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**

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

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

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

The trust provides urgent and emergency care services 24 hours a day seven days a week from two locations. The Royal Sussex County Hospital (RSCH) Brighton and the Princess Royal Hospital in Haywards Heath. The Royal Sussex County Hospital has a type one emergency department which is the regional major trauma centre and is co-located with an urgent care centre for patients with minor illnesses and minor injuries.
Emergency services for children are provided at the Royal Alexandra Children’s Hospital and the Sussex Eye Hospital provides an eye casualty service. PRH has a type one emergency department.

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

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

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

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
</tr>
</thead>
</table>
| Royal Sussex County Hospital (including Royal Alexandra Children’s Hospital and the Sussex Eye Hospital) | Royal Sussex County Hospital, Brighton, BN2 5BE | • Medicine includes elderly, dermatology, respiratory  
• Clinical infection service  
• Haematology/oncology  
• Trauma  
• Surgery including vascular, upper GI, complex urology, Gynae oncology, head and neck cancer  
• Renal services including dialysis  
• Cardiac services including cardiac surgery  
• Breast care services  
• Accident and emergency  
• Elective ophthalmology services  
• Maternity  
• Paediatrics and neonates including day case  
• HIV  
• Oncology, including haematology–oncology  
• Intensive care  
• Orthopaedics  
• Neurosciences including neurosurgery and neuro-intensive care  
• Sexual health and contraception |
| Princess Royal Hospital | Lewes Road, Haywards Heath, RH16 4EX | • Medicine includes elderly, dermatology, respiratory  
• General elective surgery  
• Accident and Emergency  
• Intensive care  
• Orthopaedics  
• Maternity  
• Rehabilitation |
The trust also provides physiotherapy, dermatology and outpatients services out of Brighton General Hospital and are registered with CQC to provide services from the following locations:

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

(Source: Trust Website)

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

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

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

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

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

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

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

In October 2017, we conducted a focused, unannounced inspection to specifically review staff understanding of COSHH after CQC was notified of a patient death following a COSHH incident.
Is this organisation well-led?

Leadership

Board Members

The trust board had the appropriate range of skills, knowledge and experience to perform its role. From 1st April 2017 the entire Western Sussex Hospitals NHS Foundation trust board (rated outstanding by the CQC) entered into a three-year management contract with NHS Improvement and Brighton and Sussex University Hospitals. This new arrangement provided a level of stability that had been absent over several years. There had been more than five changes of chief executive in five years. One of the first objectives of the new executive team was to address the leadership and organisation's structural issues identified in the 2016 and 2017 CQC report.

New corporate structures were implemented across Brighton and Sussex University Hospitals and Western Sussex Hospitals NHS Foundation Trust with new trust directors and group directors positions created. This included dedicated medical, nursing, finance, operations, facilities and estates and human resource directors for Brighton and Sussex University Hospitals.

The chief executive was appointed on 1 April 2017. She was also chief executive of Western Sussex Hospitals NHS Foundation Trust. In March 2018 she became the first female to be the Health Service Journal chief executive of the year. She 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 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.

The chair joined the trust in October 2018 between the CQC core service and well-led inspections. They were the chair of both Western Sussex Hospitals and Brighton and Sussex University Hospitals. They were a chartered civil engineer with 40 years’ experience in the public sector, including five years as chief executive of Brighton and Hove City Council and eight years as chair of Surrey and Sussex University Hospitals NHS Trust.

The chief medical officer was appointed in April 2017. They joined Western Sussex Hospitals Foundation Trust as medical director in January 2014. They were an experienced clinical leader at national and regional level and a specialist intensive care consultant. In 2011, they participated in the Health Foundation’s GenerationQ leadership and quality improvement programme.

The chief nursing and patient safety officer joined the trust in May 2017. They were previously the director of nursing and quality at Frimley Health NHS Foundation Trust which was the first NHS Trust to be rated as outstanding by the CQC and was part of the Executive Team that led the acquisition and improvement of Wexham Park.

The chief delivery and strategy officer was appointed in April 2017. They hold the same post for Western Sussex Hospitals Foundation Trust. From January 2018, they had also been performing the role of chief operating officer for Brighton and Sussex University Hospitals.

The chief financial officer was appointed in April 2017. They worked in several NHS organisations and had at Brighton and Sussex University Hospitals for 12 years before moving to Western Sussex Hospitals Foundation Trust as director of finance in 2014.
The chief workforce and organisational development officer was appointed in April 2017. They hold the same post at Western Sussex Hospitals Foundation Trust. They joined Royal West Sussex NHS Trust in February 2008 as director of human resources and organisational development and were appointed to Western Sussex Hospitals Foundation Trust after the merger with Worthing and Southlands.

The trust has seven non-executive directors who work across Western Sussex Hospitals Foundation Trust and Brighton and Sussex University Hospitals. They have a range of experience and skills including finance, human resources, medicine, governance and audit. We found non-executive directors to be an engaged group who brought a wealth of different skills and experiences to the trust. They were open and honest and expressed total confidence in the executive directors. They spoke of taking account of the risks to managerial capacity before agreeing to the three-year management contract with NHS Improvement. All non-executive directors were unanimous in their view that everyone in the trust, from wards and departments to the trust board had worked tirelessly to address the failings which had placed the trust in special measures. They understood the need for long-term sustainability.

Of the executive board members at the trust, 16.7% were British Minority Ethnic (BME) and 67% were female.

Of the non-executive board members 0% were BME and 42.9% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>16.7%</td>
<td>67.0%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0.0%</td>
<td>42.9%</td>
</tr>
<tr>
<td>All board members</td>
<td>7.7%</td>
<td>53.8%</td>
</tr>
</tbody>
</table>

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

Several other corporate functions were established across both organisations including Service improvement, Strategy, IT and Communications. All leaders in the new structure were required to go through a formal selection process to ensure that all the individuals appointed had the right skills, experience and behaviours to demonstrate that they met the ‘Fit and Proper Person’ criteria.

The trust had a senior leadership team in place with the appropriate range of skills, knowledge and experience. The trust commissioned an external organisational development professional to undertake a detailed training needs analysis at all levels of the organisation. This informed the development of the trusts ‘Leadership Development Strategy’ which had been reviewed by the Quality Assurance Committee and was due to be signed off by the board in October.

From December 2017 a new divisional structure was created around the pre-existing directorate structure. The directorates were grouped under five clinical divisions and 15 new senior leadership posts were created to strengthen the existing leadership and management arrangements of the clinical services.

