to up to date information on patient care and treatment and were aware of how to use and store confidential information. The information used in reporting, performance management and delivering quality care was consistently found to be accurate, reliable, valid, timely and relevant.**

There was a clear commitment at all levels to sharing data and information to actively drive and support internal decision making and system-wide improvement. We saw information on the unit's performance with Intensive Care Audit Research Centre (ICNARC) was prominently displayed on notices boards for both the staff and public to see. Staff told us that data is discussed during huddles to ensure accurate data management and collection.

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

There was a holistic understanding of performance, which covered and integrated people's views with information on quality, operations and finances. Information was used to measure for improvement, not just assurance.

Staff on the St Richards site knew how their performance compared to their sister site at Worthing, this was not to compete but to consider why there was a difference and whether there were any improvements that could be shared across both sites.

Safety Huddle Boards were used to 'grow ideas' and to provide problem solving opportunities. An example given was around the use of Gentamycin as an antibiotic for the management of sepsis. Following an incident where there had been a repeated dose given to a patient – one in the emergency department and one on the critical unit, it was decided that the simple question, "Is there anyone on Gentamycin?" would always be asked out loud at every huddle and then there would be consultant review at the ward round.

Raspberry Pi screens had been introduced to highlight specific information to staff in a simple way. These were small computers that could be attached directly to large screens in prominent places to remind staff about specific things. We saw a screen that reminded staff about their responsibilities and the requirements of the Mental Capacity Act 2005.

The service submitted data to the Intensive Care National Audit & Research Centre (ICNARC). The most recent data was only made available during the week preceding the inspection visit. All

indicators showed performance about comparator trusts and within two standard deviations from the average. Both sites had performance that was better than expected.

The high-risk admissions from the ward had been reduced since the previous report because the outreach team were now better resourced and able to intervene at an earlier stage.

Discharges from the unit direct to patients' homes was within the two standard deviations but the staff had still considered why they had any and were able to identify the individual patients and the reasons these discharges had been in their best interest.

Aside from the ICNARC data, the service monitored other aspects of care and patient outcomes such as falls and pressure damage. These were reported via the electronic reporting systems and fed into the hospitals governance processes. There had not been any serious incidents in the year preceding the inspection.

Information technology and technology research was encouraged to support improvement in patient care. One example was a member of staff who had developed a teaching model that was used to teach clinical staff about the use of cricoid pressure in managing complex airways.

Whiteboards were used to highlight the needs of individual patients, but these were coded, and initials were used to protect patient identity.

## Engagement

**The service actively engaged with patients, staff and the public to plan and manage services. Patient, relatives and carers were always encouraged to contribute to the running of the service through participation and feedback. Staff were actively engaged, and their views were often reflected in the planning and delivery of the service.**

Engagement with staff and people who used the services including all equality groups, was consistently of the highest level of constructive communication. Rigorous and constructive challenges from people who used the service were welcomed and understood to be the best way of holding services to account.

Services have been developed with the full participation of those who use them, staff and external partners. Innovative approaches were used to gather feedback from patients and the local population, including people in different equality groups, and there is an established commitment to feedback.

The service takes a leadership role in its health systems to identify and proactively react to challenges to meet the needs of the local population.

Feedback was sought from patients, relatives and staff about their experiences and their feedback was used to improve the service.

An annual junior doctors survey was developed from the wider GMC survey. We were provided with examples where consultant practice had changed in response to the feedback that they received and how it had led to a more supportive environment.

Patients were invited to attend a follow-up clinic which included talking through and understanding their experience on the critical are unit. This was longer stay patients and those with particularly complex care needs but was available to all.

Open staff briefings took place every two weeks at different times of the day across the trust to maximise opportunities for attendance. Each meeting had between 50 and 100 attendees.

Leaders at all levels said recruitment was the greatest challenge. They also said they wanted to make sure they recruited the right staff not just staff. They had several local and trust wide initiatives to support the recruitment and retention of staff and the Care Group was fully established, with some long serving staff members forming a stable core group that had been enhanced by new members of staff bringing fresh ways of working.

Leaders and other staff talked to us about times they felt they had things wrong (usually related to managing other staff rather than patient care) and how they had been honest in their approach to reducing the impact of their actions.

The NHS staff survey was used by the trust and local services to develop and improve the staff experience. Since 2016 overall staff engagement and confidence in the organisation had remained consistent, ranking Western Sussex Hospitals in the top 20 for staff engagement compared with other acute trusts. Despite not achieving an increase since 2016 the Trust remains above the average comparator for acute trusts scoring 7.0.

The trust had an explicit objective to become an NHS model employer; they had a workstream, 'Our People' aimed at becoming the top performing Acute Trust by 2020. Based on the new methodology scoring a trust wide target has been agreed to achieve a score of 7.6. To support staff in parallel to the 'Reducing Abusive Behaviours' project the trust was participating in the 'Best Place to Work' cultural transformation scheme.

The lowest scoring parameter for the staff survey was around a safe environment and staff experiencing violence/aggression. There was trust wide work involving the Freedom to Speak Up Guardians, the Health and Wellbeing Group and the mental health sub group.

An 'Above and Below the Line' Behaviour Framework had been agreed and had involved a group of staff looking at values and behaviours. The framework was shared at a staff conference to gain 'buy in'. There was now work in progress to give staff words they could use when they observed or experienced inappropriate behaviour. The suggestions that were being considered were around non-confrontational, simple statements that made the point that the behaviour was unacceptable whilst reducing the risk of it escalating to open hostility.

There were two Freedom to Speak Up Guardians who were well known and who were supported by a lead non-executive director.

All Health and Safety training which is mandatory and attended by 91% of all staff begins with a session on culture and equality and diversity as part of a planned process to 'water the plants' of cultural development. The CEO chaired the Diversity Matters Group.

All care was planned and provided with a view to ensuring individual preferences and needs were considered. There were regular visits from the chaplaincy service who could provide support or signpost to other religious leaders. Several staff had learned Makaton sign language to support them in caring and communicating with a patient with Down Syndrome. The unit used an 'About Me' booklet completed by relatives to enable staff to understand the usual preferences of the patient.

Critical care staff and leaders worked with two local networks to provide support and care in the best interests of patients. Technically they were part of the Kent, Surrey and Sussex network but historically the Chichester site had been part of the Wessex network from before the trust merger. They had negotiated with the network to ensure that they could share learning and get specific expert advice from either network. Where staff needed advice or to transfer a patient with

neurological or cardiothoracic surgical intensive care needs from St Richard's Hospital they worked with the staff from Portsmouth or Southampton.

There were good relationships with the paediatric services and unit staff supported paediatric staff when a seriously ill child needed stabilising prior to being transferred to a paediatric intensive care unit in London, Brighton or Southampton.

Patients stories were presented monthly at divisional governance meetings as a standard agenda item.

## Learning, continuous improvement and innovation

**There was a systematic and fully embedded approach to improvement, that consistently used recognised improvement methodology. Improvement was a way to sustain performance and organisational learning. Improvement methods and skills were available and used trust wide, and staff were empowered to lead and deliver change.**

The inspection team noted that innovation was celebrated, there was a clear, systematic approach to researching and embedding new sustainable models of care.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The trust and unit commitment to learning, staff education and continuous improvement were exemplary. There was two years into a Clinical Academic Pathway Programme which enabled staff to combine clinical and academic careers for nursing, midwifery and allied Health Professionals. Staff could apply for Clinical Improvement Scholarships that involved working on improvement projects within their own practice area. They were offered two days a week backfill and a learning programme that included leadership and change management and well as research and knowledge development. It was open for all staff in bands 5 to 8a.