Each division had a chief of service, divisional director of operations and head of nursing/profession. All appointees also went through a formal process. The newly appointed
Divisional leaders undertook an initial three module personal development programme on appointment.

The trust had a lead for child and adolescent mental health, learning disability and autism and a learning disabilities nurse lead, who was employed by Sussex Partnership NHS Foundation Trust. They were line managed by the community learning disabilities team and reported within the trust to the nurse director. The trust also has a child and adolescent mental health services lead within the Children’s and Women’s division.

Fit and proper person checks were in place. We reviewed the trust’s declaration of interests and fit and proper persons procedure, an update of which was presented and approved by the trust board on 25th July 2018. For the purposes of good governance, oversight of compliance for this procedure was held by the Audit Committee with the deputy chief executive officer accountable as the responsible executive director and the company secretary with designated responsibility for oversight of the process.

Our review of the annual declarations of interest and the fit and proper persons annual declarations of trust board members and ‘equivalents’ (defined as those of sufficient seniority whose advice and input the board would rely upon) confirmed the trust was compliant with the statutory requirements of Regulation 5 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Fit and Proper Persons: Directors.

The trust made available copies of the directors and equivalents. Annual declarations of interest and declarations of fit and proper persons, all were signed and dated. A full schedule of compliance for quarter four 2017/2018 listing by name and job title the directors and equivalents were presented to the trust board on the 27th July 2018.

We requested sight of the personnel files of the most recent appointments to the trust board to check on the fit and proper person requirement of the appointments process. The files were made available within 30 minutes from our request and were presented in a logical and demonstrated best practice.

We also reviewed appraisal documentation for the executive team. Records showed these were up to date, comprehensive and included annual 360-degree feedback from both non-executive and executive board members.

A copy of the national NHS Jobs advertisement and candidate information pack was at the front of each file we looked at, followed by a very detailed job description and person specification.

There was clearly documented evidence of the checks undertaken by NHS Improvement on disqualified directors, insolvency and bankruptcy searches along with the required statutory checks. All the essential documents to support the appointment were available such as three references, interview notes, ID checks, a declaration of interest’s occupational health clearance, confirmation of appointment, signed contract of employment which contained appropriate references to the requirement for annual declaration of interests and fit and proper person requirement declarations.

The policy ‘Managing Conflicts of Interest and Fit and Proper Persons Declarations’ was presented to the trust’s audit committee as agenda item 13 on the 12 October 2018. This was a new policy which had been developed with the trust’s local counter fraud specialist. This was a comprehensive policy which referred to links with other policies such as an ‘Anti-fraud and Corruption Policy’, ‘Freedom to Speak Up Policy’ and ‘Procurement, Management and Use of Clinical Point of Care Testing Equipment Policy’.
The trust leadership team had a comprehensive knowledge of current priorities and challenges and acted to address them. Through the trust’s vision and strategy ‘Patient First’ and the ‘true north’ and breakthrough objectives, leaders clearly understood the challenges of the organisation and were able to identify actions to address these challenges.

The trust’s ‘Board Assurance Framework’ although not yet fully embedded described the key strategic risks with actions to mitigate them. Through board committees these risks were being managed and scrutinised; actions had been taken to mitigate risks and address gaps in control.

The board and its committees regularly undertook ‘deep dives’ into areas of concern to identify that the actions being taken effectively addressed the challenges faced. The Patient First ‘Strategic Deployment Review’ process ensured that there was ‘ward to board’ visibility within the trust. All leaders within the organisation demonstrated a joint view and approach to addressing the trust’s challenges.

The trust executive committee ensured mitigating actions were identified and addressed via the strengthened divisional and corporate infrastructure. The Trust Executive Committee monitored operational risks and ensured that where these indicated a risk to the achievement of the trust's strategic objectives appropriate action was taken.

Corporate work streams and management groups focused on specific areas of risk such as emergency care and financial efficiency which were integrated into the trust’s governance arrangements.

The trust is investing significantly in a major capital development project, known as 3Ts (trauma, teaching and tertiary). It is a £485m rebuild on the Royal Sussex campus in Brighton replacing the existing Barry building and addresses other estates issues. The scheme is forecast to be delivered within budget.

In July 2018 NHS Improvement confirmed that the trust had exited Special Measures for financial reasons. A series of undertakings are in the process of being agreed between NHS Improvement and the trust, these focus on agreeing robust and stretching financial plans going forward in the medium term, covering the initial construction phase of the 3Ts project.

There is a chief financial officer with group oversight for the two organisations and a finance director at trust level. Both individuals have strong board level experience. At the start of the management contract there was a significant level of vacancy within the finance team. This has been successfully addressed and the capacity and capability of financial support to the operational teams has been strengthened through a business partner model.

There was a programme of board visits to services and staff we spoke with told us that that leaders were approachable. Across the core service inspections and focus groups staff spoke with us about the improved visibility of the executive and divisional leaders. Executives, non-executives and divisional leads regularly attended safety huddles on the wards and departments.

The executive team also held regular Patient First briefing sessions, and the Chief nurse organised and attended away days with band six, seven and eight nurses. Staff spoke enthusiastically about improved communications across the trust, for example ‘Chief Executives Message and Headlines’.

Staff spoke about their participation in the STAR Awards and other social occasions which included members of the executive and divisional leads. The lesbian, gay, bisexual, transgender and queer (or questioning) and others (LGBTQ+) focus group told us how pleased they were when the chief executive and chief nurse participated in the annual Brighton Pride event.
Leadership development opportunities were available, including opportunities for staff below team manager level. Succession planning was in place throughout the trust. The trust’s leadership development strategy comprised of two activities. These were developing leaders through meeting learning needs in a timely and effective way and succession planning through understanding the trust’s future needs and managing the talent within the trust so that they had ‘ready now’ people to fill key roles. An example being that the chief nurse and nursing directors had held a ‘speed dating’ type event where they had quickly met and assessed band six nurses in the trust and had highlighted those that were ready for development into band seven roles.

The trust’s succession plan was based on their first five years of their contract. In years one and two the trust would concentrate on the learning needs analysis findings along with rolling out Patient First training to staff. In years two to three the trust planned to build on their ability to meet learning needs in a timely and appropriate way, and to use their talent wisely looking to succession plan and increase leadership capability. By years three to five the trust planned to have a robust and structured pathway for leadership development that was fully embedded, supported Patient First, met changing needs and assured them of their ability to attract and retain talent.

A full leadership training needs analysis had been completed and a new leadership development strategy and succession plan will be presented to the board in October. All the new divisional leadership teams undertook an initial modular personal development programme as part of their induction and first three months in their role.

The trust leadership was inclusive as evidenced through its Equality and Diversity Strategy. The trust leadership had supported the development of the LGBTQ+ leadership mentoring programme.
The trust had a clear vision and set of values with quality and sustainability as the top priorities. The trust's clear vision and values is encapsulated in its 'Patient First' approach which was agreed by the board. This is summarised by the Patient First triangle, with 'the patient first and foremost' at the apex of the triangle.

Patient First has four strategic themes - 'Our People' 'Quality Improvement' 'Sustainability' and 'Systems and Partnerships'. The trust set out its strategic aims through its 'True North' which was the trust's key long term aims which aligned to its strategic themes which focused on quality and sustainability.

There was a robust and realistic strategy for achieving trust priorities and developing good quality, sustainable care. The trust's Patient First approach provided the integrated framework for the development of a robust and realistic strategy. The trust's quality priorities were aligned with Patient First and set out in the trust’s ‘Quality Improvement Plan’. As part of planning and performance management each clinical division had identified how they contribute to ‘True North’ and what areas of the strategic framework they would be driving delivery on. This process had set the divisional objectives for the financial year, with monitoring and reviewing of divisional priorities taking place in the monthly Divisional Strategy Deployment Review meetings.

The trust’s approach to business planning has used Patient First as the framework for prioritisation. This was mirrored in the trust’s operational plan. The trust plans to further develop
this in 2019/20 as part of the two-year operational planning approach to the completion of Stage one of the 3Ts (Trauma, Teaching and Tertiary Care programme).

The trust's ‘Operational Plan’ set out its ‘True North’ and its Breakthrough Objectives for the year. Breakthrough Objectives identify what the trust is specifically focusing on achieving in the coming year. The Operational Plan also set out the trust’s strategic initiative.

The Patient First vision and strategy was delivered through the trust's ‘Strategic Deployment Review’ approach. Strategic deployment provided a framework for staff at all levels to be clear about priorities, progress against them and how they could contribute. We attended two of these meetings at divisional level during inspection and found that they steered the development of improvement initiatives.

These meetings were held in a central point for the visual management of progress which the trust named their ‘Strategy Deployment Room’. Meetings were held monthly with the executive team, weekly at divisional level and locally at unit/ward level where improvement huddles were held three times a week.

We attended improvement huddles across all the core services we inspected and during CQC engagement events before the inspection. We found that these aligned clearly with the trust strategy and were supportive, effective and staff at all levels were engaged in the process.

The trust was developing a fully refreshed clinical strategy, which was aligned to the trust's Patient First strategy at the time of the inspection. Therefore, we are unable to form a judgement on the effectiveness of this strategy in this inspection report. The trust was also developing a medium term financial plan, to fully understand the financial context of the trust and develop a programme of measures to address this.

There were plans to refresh the ‘Quality Strategy’ for 2019/20 through the engagement of staff, patients, the public, other partners and stakeholders. The refreshed strategy would be aligned to the delivery of the ‘True North’ aims and the ‘Darzi’ quality pillars of patient safety, clinical outcomes, patient experience, staff engagement and experience.

Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services. The trust had engaged with staff to communicate its Patient First Strategy through a range of engagement events. These included staff roadshows, leadership events, internal communications such as the CEO message and ‘The Buzz’ (read by 2,100 staff per week), staff drop in sessions (250 staff to date), trust briefs and the Strategic Deployment Reviews (400 staff had either completed or were undergoing strategic deployment review training).

The trust also engaged staff in the Patient First strategy at induction (850 staff to date). The trust patient first website provided staff with information about the strategy and has had 12,600 views since October 2017.

The trust had a ‘Patient Experience Committee’ which was co-chaired by Healthwatch which influenced the trust’s approach.

All staff we spoke with on inspection were clear about the trust's approach and priority to deliver high quality sustainable care to patients. Staff knew and understood the trust's vision, values and strategy and how achievement of these applied to the work of their team. To support the roll-out of Patient First across the trust, a communications plan was developed and implemented. The plan was tailored to different audiences to best reach staff in different parts of the organisation.
The trust pulse surveys showed that by August 2018 84% of staff recognised Patient First and were able to describe the trust’s vision, to improve the patient experience. Of those who were aware of Patient First 95% believed that it will help the organisation improve. Of those who responded 88% of staff stated that they said they could see how they could contribute to the strategy.

The trust is currently refreshing its clinical strategy with appropriate stakeholder engagement and this will be a key plank of the medium term financial plan to deliver sustainability. This was work in progress at the time of the inspection.

The board are well sighted on the financial challenges faced by the trust and there is a good understanding of the key drivers of the underlying deficit. This diagnostic is an important component of the trust’s medium term financial plan.

Sustainability is a key pillar of the “Patient First” improvement programme and this embraces financial health. It has equal weighting with the quality agenda and this is recognised across the organisation with the focus of the cost improvement programme on improving productivity, efficiency and reducing premium costs.

Clear arrangements are in place for reporting on the cost improvement programme. All schemes have an executive sponsor and a workstream lead. Programme management arrangements are in place to manage the identification and delivery of the programme with appropriate resource available to support the divisions. The programme management office is led by the director of efficiency and delivery who reports jointly to the chief operating officer and chief financial officer.

The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans. Progress on the trust strategy and improvement journey was reviewed regularly with external partners through various forums including Health Oversight Scrutiny Committee with the county and city councils, Integrated Assurance Meetings and System Assurance Meetings with NHS Improvement, board to board with the Commissioning Alliance, the Quality Oversight Committee with the CQC, NHS Improvement, NHS England, Clinical Commissioning Groups, Healthwatch, Health Education England, and the various sustainability and transformation plans forums.

The trust worked with external partner organisations, commissioners, other providers, staff, patients, local authorities and the sustainability and transformation plans. This was evidenced through the collaborative work at both a strategic and tactical level in several areas for example; patient experience, urgent and emergency care, safeguarding, the aligned incentive contract (with the five local clinical commissioning groups). The trust had agreed three strategic memorandums of understanding with other key Providers.