Year one had offered four scholarships and year two, eight. The outcomes of the programme showed improved recruitment, retention and promoted a culture of evidence-based practice.

Patient stores were used throughout the organisation to enable staff to understand the impact of the care they provided. Stories were published in the trust Patient Safety Newsletter via the Huddle Headlines, the Trust Brief and on the intranet.

As previously mentioned in this report, in 2018/2019 the critical care team participated in several international research trials including:

- POETICS2 (VIP2). The VIP2 study is an international, multicentre study of the old intensive care unit population. The STARRT AKI which is a research programme that compares standard versus accelerated initiation of renal replacement therapy in Acute Kidney Injury (AKI). Acute kidney injury is a common and devastating complication of critical illness.
- STARRT AKI which is a research programme that compares standard versus accelerated initiation of renal replacement therapy in Acute Kidney Injury (AKI). Acute kidney injury is a common and devastating complication of critical illness. Once AKI is established, treatment is supportive, to date no intervention has been found to restore kidney function or improve overall survival. Renal replacement therapy (RRT), usually in the form of haemodialysis, is frequently

needed to manage patients with severe AKI. Such patients have an in-hospital mortality that consistently exceeds 50% with delays in RRT initiation implicated as a contributor.

- The ’65’Trial which is a programme evaluating the clinical and cost-effectiveness of permissive hypotension in critically ill patients aged 65 years or over with vasodilatory hypotension.

The trust won the national safety prize for the Annual Association of Anaesthetists twice in the last six years. One of these was for a doctor who had developed a new gel to enable the creation of simulation models for training clinical staff in the management of patients with different body shapes or anomalies.

The trust was rated ‘Gold ’by the Organ Donation Service. In 2018/2019 they achieved a 100% early referral rate and 100% for specialist organ donation nurse presence when approaching relatives about potential donations. They number of organ donations had increased from six consented donors in 2017/2018 to 13 consented donors in 208/2019 with 29 patients receiving a donated organ during this time.

The critical care service completed Patient First improvement programme across the trust and reduced he 24 hour delayed discharges by 75%. Western Sussex were the only trust ion the country to achieve the national CQUIN (30%) and to have maintained this position.

# Outpatients

## Is the service responsive?

**The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**

Managers planned and organised services so that they met the changing needs of the local population. The trust has invested in the ophthalmology centre at Shoreham hospital to meet the increasing need for eye care because of an ageing local population. Facilities and specialist staff were all based in one place to optimise care and treatment and reduce the need for several appointments,

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. An example of this was a first appointment’ one-stop clinic for urology patients.

Facilities and premises were appropriate for the services being delivered. The hospital had invested in services to ensure they were appropriate to deliver outpatient services. Adult services for diagnosis, treatment and monitoring were based at two dedicated cancer units at St Richard’s and Worthing Hospitals. At St Richard’s Hospital there was a £3.5 million purpose-built cancer unit where patients with cancer attended as day patients for chemotherapy and also had outpatient appointments. There was a Macmillan information centre on site supported by volunteers. Prior to the Fernhurst centre opening in 2009, patients had to travel to an adjacent trust in Portsmouth.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia).

The service had systems to help care for patients in need of additional support or specialist intervention. The trust website made it easy for people to access information and there were volunteers to guide people around the hospitals. A recent Way finder project with learning from a local airport and which involved staff, patients and other stakeholders had resulted in clearer pictorial signs that meant people arriving at the hospital could quickly and easily find where they needed to go. This include a medicine bottle sign to guide people to pharmacy and a skeletal hand picture to guide people towards the x-ray department. Painted murals of trees on junction walls encourage the eye in the direction of travel and helped people see where there were direction signs.

Managers monitored and acted to minimise missed appointments. The Did Not Attend rate for all trust hospitals was consistently better than the national comparators.

Managers ensured that patients who did not attend appointments were contacted. Letters were sent to patients and copied to their GPs explaining that an appointment had been missed and asking the patient to telephone to make a new appointment.

## Service delivery to meet the needs of local people

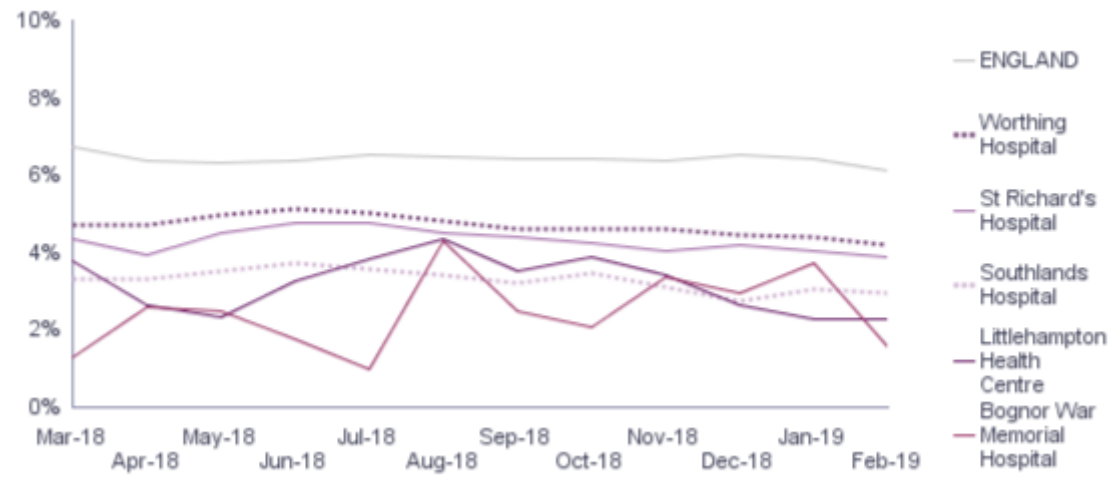
The trust provided outpatient services in a variety of settings outside of their hospitals. For example, outpatient appointments were held in a health centre in Littlehampton for children and young people. This means that families living in poverty who need to see a paediatrician are able to make local appointments, which do not involve the costs of travel. In relation to “neighbourhood level” deprivation, West Sussex now has three areas, all in Littlehampton, falling in the 10% most deprived areas in England.

The board minutes from March 2019 showed that the Board was advises that the trust was working with commissioning partners in the development of demand, activity and capacity planning for 2019/20, the methodology drew on historic trending, forecast projections on the basis of typical historic phasing by service area to create a baseline activity level. This was adjusted for expected age specific growth in the catchment, aligned to the age and sex distribution of main service areas, plus an assessment associated with non-demographic growth, this approximated to a 1.1% increase against baseline for outpatients.

**Did not attend rate**

From March 2018 to February 2019 the ‘did not attend’ rates for all sites at the trust were lower than the England average. The chart below shows the ‘did not attend’ rate over time.

**Proportion of patients who did not attend appointment, Western Sussex Hospitals NHS Foundation Trust.**




*(Source: Hospital Episode Statistics)*

The trust had worked hard to ensure that patients were able to negotiate their appointments at a time to suit them. Follow up appointments could be booked directly with outpatient department staff following attendance at a clinic.