The trust also acted as the lead Clinical Network hub for the region, and formally led the Vascular, Major Trauma, and Hepatitis C networks. The trust was part of the regional Cancer Alliance, and chaired the Sustainability and transformation plans Clinical Senate. The trust was also part of the Joint Venture “Frontier Pathology” with Surrey and Sussex Hospitals which has been selected the regional pathology hub for network seven. In total, 12 networks have agreed across England in line with NHS Improvement recommendations.

The trust has agreed an ‘Aligned Incentive Contract’ with local CCGs for 2018/19. This allows the commissioners and trust to engage in transformational programmes of work which will benefit patients and the local health economy where both parties are incentivised to collaborate. Workstreams for 2018/19 included repatriation of independent sector work and medicines management.
The core service inspection findings showed that the trust was meeting the needs of patients with a mental health, learning disability, autism or dementia diagnosis. The trust had a Mental Health and Mental Capacity Board. In addition, the nurse director and medical director were members of the Mental Health Crisis Board, which was citywide for Brighton and Hove. The trust’s dementia strategy and mental health strategy were in development at the time of the inspection.

**Culture**

Without exception all staff we spoke with both on inspection and engagement talked about a paradigm shift in culture across the whole trust. Staff described the culture as inclusive, empowering, and positive. Staff were described by inspectors and specialist advisors as energetic and enthusiastic. This mirrored what we found on engagement with the trust prior to inspection.

The senior leaders in the organisation wrote to the CQC stating, “As the senior clinical leadership team at BSUH, we felt it would be helpful for us to express our support for the executive team. Many of us have held leadership roles for some time and are well sighted on some of the longstanding historical challenges which confront us. Weak governance structures for safety and quality, and operational and financial performance had conferred additional challenge on our ability to influence and effect change.

Providing a framework around the Patient First Improvement System has proved valuable in aligning priorities and processes. It has empowered teams to work through bottom-up solutions and effect change for themselves and their patients. Whilst this is still embedding, we have seen commitment and enthusiasm for the approach”.

Staff felt respected, supported and valued. The executive teams and divisional leaders told us how they felt that improving the experience and engagement of their staff was fundamental to delivering a culture of high sustainable care and trust strategic objectives.

One of the trusts top strategic themes was their ambition to be in the top 20% of all NHS employers for staff engagement. The strategic objective for their workforce was to value and respect all staff equitably and to involve them in decisions about the services they provide and offer; and deliver training to ensure they develop the skills they need to fulfil their roles.

The trust’s Patient First Improvement System empowered staff to make improvements and to be listened to and respected. In areas where Patient First had been introduced the level of engagement and motivation had significantly improved as staff felt empowered to make improvements in their work. This was evident both on CQC engagement events at the trust and on inspection.

**NHS Staff Survey 2017 – results better than average of acute trusts**

The trust has no key finding that exceeded the average for similar trusts in the 2017 NHS Staff Survey
The trust has 31 of the 32 key findings worse than the average for similar trusts in the 2017 NHS Staff Survey with 25 of these 31 key findings scoring in the worst 20% of trusts. The results for the 31 key findings worse that the average of acute trusts is below:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF29. % reporting errors, near misses or incidents witnessed in last month</td>
<td>89</td>
<td>90</td>
</tr>
<tr>
<td>KF11. % appraised in last 12 months</td>
<td>84</td>
<td>86</td>
</tr>
<tr>
<td>KF12. Quality of appraisals</td>
<td>2.97</td>
<td>3.11</td>
</tr>
<tr>
<td>KF13. Quality of non-mandatory training, learning or development</td>
<td>3.95</td>
<td>4.05</td>
</tr>
<tr>
<td>KF20. % experiencing discrimination at work in last 12 months</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>KF21. % believing the organisation provides equal opportunities for career progression / promotion</td>
<td>82</td>
<td>85</td>
</tr>
<tr>
<td>KF28. % witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>40</td>
<td>31</td>
</tr>
<tr>
<td>KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.57</td>
<td>3.73</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.50</td>
<td>3.65</td>
</tr>
<tr>
<td>KF17. % feeling unwell due to work related stress in last 12 months</td>
<td>45</td>
<td>36</td>
</tr>
<tr>
<td>KF18. % attending work in last 3 months despite feeling unwell because they felt pressure</td>
<td>57</td>
<td>52</td>
</tr>
<tr>
<td>KF19. Org and management interest in and action on health and wellbeing</td>
<td>3.40</td>
<td>3.62</td>
</tr>
<tr>
<td>KF15. % satisfied with the opportunities for flexible working patterns</td>
<td>50</td>
<td>51</td>
</tr>
<tr>
<td>KF16. % working extra hours</td>
<td>74</td>
<td>72</td>
</tr>
<tr>
<td>KF1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.49</td>
<td>3.75</td>
</tr>
<tr>
<td>KF4. Staff motivation at work</td>
<td>3.76</td>
<td>3.92</td>
</tr>
<tr>
<td>KF7. % able to contribute towards improvements at work</td>
<td>66</td>
<td>70</td>
</tr>
<tr>
<td>KF8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.83</td>
<td>3.91</td>
</tr>
<tr>
<td>KF9. Effective team working</td>
<td>3.59</td>
<td>3.72</td>
</tr>
<tr>
<td>KF14. Staff satisfaction with resourcing and support</td>
<td>3.13</td>
<td>3.31</td>
</tr>
<tr>
<td>KF5. Recognition and value of staff by managers and the organisation</td>
<td>3.34</td>
<td>3.45</td>
</tr>
<tr>
<td>KF6. % reporting good communication between senior management and staff</td>
<td>23</td>
<td>33</td>
</tr>
<tr>
<td>KF10. Support from immediate managers</td>
<td>3.65</td>
<td>3.74</td>
</tr>
<tr>
<td>KF2. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>3.78</td>
<td>3.91</td>
</tr>
<tr>
<td>KF32. Effective use of patient / service user feedback</td>
<td>3.56</td>
<td>3.71</td>
</tr>
<tr>
<td>KF22. % experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>19</td>
<td>15</td>
</tr>
<tr>
<td>KF23. % experiencing physical violence from staff in last 12 months</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>KF24. % reporting most recent experience of violence</td>
<td>64</td>
<td>66</td>
</tr>
<tr>
<td>KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>35</td>
<td>28</td>
</tr>
<tr>
<td>KF26. % experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>30</td>
<td>25</td>
</tr>
<tr>
<td>KF27. % reporting most recent experience of harassment, bullying or abuse</td>
<td>43</td>
<td>45</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)

In response to the 2017 NHS National Staff Survey the trust had developed trust and divisional level plans to improve staff experience and engagement. To measure any improvements, the trust had developed a monthly ‘pulse survey’. The pulse surveys had shown staff agreeing that care is the top priority has risen from under 70% to over 80% in the past 12 months. Staff who recommend the trust as a place to work had risen from under 50% to over 70% in the past 12 months.

The results of the 2017 staff survey highlighted increasing levels of violence and aggression being experienced by trust staff. Using the Patient First principles a diagnostic was completed by the trust which included representatives from ward leaders in hot spot areas, strategic and operational security team members, team managers and representatives from the mental health and safeguarding. The trust has completed an initial deep dive into ward areas where violence and aggression had been most prevalent, completed a deep dive into security team and submitted a business case for a full personal protective equipment review for the security team and commencement of new equipment in the security team including body worn cameras.

Staff felt positive and proud about working for the trust and their team. Staff we spoke with on CQC engagement events and inspection were overwhelmingly positive and proud to work in the trust. The trust recognised staff success by staff awards and through feedback. The trust held its first annual STAR Awards in the summer of 2018 and staff spoke about these awards and the pride they felt in being presented with an award and recognised for their contribution to improving care for patients. As we walked the floor with the chief executive, chief nurse, and divisional leads we saw that they knew their staff and spoke encouragingly with them about their achievements and challenges.
Friends and Family test

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust scored about the same as the England average for recommending the trust as a place to receive care from August 2017 to July 2018.

Friends and family test (% recommended)

(Source: Friends and Family Test)

The trust’s strategy, vision and values underpinned a culture which was patient centred. Through the Patient First vision and values the trust encouraged a culture which focused primarily on patients. The Patient First Improvement System had empowered front line staff by equipping them with the lean tools, methods and a structured process which has helped to build and promote a culture of continuous improvement across the whole trust. The divisional leads told us that front line staff often had the best ideas (as they are closest to the problem), and that Patient First helped them feel empowered to make changes.

We saw engagement of staff, from several disciplines, clinical and non-clinical during ‘patient first’ improvement huddles which enabled them to discuss and prioritise issues, challenge practice, and make improvements.

The chief executive spoke about how by staff feeling that their contribution is valued they would want to do all they can to continue to propose new ideas, solve problems daily, “remove rocks from their shoes”, and help to sustain change.

The trust worked appropriately with trade unions. We spoke with the chair of staff side who reported good engagement with the leaders in the trust including the human resources team.
The handling of concerns raised by staff always met with best practice. We reviewed how a sample of internal grievances had been addressed. Issues were addressed in line with policy, while being sensitive to individual need and respecting confidentiality. All matters were thoroughly investigated which enabled a proportionate response to the issues raised and when taking disciplinary action if necessary.

Staff felt able to raise concerns without fear of retribution. Staff we spoke with told us that with an improved culture they now felt that they could and would raise concerns without fear. In the Autumn of 2016 the former chief executive at the trust launched an anti-bullying campaign called “Working together Effectively”. The initiative included a comprehensive poster campaign supported by extensive workshops for managers, teams and individuals.

The campaign resulted in a significant reduction in informal and formal grievance/dignity at work complaints. As part of the human resource restructure in 2016, a new service specifically dedicated to supporting staff was established. This service was called ‘Connections’ and was managed by a senior member of the human resource team who was professionally trained as a mediator. The head of the service was also a trained mediator. The service provided a “listening ear service” and advised staff confidentially on a range of issues including advice to staff on dealing with concerns about bullying.

The trust also has a dedicated employee relations team which supported staff and managers. All Employee Relations Managers were professionally qualified. The team operated a hotline for immediate advice for staff and managers on all employee relations matters. In addition, each division had a dedicated employee relations manager. The service undertook regular customer satisfaction surveys. Learning from cases were analysed on a quarterly basis to inform improvements in practice which was shared with the Quality and Assurance Committee.

The trust had appointed a Freedom to Speak Up Guardian and provided them with sufficient resources and support to help staff to raise concerns. The role of the Freedom to Speak Up Guardian in NHS trusts was introduced following Sir Robert Francis’ review and subsequent report into the failings in Mid-Staffordshire. The report recommended that every trust in England has a Freedom to Speak Up Guardian (FTSUG) as one of the ways to help normalise the raising of concerns by staff for the benefit of all patients. In the past this would have been referred to as ‘Whistleblowing’ but as this term has been the subject of adverse attention in the NHS, there is a move away from it towards staff having the freedom to speak up without fear of reprisal. In April this year the role became a requirement in the national contract. Staff mostly knew how to use the whistle blowing process and about the role of the FTSUG. However, we found a few staff who were not aware of who the FTSUG was. Between January and June 2017 there were 24 cases reported to the FTSUG. There were 23 cases in the same period this year.
Number of staff approaching the Freedom to Speak Up Guardian for support:

Speaking Up Themes*

* Categories recommended by National Guardian
The trust applied Duty of Candour appropriately.

The most recent national complaints guidance, and the approach supported by the Parliamentary and Health Service Ombudsman (PHSO) is to remove a requirement on NHS providers to adhere to specific response times. The focus is on the individual, making sure there is a quick acknowledgement, early engagement with the patient and to seek to resolve the complaint to their satisfaction. We looked at a sample of complaints across divisions, and the trust were relatively consistent in making sure that they responded to complaints in this way.

The trust did however work to a 25-working day response target. This target was not published or shared with the complainant it was an internal driver to make sure complaints were investigated in a timely way.

The complaints lead, and their team, acknowledged complaints early, contacted complainants and led the coordination and response to complaints effectively. All but one of the divisions whose complaints we reviewed were effective at working together to provide a timely response in the examples we looked at. Maternity stood out as an outlier in our review as the division that were not as effective as others at coordinating a response. The division recognised this when we spoke with them on inspection.

There was a focus on resolving issues and not waiting until the complaint had been investigated in full. Complainants were offered meetings to discuss ongoing care and treatment and / or their complaint while the investigation was ongoing. Thought was given to who should respond to the complainant. In one example, a consultant who had known the patient for a long period of time wanted to pen a personal response to the complainant.