Letters sent out provided a direct dial number to ensure people could speak with medical secretaries when they were unable to attend a planned appointment.

The trust used an automated telephone reminder system to remind patients about appointments. Patients received an automated appointment reminder and were asked to select the appropriate options when asked.

The trust website provided a graph that showed the number of calls made for outpatient departments hourly on each day which allowed patients to see when the telephone lines were likely to be busiest. This allowed patients to choose a quieter time to telephone.

## Meeting people's individual needs

The trust strategy and quality improvement methodology, Patient First' permeated all areas of the trust services and was the key driver to ensuring care was provided that met the individual needs of patients and their families.

The trust scored above the national average for questions related to outpatients in the National Cancer Patient Experience Survey. The average rating given by respondents when asked to rate their cancer care provided at WSHFT on a scale of 0, (very poor) to 10, (very good) was 8.8. Ninety-four percent said that the hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital. Ninety-one percent said that they were given the name of a Clinical Nurse Specialist who would support them through their treatment.

The trust had Guidelines for Staff on Caring for Adult Patients with a Learning Disability in the Acute Hospital. This provided advice and made clear the role of outpatient nursing staff in helping to meet the needs of people with learning disability. Where a patient was a regular attendee to the Out-Patient Department the clinic nursing staff liaised with the patient's main carer to discuss and identify specific care needs the patient may have during attendance. Additional support and reasonable adaptation was offered such as:

- Scheduling or rescheduling the appointment to the first or other suitable slot on the clinic list, e.g. to reduce chance of delay in seeing the doctor, waiting room being quieter.
- Offering a double appointment
- Providing easy read information relevant to the appointment
- Planning additional support, sedation and / or other adjustments as appropriate prior to the appointment

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. In addition to leaflets about specific conditions, the trust provided complaints management information in different languages and formats on request (e.g. audio tape and web based and easy read) to meet the needs of individuals. They used trained interpreters, when required, and ensuring interpreting services are aware of the complaint's management process.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports**.**

There was a dementia strategy that detailed the care and facilities available to support people living with dementia and their carers. The trust had installed 4 rest stops with images on each acute, site supporting the dementia friendly hospitals charter. The trust had pledged to John's Campaign and provided appropriate signage for the main hospital areas.

The Trust Dementia website had been renewed to highlight the care provision available for people with a dementia and their carers.

The Wayfinding Steering Group which included staff from Equality & Diversity and Facilities & Estates had worked together to redesign the signage and way finding at the trust. Careful thought had been given to disability accessibility including physical way finding and the appearance of the signage. The signage has been designed to meet the widest range of accessibility needs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

In partnership with Brighton and Sussex University Hospitals Trust, the trust had purchased a 2-year contract for the 'Recite Me' system to improve accessibility of the trust's website, and outpatients booking service. 'Recite Me' is a web-based tool that allows patients and staff to customise the trust website in way individuals need it to work for them personally. The easy to use facility included large font, text to speech functionality, dyslexia software, an interactive dictionary, a translation tool with over 100 languages and many other features. These functions not only benefit individuals with sensory impairments, but also benefit those with learning disabilities / difficulties and overseas language speakers.

The trust had produced Guidelines for Supporting Trans Patients which made explicit the expectations of staff behaviours and attitudes as well as the legal framework. Some clinics provided gender-specific or gender segregated services. An example of the former may be a clinic performing prostate examinations. It would be unacceptable to require a trans woman to use a waiting room for men in the former case, or for a trans man to share a female clinic waiting area in the case of a gynaecological condition. If an examination needed to be conducted in a specific room because it contained appropriate equipment, but which would not ordinarily be used for a person of that gender (for example, a trans man needing to be examined in a room ordinarily used

for the examination of women), this should be clearly explained to the patient and sensitively managed

## Access and flow

The trust had seen performance slip in some referral to treatment times for elective procedures. There was an agreed recovery plan and data showed that there was an Improvement Plan which was on target to recover performance to compliant position by end of 2019/2020. The data to April 2019 was nationally available data but local data held by the trust showed sustained improvement towards meeting the action plan for recovery.

**Referral to treatment**

From May 2018 to April 2019 the trust's referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. The latest figures for April 2019, showed 81.6% of this group of patients were treated within 18 weeks versus the England average of 87.0%.

The commissioners had agreed a recovery plan and the trust had met this. A new target had ben agreed for 2019/2020 and the trust was showing evidence that they would meet this. The current RTT performance was 92%.

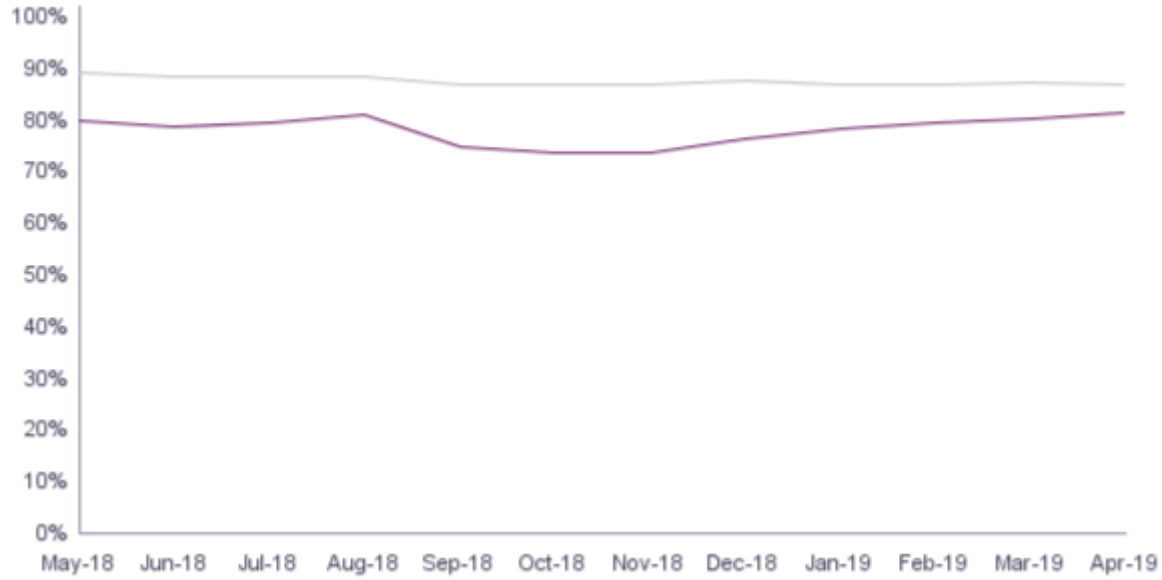
Cancer Performance – The trust have observed significant increases in demand for Coastal West Sussex CCG Patients in 2018/19 in comparison to the previous year, notably an overall rise of 8.9% rise in 2-week referrals & a 7.7% rise in 62-day urgent referrals. Specialities that have seen a significant increase include Colorectal, Urology, Skin, Breast and Head & Neck.

Despite this, overall the trust exceeded national performance for all one indicator & achieved compliance for 5 of the 7 Cancer performance indicators with a target in 2018/19

18 Week RTT Performance – The trust achieved compliance with the revised NHSE target that their waiting list in March 19 should be no higher than that of March 2018 both for Coastal West Sussex CCG patients and as a trust.