We reviewed several complaints that had been referred to the PHSO by complainants for them to review. There were no notable concerns about the trust’s approach, investigation or response to these complaints with all but one referral not upheld by the PHSO.

The trust took action and shared learning from concerns raised. Divisions received a monthly report that included all informal, formal and plaudits received in month together with all responses sent in month to inform discussion regarding service improvement and quality improvement initiatives. All specialties had received bespoke training on access and disseminating friends and family data to ensure the actions taken on feedback given were shared.

All staff had the opportunity to discuss their learning and career development needs at appraisal. This included agency and locum staff and volunteers. The trust had significantly improved their appraisal completion rates since our last inspection. The trust undertook audits to test the effectiveness and quality of the appraisal conversations.

The trust had an education directorate that supported the learning needs of all staff and the trust held an annual multi-professional conference. The trust had over 50 practice educators working clinically across the trust. On the core service inspection staff spoke positively about the input and learning they received from practice educators. A new ‘Education and Knowledge Strategy’ was being developed at the time of our inspection.

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)

Staff had access to support for their own physical and emotional health needs through occupational health. The trust had an executive led ‘Leadership, Culture and Workforce
programme’ which comprised of 13 different workstreams on health. Two of these workstreams were health and well-being and reducing incidents of violence and aggression from patients.

The trust had an in-house occupational health service and a dedicated physiotherapy service for staff. The trust offered staff general support and assistance through their Connections service and wellbeing features in the trust induction programme.

Staff felt equality and diversity were promoted in their day to day work. We spoke with the newly formed Black and minority ethnicity working group. The trust had held an event in May where over 200 members of staff had come together to discuss equality and Black and minority ethnicity issues and start the forming of a new strategy. The output of this meeting was three workstreams; communication, recruitment, and education. The group we spoke with told us that they had seen a dramatic change in the past 6-9 months. They described this as powerful, positive and feeling included in the strategy and change.

The relationship between the trust and the previous BME representative group (referred to in our last report) had broken down and the trust no longer recognised this group. CQC facilitated a focus group with the previous BME representative group who chose not to attend to share their views with us, however they submitted a written statement of their views. BME staff we spoke with that were working at the trust described the damage they felt had been done by the previous BME representative group. They told us that now they were not operating in the trust, “the fear had gone”.

As part of the ‘Leadership Culture and Workforce Programme’ the chief executive directly led the equality and diversity workstream. The trust had a dedicated ‘Equality, Diversity and Inclusion Team’ comprising of a head of equality, diversity and inclusion, deputy head, equality manager and adviser. This team provided expert advice on all equality issues for staff and patients. The team managed over half a million pounds contract for language support for patients who need additional support for example interpreting and British Sign Language, the deputy head of equality, diversity and inclusion advises on the equality issues for all service changes for example physical premises changes and signage.

The chief executive had taken advice from Yvonne Coghill OBE on how to address the Workforce Race Equality Standard (WRES) data and how the trust could move forward on their race equality agenda. Yvonne is currently the director of WRES implementation in NHS England. Yvonne spoke with staff at the equality event in May 2018 and helped staff to understand the importance of WRES data and how this could help the trust with the forming of their new strategy. Yvonne told us that the chief executive had approached the WRES team at NHS England to request help on how to improve the experiences and opportunities for BME staff at her organisation. She became the first chief executive to attend a WRES team meeting. Since then, the trust had led a race equality workshop attended by more than 200 members of staff. The trust had also supported their head of equality, diversity and inclusion to take part in the WRES experts programme.
The Workforce Race Equality Standard is a set of metrics that require all NHS organisations to demonstrate progress against a number of indicators of race equality. The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and minority ethnicity staff, as required for the Workforce Race Equality Standard. Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

To preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

Of the four questions shown above, two showed a statistically significant difference in score between White and BME staff, KF21 and Q17b.

The trust had developed a Workforce Race Quality Standard Report which had been presented to the board in July 2018. The report interrogated the WRES data and action plan. The WRES action plan concentrated on the main issues drawn from the data. The Head of Equality, Diversity and Inclusion was able to translate WRES data and describe the actions that the trust was taking to address these. For example, the trust was giving training to Black and ethnic minority staff so that they could be represented on interview panels.

(Source: NHS Staff Survey 2017)

Yvonne Coghill OBE provided us with an overview of her assessment of WRES data below:
<table>
<thead>
<tr>
<th>Indicator Type</th>
<th>WRES Indicator</th>
<th>Metric Description</th>
<th>2016 Score</th>
<th>2017 Score</th>
<th>2018 Score</th>
<th>Direction</th>
<th>2017 National</th>
</tr>
</thead>
<tbody>
<tr>
<td>WORKFORCE</td>
<td>2</td>
<td>Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts</td>
<td>1.17</td>
<td>0.92</td>
<td>1.27</td>
<td>↑</td>
<td>1.60</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process.</td>
<td>1.95</td>
<td>0.73</td>
<td>1.34</td>
<td>↑</td>
<td>1.37</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Relative likelihood of White staff accessing non mandatory training and CPD compared to BME staff</td>
<td>0.62</td>
<td>1.79</td>
<td>0.93</td>
<td>↓</td>
<td>1.22</td>
</tr>
<tr>
<td>STAFFSURVEY</td>
<td>5</td>
<td>KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.</td>
<td>41.0%</td>
<td>34.3%</td>
<td>39.3%</td>
<td>↑</td>
<td>28.0%</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.</td>
<td>43.6%</td>
<td>36.9%</td>
<td>30.0%</td>
<td>↓</td>
<td>23.7%</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.</td>
<td>68.4%</td>
<td>64.0%</td>
<td>71.5%</td>
<td>↑</td>
<td>85.5%</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Q17. In the last 12 months have you personally experienced discrimination at work from any of the following?b) Manager/team</td>
<td>21.6%</td>
<td>20.8%</td>
<td>17.6%</td>
<td>↓</td>
<td>12.6%</td>
</tr>
<tr>
<td>BOARD</td>
<td>9</td>
<td>Percentage of BME Board membership</td>
<td>13.3%</td>
<td>6.3%</td>
<td>7.7%</td>
<td>↑</td>
<td>7.0%</td>
</tr>
</tbody>
</table>

Table 1: Indicator 2 – 9 (2016 – 2018)
BME staff are relatively less likely to be appointed from shortlisting and more likely to enter the formal disciplinary process. BME staff are more likely to access non-mandatory training and CPD. In 2018, five indicators improved and three deteriorated. Indicators 6, 7 and 8 which are taken from the NHS staff survey have improved. The latest results for these indicators are the best ever for the organisation. It should be noted that indicators 5 to 8 are based on the views of staff and they show the culture within the organisation. From the WRES staff survey questions, only indicator 5 worsened. This indicator looks at harassment from patients and members of the public.