The latest published data (May 2019) showed that the trust had no 52+ week breaches. Provisional data showed the waiting list at WSHFT for Coastal West Sussex CCG patients was currently 3.1% higher than for March 2019 while the backlog is 6.4% lower. The number of completed pathways in May 2019 was 5.6% higher than for March 2019 with the number of 'clock starts' being 1.2% higher.

**Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Western Sussex Hospitals NHS Foundation Trust.**




*(Source: NHS England)*

Three specialties were above the England average for non-admitted pathways RTT (percentage within 18 weeks).

| Specialty grouping | Result | England average |
|---|---|---|
| Dermatology | 92.4% | 88.0% |
| Gynaecology | 92.0% | 91.2% |
| Trauma & Orthopaedics | 86.0% | 85.6% |

Thirteen specialties were below the England average for non-admitted pathways RTT (percentage within 18 weeks).

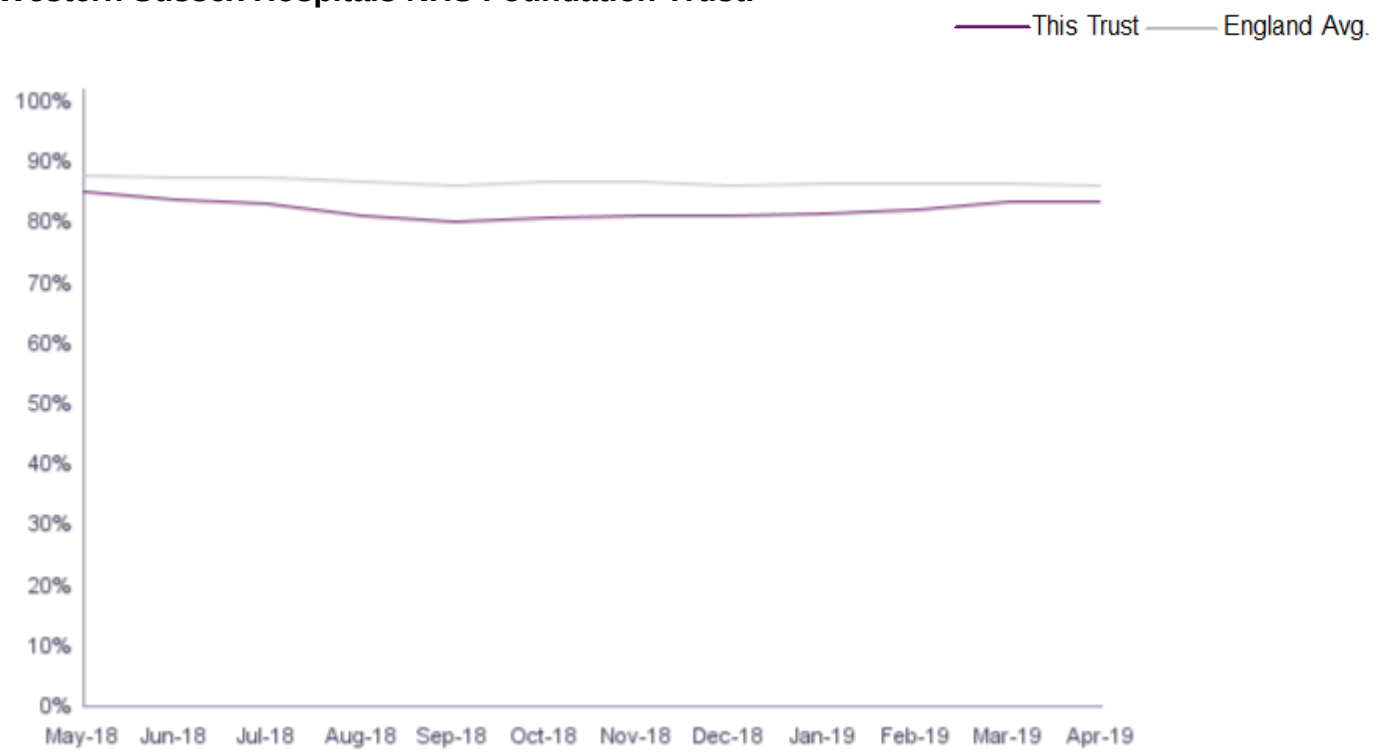
| Specialty grouping | Result | England average |
|---|---|---|
| Geriatric Medicine | 91.1% | 95.0% |
| General Medicine | 89.0% | 90.8% |
| Other | 86.4% | 90.0% |
| General Surgery | 85.4% | 88.3% |
| Urology | 83.0% | 84.8% |
| Thoracic Medicine | 80.8% | 86.0% |
| Ear, Nose & Throat (ENT) | 71.4% | 83.7% |
| Ophthalmology | 68.4% | 88.5% |
| Cardiology | 66.1% | 85.4% |
| Oral Surgery | 63.1% | 80.4% |
| Gastroenterology | 60.7% | 81.2% |
| Rheumatology | 59.8% | 86.3% |
| Neurology | 44.9% | 77.3% |

*(Source: NHS England)*

From May 2018 to April 2019 the trust's referral to treatment time (RTT) for incomplete pathways has been worse than the England overall performance. The latest figures for April 2019, showed 83.3% of this group of patients were treated within 18 weeks versus the England average of 86.1%.

The commissioners had agreed a recovery plan and the trust had met this. A new target had been agreed for 2019/2020 and the trust was showing evidence that they would meet this.

**Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Western Sussex Hospitals NHS Foundation Trust.**




*(Source: NHS England)*

Six specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

| Specialty grouping | Result | England average |
|---|---|---|
| General Medicine | 94.7% | 91.5% |
| Thoracic Medicine | 92.1% | 88.9% |
| Other | 90.9% | 89.1% |
| Gynaecology | 90.8% | 87.8% |
| General Surgery | 87.5% | 83.8% |
| Urology | 85.9% | 85.1% |

Ten specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

| Specialty grouping | Result | England average |
|---|---|---|
| Geriatric Medicine | 93.9% | 95.8% |
| Dermatology | 86.2% | 89.6% |
| Cardiology | 85.8% | 89.4% |
| Rheumatology | 85.2% | 91.3% |
| Gastroenterology | 78.8% | 88.2% |
| Ophthalmology | 77.8% | 86.7% |
| Ear, Nose & Throat (ENT) | 77.2% | 83.9% |
| Oral Surgery | 76.2% | 82.3% |
| Trauma & Orthopaedics | 73.2% | 81.3% |

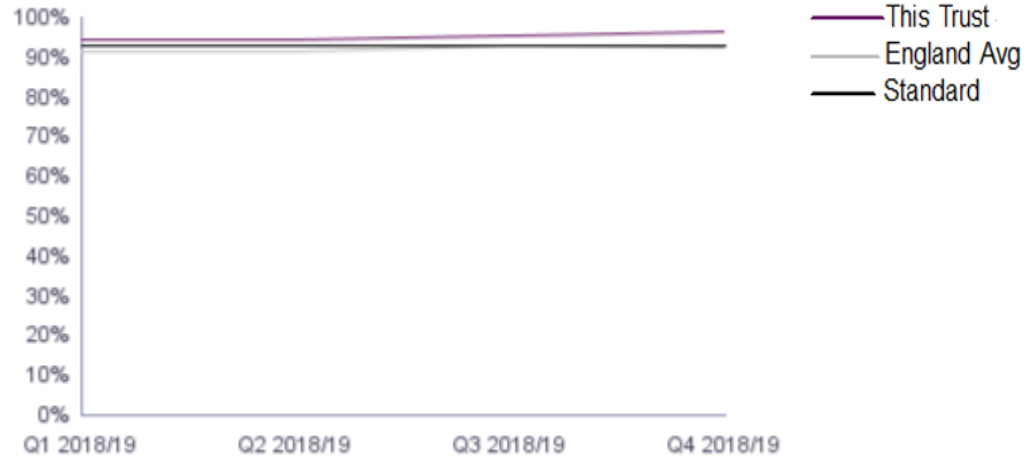
| | | |
|---|---|---|
| Neurology | 72.0% | 86.6% |

*(Source: NHS England)*

**Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)**

The trust is performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The performance over time is shown in the graph below.

**Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Western Sussex Hospitals NHS Foundation Trust**

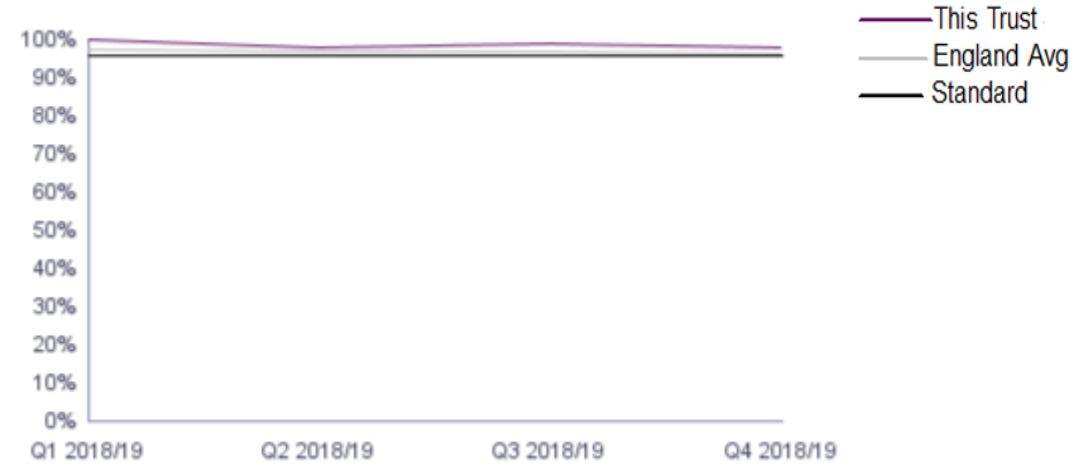



*(Source: NHS England – Cancer Waits)*

**Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)**

The trust is performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.

**Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Western Sussex Hospitals NHS Foundation Trust**



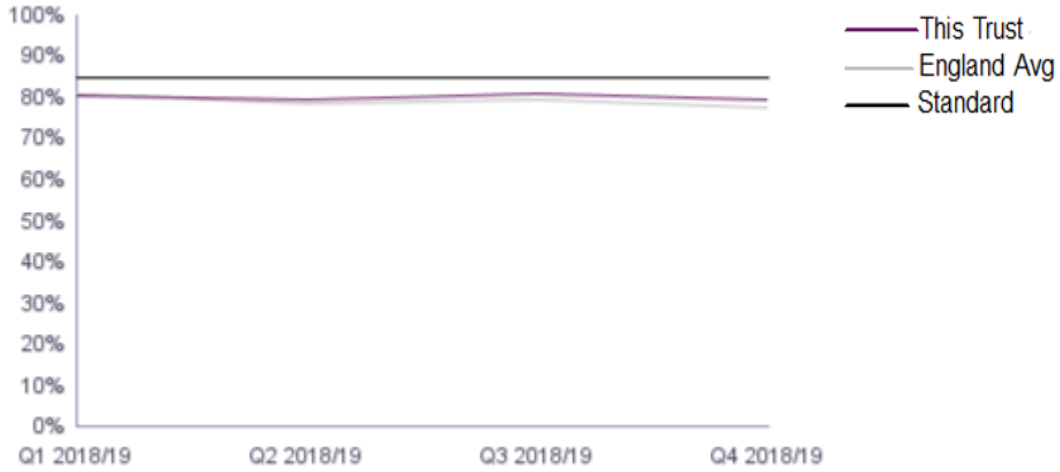

*(Source: NHS England – Cancer Waits)*

**Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment**

The trust is performing worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

However, cancer provisional performance for April-19 was 82.1 % of patients treated within 62 days from referral as per the Trust's recovery plan and in the context of continued significant increased demand, compared to 79.75 National Average (March).

**Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Western Sussex Hospitals NHS Foundation Trust**




*(Source: NHS England – Cancer Waits)*

Diagnostic performance was compliant with the national target for the full 12 months of 2018/2019 and continues to be compliant in April 2019. This is despite demand increases, which have been matched through increased activity and productivity

The Patient Experience and Feedback Committee met on behalf of the trust board four times a year to discuss the PALS enquiries and formal complaints received in detail, reviewing any patterns and themes emerging.

## Learning from complaints and concerns

**Summary of complaints**

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The service clearly displayed information about how to raise a concern in patient areas.

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**Number of compliments made to the trust**

From April 2018 to March 2019 there were 653 compliments about outpatients at the trust. A breakdown of compliments by site is below:

| Site | Number of compliments | Percentage of total |
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# Acute services

## Southlands Hospital

Upper Shoreham Road
Shoreham By Sea
West Sussex
BN43 6TQ

Tel: 01903 205111

www.westernsussexhospitals.nhs.uk

# Outpatients

## Is the service responsive?

**The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**

Managers planned and organised services so that they met the changing needs of the local population. The trust has invested in the ophthalmology centre at Shoreham hospital to meet the increasing need for eye care because of an ageing local population. Facilities and specialist staff were all based in one place to optimise care and treatment and reduce the need for several appointments,

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. An example of this was a first appointment' one-stop clinic for urology patients.

Facilities and premises were appropriate for the services being delivered. The hospital had invested in services to ensure they were appropriate to deliver outpatient services. Adult services for diagnosis, treatment and monitoring were based at two dedicated cancer units at St Richard's and Worthing Hospitals. At St Richard's Hospital there was a £3.5 million purpose-built cancer unit where patients with cancer attended as day patients for chemotherapy and also had outpatient appointments. There was a Macmillan information centre on site supported by volunteers. Prior to the Fernhurst centre opening in 2009, patients had to travel to an adjacent trust in Portsmouth.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia).

The service had systems to help care for patients in need of additional support or specialist intervention. The trust website made it easy for people to access information and there were volunteers to guide people around the hospitals. A recent Way finder project with learning from a local airport and which involved staff, patients and other stakeholders had resulted in clearer pictorial signs that meant people arriving at the hospital could quickly and easily find where they needed to go. This include a medicine bottle sign to guide people to pharmacy and a skeletal hand picture to guide people towards the x-ray department. Painted murals of trees on junction walls encourage the eye in the direction of travel and helped people see where there were direction signs.

Managers monitored and acted to minimise missed appointments. The Did Not Attend rate for all trust hospitals was consistently better than the national comparators.

Managers ensured that patients who did not attend appointments were contacted. Letters were sent to patients and copied to their GPs explaining that an appointment had been missed and asking the patient to telephone to make a new appointment.