<table>
<thead>
<tr>
<th>NHS Staff survey question</th>
<th>White staff</th>
<th>BME staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>I look forward to going to work.</td>
<td>48.9%</td>
<td>62.6%</td>
</tr>
<tr>
<td>I am trusted to do my job.</td>
<td>92.6%</td>
<td>93.5%</td>
</tr>
<tr>
<td>There are frequent opportunities for me to show initiative in my role.</td>
<td>68.7%</td>
<td>76.2%</td>
</tr>
<tr>
<td>I am able to make suggestions to improve the work of my team / department.</td>
<td>73.3%</td>
<td>71.2%</td>
</tr>
<tr>
<td>The recognition I get for good work.</td>
<td>49.3%</td>
<td>57.4%</td>
</tr>
<tr>
<td>The support I get from my immediate manager.</td>
<td>65.7%</td>
<td>67.6%</td>
</tr>
<tr>
<td>The support I get from my work colleagues.</td>
<td>79.1%</td>
<td>75.3%</td>
</tr>
<tr>
<td>The extent to which my organisation values my work.</td>
<td>32.0%</td>
<td>48.4%</td>
</tr>
<tr>
<td>The opportunities for flexible working patterns.</td>
<td>48.4%</td>
<td>58.0%</td>
</tr>
<tr>
<td>My immediate manager...encourages those who work for her/him to work as a team.</td>
<td>71.6%</td>
<td>76.2%</td>
</tr>
<tr>
<td>My immediate manager...can be counted on to help me with a difficult task at work.</td>
<td>68.7%</td>
<td>73.3%</td>
</tr>
<tr>
<td>My immediate manager...gives me clear feedback on my work.</td>
<td>55.3%</td>
<td>64.5%</td>
</tr>
<tr>
<td>My immediate manager...asks for my opinion before making decisions that affect my work.</td>
<td>51.3%</td>
<td>58.6%</td>
</tr>
<tr>
<td>My immediate manager...is supportive in a personal crisis.</td>
<td>73.3%</td>
<td>70.4%</td>
</tr>
<tr>
<td>My immediate manager...takes a positive interest in my health and well-being.</td>
<td>65.1%</td>
<td>65.7%</td>
</tr>
<tr>
<td>My immediate manager...values my work.</td>
<td>72.2%</td>
<td>71.7%</td>
</tr>
<tr>
<td>Communication between senior management and staff is effective.</td>
<td>29.1%</td>
<td>39.4%</td>
</tr>
<tr>
<td>Senior managers here try to involve staff in important decisions.</td>
<td>22.6%</td>
<td>36.6%</td>
</tr>
<tr>
<td>Senior managers act on staff feedback.</td>
<td>21.3%</td>
<td>33.1%</td>
</tr>
<tr>
<td>% saying their organisation definitely takes positive action on health and well-being</td>
<td>19.1%</td>
<td>31.5%</td>
</tr>
<tr>
<td>My organisation treats staff who are involved in an error, near miss or incident fairly.</td>
<td>48.1%</td>
<td>60.4%</td>
</tr>
<tr>
<td>My organisation encourages us to report errors, near misses or incidents.</td>
<td>82.0%</td>
<td>86.1%</td>
</tr>
<tr>
<td>% saying if they were concerned about unsafe clinical practice they would know how to report it</td>
<td>92.6%</td>
<td>95.1%</td>
</tr>
<tr>
<td>I would feel secure raising concerns about unsafe clinical practice.</td>
<td>66.0%</td>
<td>70.3%</td>
</tr>
<tr>
<td>I am confident that my organisation would address my concern.</td>
<td>45.4%</td>
<td>56.4%</td>
</tr>
</tbody>
</table>
Table 2: 2017 NHS staff questions by ethnicity
For the majority of the non WRES staff survey questions, BME staff report having a better experience at work compared to their white colleagues.

Figure 1: Staff by AfC pay band: 2017
As at 31 March 2018, 17.3% (1,440) staff were from BME backgrounds. 83% of BME staff work in clinical roles. BME staff are underrepresented in Senior AfC Bands.

Conclusion
Based on the WRES and staff survey data, there is no evidence or objective information that things are getting worse for BME staff at Brighton and Sussex University Hospital Trust. There is still work to be done in regards to increasing BME representation at Senior AfC Bands and the formal disciplinary process.
Staff Diversity

The trust provided the following breakdowns of clinical and non-clinical staff by ethnic group from the Brighton and Sussex University Hospitals NHS Trust Workforce Race Equality Standard 2017 report. For comparison the trust report that in the 2011 census the south-east England region comprised 91% white and 9% BME with 0% unknown.