### Service delivery to meet the needs of local people

The trust provided outpatient services in a variety of settings outside of their hospitals. For example, outpatient appointments were held in a health centre in Littlehampton for children and young people. This means that families living in poverty who need to see a paediatrician are able

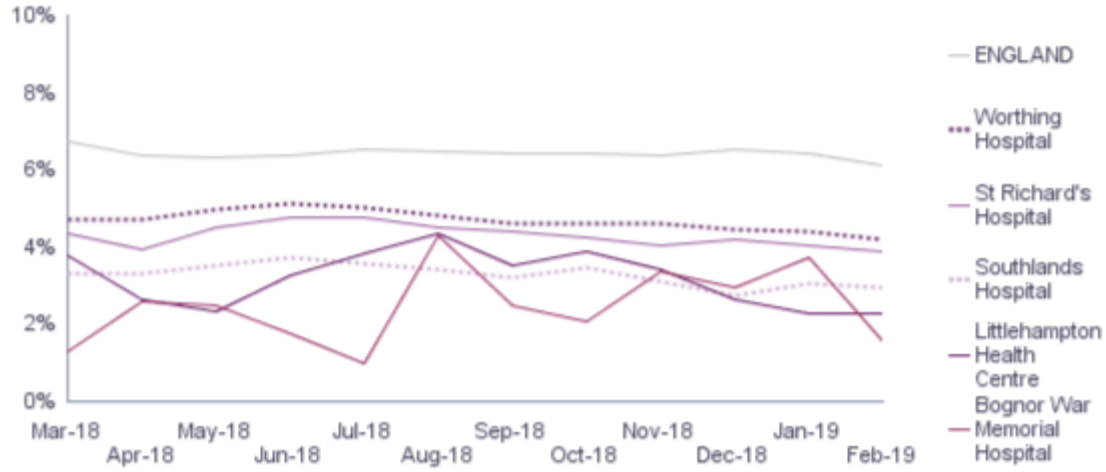
to make local appointments, which do not involve the costs of travel. In relation to “neighbourhood level” deprivation, West Sussex now has three areas, all in Littlehampton, falling in the 10% most deprived areas in England.

The board minutes from March 2019 showed that the Board was advises that the trust was working with commissioning partners in the development of demand, activity and capacity planning for 2019/20, the methodology drew on historic trending, forecast projections on the basis of typical historic phasing by service area to create a baseline activity level. This was adjusted for expected age specific growth in the catchment, aligned to the age and sex distribution of main service areas, plus an assessment associated with non-demographic growth, this approximated to a 1.1% increase against baseline for outpatients.

**Did not attend rate**

From March 2018 to February 2019 the ‘did not attend’ rates for all sites at the trust were lower than the England average. The chart below shows the ‘did not attend’ rate over time.

**Proportion of patients who did not attend appointment, Western Sussex Hospitals NHS Foundation Trust.**




*(Source: Hospital Episode Statistics)*

The trust had worked hard to ensure that patients were able to negotiate their appointments at a time to suit them. Follow up appointments could be booked directly with outpatient department staff following attendance at a clinic.

Letters sent out provided a direct dial number to ensure people could speak with medical secretaries when they were unable to attend a planned appointment.

The trust used an automated telephone reminder system to remind patients about appointments. Patients received an automated appointment reminder and were asked to select the appropriate options when asked.

The trust website provided a graph that showed the number of calls made for outpatient departments hourly on each day which allowed patients to see when the telephone lines were likely to be busiest. This allowed patients to choose a quieter time to telephone.

## Meeting people’s individual needs

The trust strategy and quality improvement methodology, Patient First' permeated all areas of the trust services and was the key driver to ensuring care was provided that met the individual needs of patients and their families.

The trust scored above the national average for questions related to outpatients in the National Cancer Patient Experience Survey. The average rating given by respondents when asked to rate their cancer care provided at WSHFT on a scale of 0, (very poor) to 10, (very good) was 8.8. Ninety-four percent said that the hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital. Ninety-one percent said that they were given the name of a Clinical Nurse Specialist who would support them through their treatment.

The trust had Guidelines for Staff on Caring for Adult Patients with a Learning Disability in the Acute Hospital. This provided advice and made clear the role of outpatient nursing staff in helping to meet the needs of people with learning disability. Where a patient was a regular attendee to the Out-Patient Department the clinic nursing staff liaised with the patient's main carer to discuss and identify specific care needs the patient may have during attendance. Additional support and reasonable adaptation was offered such as:

- Scheduling or rescheduling the appointment to the first or other suitable slot on the clinic list, e.g. to reduce chance of delay in seeing the doctor, waiting room being quieter.
- Offering a double appointment
- Providing easy read information relevant to the appointment
- Planning additional support, sedation and / or other adjustments as appropriate prior to the appointment

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. In addition to leaflets about specific conditions, the trust provided complaints management information in different languages and formats on request (e.g. audio tape and web based and easy read) to meet the needs of individuals. They used trained interpreters, when required, and ensuring interpreting services are aware of the complaint's management process.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports**.**

There was a dementia strategy that detailed the care and facilities available to support people living with dementia and their carers. The trust had installed 4 rest stops with images on each acute, site supporting the dementia friendly hospitals charter. The trust had pledged to John's Campaign and provided appropriate signage for the main hospital areas.

The Trust Dementia website had been renewed to highlight the care provision available for people with a dementia and their carers.

The Wayfinding Steering Group which included staff from Equality & Diversity and Facilities & Estates had worked together to redesign the signage and way finding at the trust. Careful thought had been given to disability accessibility including physical way finding and the appearance of the signage. The signage has been designed to meet the widest range of accessibility needs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

In partnership with Brighton and Sussex University Hospitals Trust, the trust had purchased a 2-year contract for the 'Recite Me' system to improve accessibility of the trust's website, and outpatients booking service. 'Recite Me' is a web-based tool that allows patients and staff to customise the trust website in way individuals need it to work for them personally. The easy to use facility included large font, text to speech functionality, dyslexia software, an interactive dictionary, a translation tool with over 100 languages and many other features. These functions not only benefit individuals with sensory impairments, but also benefit those with learning disabilities / difficulties and overseas language speakers.

The trust had produced Guidelines for Supporting Trans Patients which made explicit the expectations of staff behaviours and attitudes as well as the legal framework. Some clinics provided gender-specific or gender segregated services. An example of the former may be a clinic performing prostate examinations. It would be unacceptable to require a trans woman to use a waiting room for men in the former case, or for a trans man to share a female clinic waiting area in the case of a gynaecological condition. If an examination needed to be conducted in a specific room because it contained appropriate equipment, but which would not ordinarily be used for a person of that gender (for example, a trans man needing to be examined in a room ordinarily used for the examination of women), this should be clearly explained to the patient and sensitively managed

## Access and flow

The trust had seen performance slip in some referral to treatment times for elective procedures. There was an agreed recovery plan and data showed that there was an Improvement Plan which was on target to recover performance to compliant position by end of 2019/2020. The data to April 2019 was nationally available data but local data held by the trust showed sustained improvement towards meeting the action plan for recovery.

**Referral to treatment**

From May 2018 to April 2019 the trust's referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. The latest figures for April 2019, showed 81.6% of this group of patients were treated within 18 weeks versus the England average of 87.0%.

The commissioners had agreed a recovery plan and the trust had met this. A new target had ben agreed for 2019/2020 and the trust was showing evidence that they would meet this. The current RTT performance was 92%.

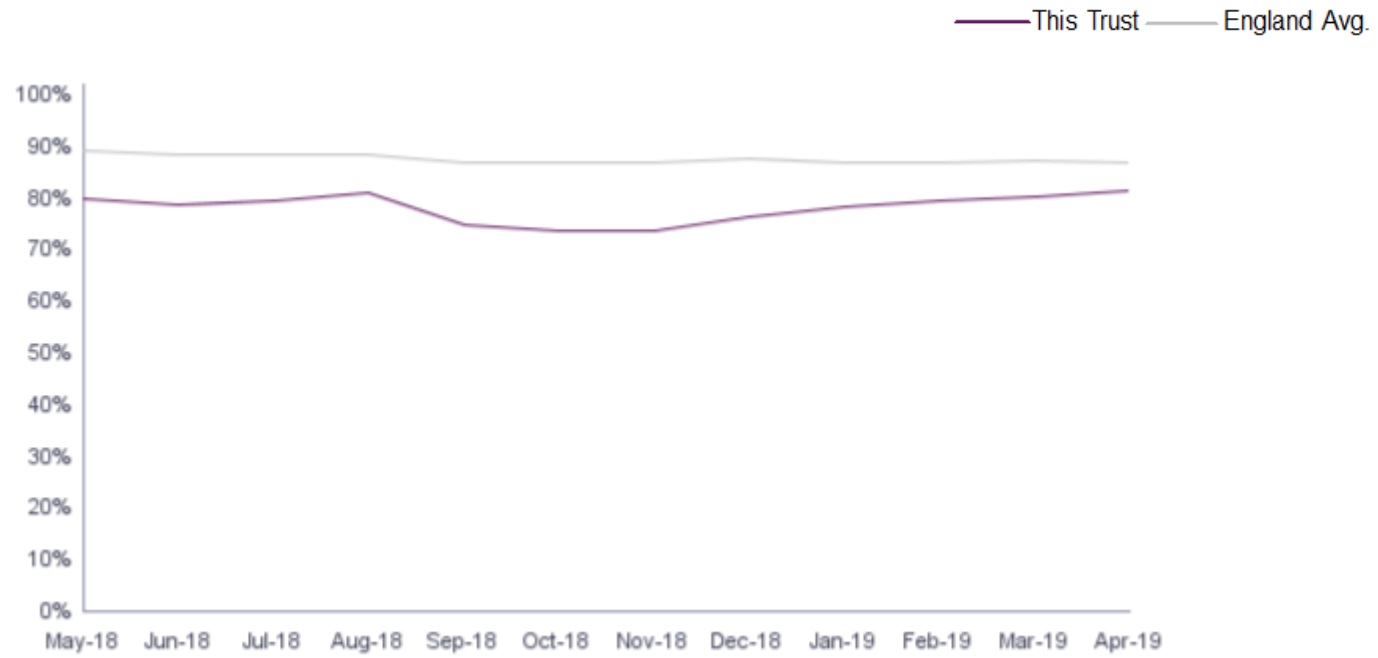
Cancer Performance – The trust have observed significant increases in demand for Coastal West Sussex CCG Patients in 2018/19 in comparison to the previous year, notably an overall rise of 8.9% rise in 2-week referrals & a 7.7% rise in 62-day urgent referrals. Specialities that have seen a significant increase include Colorectal, Urology, Skin, Breast and Head & Neck.

Despite this, overall the trust exceeded national performance for all one indicator & achieved compliance for 5 of the 7 Cancer performance indicators with a target in 2018/19

18 Week RTT Performance – The trust achieved compliance with the revised NHSE target that their waiting list in March 19 should be no higher than that of March 2018 both for Coastal West Sussex CCG patients and as a trust.

The latest published data (May 2019) showed that the trust had no 52+ week breaches. Provisional data showed the waiting list at WSHFT for Coastal West Sussex CCG patients was currently 3.1% higher than for March 2019 while the backlog is 6.4% lower. The number of completed pathways in May 2019 was 5.6% higher than for March 2019 with the number of 'clock starts' being 1.2% higher.

**Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Western Sussex Hospitals NHS Foundation Trust.**




*(Source: NHS England)*

Three specialties were above the England average for non-admitted pathways RTT (percentage within 18 weeks).

| Specialty grouping | Result | England average |
|---|---|---|
| Dermatology | 92.4% | 88.0% |
| Gynaecology | 92.0% | 91.2% |
| Trauma & Orthopaedics | 86.0% | 85.6% |

Thirteen specialties were below the England average for non-admitted pathways RTT (percentage within 18 weeks).

| Specialty grouping | Result | England average |
|---|---|---|
| Geriatric Medicine | 91.1% | 95.0% |
| General Medicine | 89.0% | 90.8% |
| Other | 86.4% | 90.0% |
| General Surgery | 85.4% | 88.3% |
| Urology | 83.0% | 84.8% |
| Thoracic Medicine | 80.8% | 86.0% |
| Ear, Nose & Throat (ENT) | 71.4% | 83.7% |
| Ophthalmology | 68.4% | 88.5% |
| Cardiology | 66.1% | 85.4% |
| Oral Surgery | 63.1% | 80.4% |
| Gastroenterology | 60.7% | 81.2% |
| Rheumatology | 59.8% | 86.3% |

| Specialty grouping | Result | England average |
|---|---|---|
| Neurology | 44.9% | 77.3% |

*(Source: NHS England)*

From May 2018 to April 2019 the trust's referral to treatment time (RTT) for incomplete pathways has been worse than the England overall performance. The latest figures for April 2019, showed 83.3% of this group of patients were treated within 18 weeks versus the England average of 86.1%.

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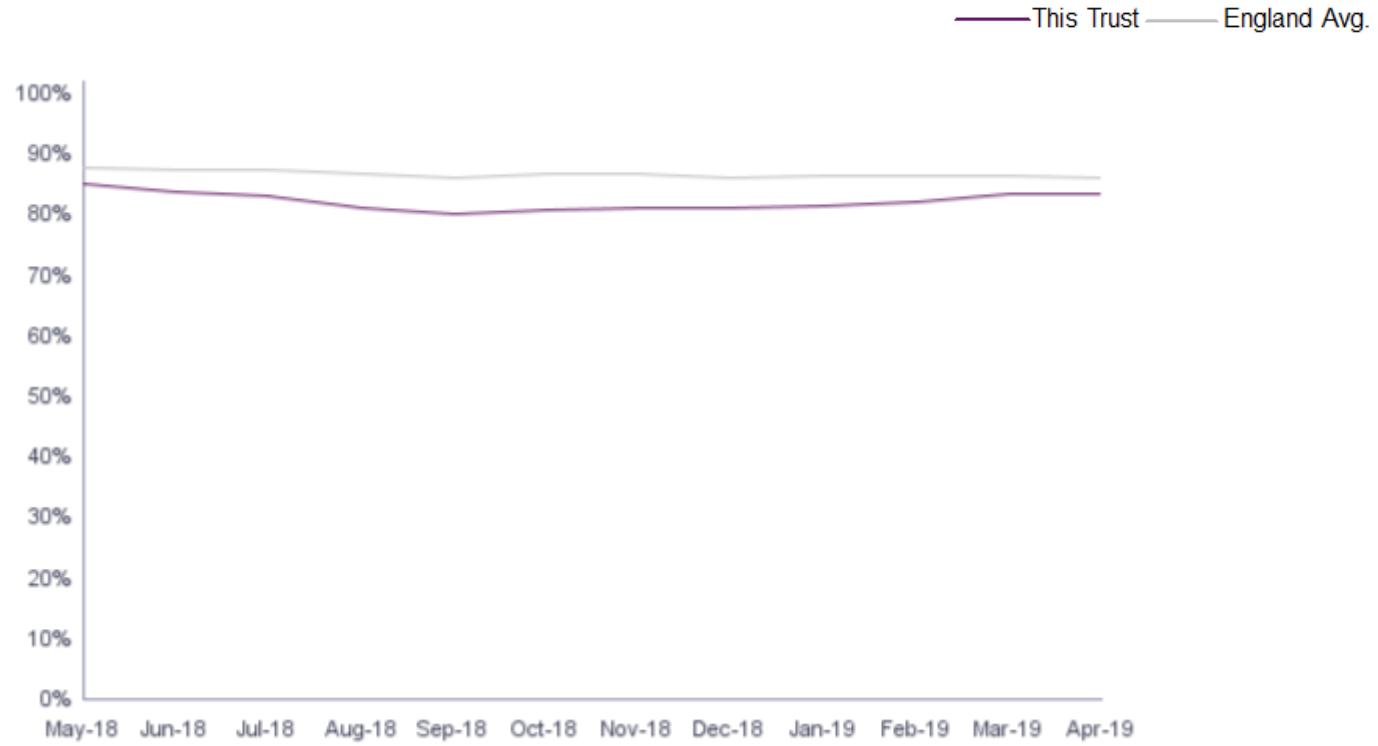


*(Source: NHS England)*

Six specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

| Specialty grouping | Result | England average |
|---|---|---|
| General Medicine | 94.7% | 91.5% |
| Thoracic Medicine | 92.1% | 88.9% |
| Other | 90.9% | 89.1% |
| Gynaecology | 90.8% | 87.8% |
| General Surgery | 87.5% | 83.8% |
| Urology | 85.9% | 85.1% |

Ten specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

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| Dermatology | 86.2% | 89.6% |
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| Trauma & Orthopaedics | 73.2% | 81.3% |
| Neurology | 72.0% | 86.6% |

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**Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)**

The trust is performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The performance over time is shown in the graph below.

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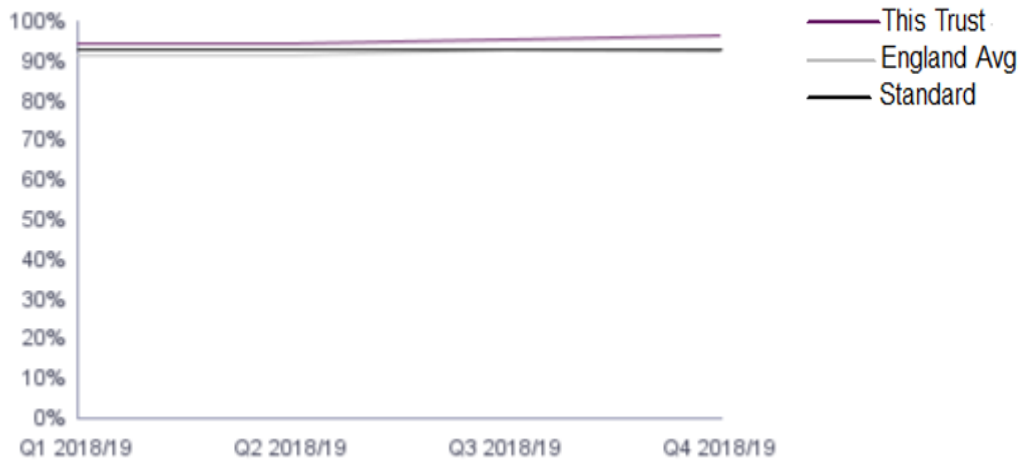


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**Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)**

The trust is performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.

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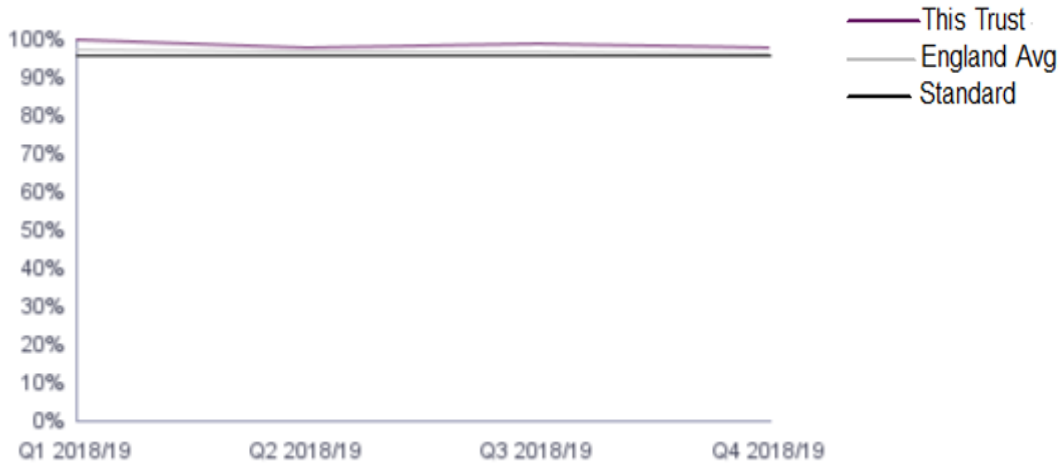


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**Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment**

The trust is performing worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

However, cancer provisional performance for April-19 was 82.1 % of patients treated within 62 days from referral as per the Trust's recovery plan and in the context of continued significant increased demand, compared to 79.75 National Average (March).

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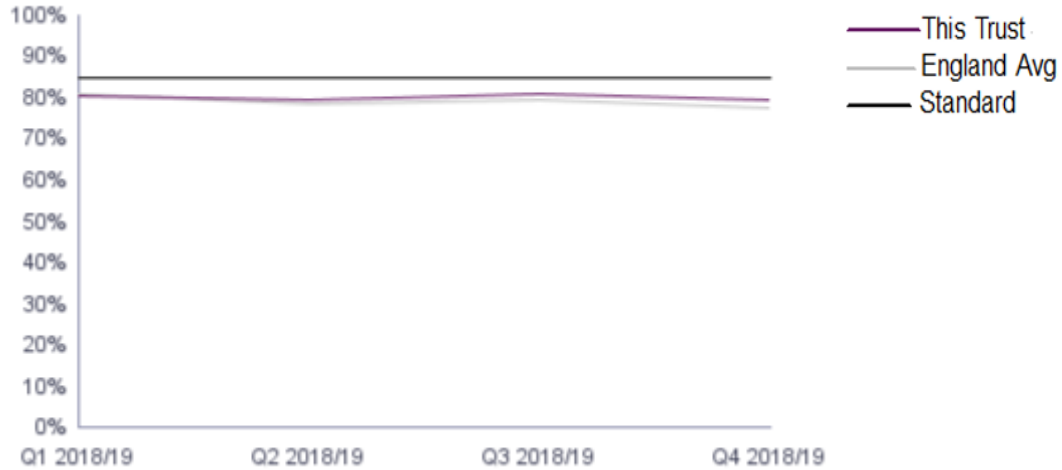


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