<table>
<thead>
<tr>
<th>Clinical</th>
<th>White</th>
<th>BME</th>
<th>Total</th>
<th>White %</th>
<th>BME%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 2</td>
<td>598</td>
<td>219</td>
<td>817</td>
<td>73.2%</td>
<td>26.8%</td>
</tr>
<tr>
<td>Band 3</td>
<td>228</td>
<td>51</td>
<td>279</td>
<td>81.7%</td>
<td>18.3%</td>
</tr>
<tr>
<td>Band 4</td>
<td>153</td>
<td>21</td>
<td>174</td>
<td>87.9%</td>
<td>12.1%</td>
</tr>
<tr>
<td>Band 5</td>
<td>1,096</td>
<td>345</td>
<td>1,441</td>
<td>76.1%</td>
<td>23.9%</td>
</tr>
<tr>
<td>Band 6</td>
<td>1,019</td>
<td>150</td>
<td>1,169</td>
<td>87.2%</td>
<td>12.8%</td>
</tr>
<tr>
<td>Band 7</td>
<td>585</td>
<td>57</td>
<td>642</td>
<td>91.1%</td>
<td>8.9%</td>
</tr>
<tr>
<td>Band 8a</td>
<td>142</td>
<td>14</td>
<td>156</td>
<td>91.0%</td>
<td>9.0%</td>
</tr>
<tr>
<td>Band 8b</td>
<td>50</td>
<td>3</td>
<td>53</td>
<td>94.3%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Band 8c</td>
<td>21</td>
<td>0</td>
<td>21</td>
<td>100.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Band 8d</td>
<td>9</td>
<td>0</td>
<td>9</td>
<td>100.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Band 9</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>100.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>VSM</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>100.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Medical: Consultants</td>
<td>506</td>
<td>202</td>
<td>708</td>
<td>71.5%</td>
<td>28.5%</td>
</tr>
<tr>
<td>Medical: Non-consultant career grade</td>
<td>35</td>
<td>42</td>
<td>77</td>
<td>45.5%</td>
<td>54.5%</td>
</tr>
<tr>
<td>Medical: Trainee</td>
<td>348</td>
<td>207</td>
<td>555</td>
<td>62.7%</td>
<td>37.3%</td>
</tr>
<tr>
<td>Other</td>
<td>75</td>
<td>34</td>
<td>109</td>
<td>68.8%</td>
<td>31.2%</td>
</tr>
<tr>
<td>Total</td>
<td>4,869</td>
<td>1,345</td>
<td>6,214</td>
<td>78.4%</td>
<td>21.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Clinical</th>
<th>White</th>
<th>BME</th>
<th>Total</th>
<th>White %</th>
<th>BME%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 1</td>
<td>283</td>
<td>95</td>
<td>378</td>
<td>74.9%</td>
<td>25.1%</td>
</tr>
<tr>
<td>Band 2</td>
<td>361</td>
<td>31</td>
<td>392</td>
<td>92.1%</td>
<td>7.9%</td>
</tr>
<tr>
<td>Band 3</td>
<td>445</td>
<td>28</td>
<td>473</td>
<td>94.1%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Band 4</td>
<td>368</td>
<td>20</td>
<td>388</td>
<td>94.8%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Band 5</td>
<td>158</td>
<td>14</td>
<td>172</td>
<td>91.9%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Band 6</td>
<td>108</td>
<td>6</td>
<td>114</td>
<td>94.7%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Band 7</td>
<td>85</td>
<td>9</td>
<td>94</td>
<td>90.4%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Band 8a</td>
<td>47</td>
<td>2</td>
<td>49</td>
<td>95.9%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Band 8b</td>
<td>42</td>
<td>7</td>
<td>49</td>
<td>85.7%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Band 8c</td>
<td>20</td>
<td>1</td>
<td>21</td>
<td>95.2%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Band 8d</td>
<td>8</td>
<td>1</td>
<td>9</td>
<td>88.9%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Band 9</td>
<td>9</td>
<td>2</td>
<td>11</td>
<td>81.8%</td>
<td>18.2%</td>
</tr>
<tr>
<td>VSM</td>
<td>9</td>
<td>0</td>
<td>9</td>
<td>100.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>1,943</td>
<td>216</td>
<td>2,159</td>
<td>90.0%</td>
<td>10.0%</td>
</tr>
</tbody>
</table>

(Source: Brighton and Sussex University Hospitals NHS Trust Workforce Race Equality Standard 2017 report)

Staff networks were in place promoting the diversity of staff. The trust had established a 'Diversity Matters' Committee lead by the chief executive. They had entered Stonewell’s Top 100 employers programme and have an LGBTQ+ conference planned for February 2019.)
We held a focus group for LGBTQ+ staff who told us that culture at the trust had improved. They told us that they had been encouraged by the workstreams that had been produced following the Black and minority ethnicity conference and were planning a similar event. They were planning to share best practice from the Black and minority ethnicity working group.

Staff also described feeling pleased that the trust had a float at the Brighton PRIDE event and that the executive team had encouraged this and had been represented on the float. This was featured in “UK Pride Life Magazine” along with an interview with the Chair of the trusts LGBTQ+ network, and a description of how the trust is ‘proudly diverse’ in its support of the LGBTQ+ community through its policies and processes designed to support staff. Staff told us that although they had not always felt supported in the past since the new executive team had arrived they now felt confident that they could raise any concerns about staff behaviours towards them with their line managers, and they felt assured that their concerns would be listened to and acted on appropriately.

The trust were members of the Equality and Inclusion Partnership and Transgender subgroup. This group was set up by Brighton and Hove City Council and has influenced the way equality was undertaken within the city and share best practice.

The trust was a part of the Pronoun campaign that was launched in 2018 during Trans Pride. The trust now had a Mx. title on their patient administration system and gender fluid staff at the trust were able to wear two badges which identified their chosen name and identity at any time.

In response to concerns raised by transgender staff the trust had delivered bespoke training for paediatric and general nursing staff. The training had helped to widen the knowledge base and staff awareness of specific needs of the transgender community.

The trust ‘Hate Crime Guidance’ has been highlighted as best practice by NHS England.

Sickness and absence figures were not outliers.
**Sickness absence rates**

The trust’s sickness absence levels from May to December 2017 were similar to the England average then were lower than the England average from January to April 2018.

(Source: NHS Digital)

**Governance**

The chief medical officer explained that when the current executive management team had taken over the management contract for the trust, they felt concerned about the governance and assurance arrangements in place and felt they did not have assurance about the quality of treatment and care being provided for patients. They found examples of good clinical governance and reporting in place at a service level, but this information was not being reported up to the board. The trust had therefore commissioned an external review of the governance arrangements from the Good Governance Institute.

Because of this review, a structure of five divisions was put in place where previously there had been 13 directorates. The divisional structure led by a triumvirate of a clinical director, general manager and head of nursing had provided the building blocks for the revised governance arrangements. The Good Governance Institute provided training in governance for these leaders. The non-executive directors and executive directors described the journey for the triumvirate leaders moving from a concern that more reporting was going to be required of them, to understanding governance and how the data and reporting would enable them to drive quality improvement.

The board invited the Good Governance Institute to carry out a review of the trust’s quality governance structures, which resulted in 31 separate recommendations being made. The trust
acted to address these issues and the Good Governance institute carried out a further review reporting on progress against these actions. A focus of this work has been to strengthen quality governance arrangements at divisional level.

The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers. Leaders regularly reviewed these structures. The trust reported regularly through its governance arrangements on progress against delivery of its strategy to the board, trust executive committee and to other relevant committees. However, the structure needed more time to become fully embedded.

In interviews with the chair of the Quality Assurance Committee, the chair of audit and the chief medical officer (the executive officer responsible for governance), all non-executive and executive directors were able to describe the governance structure and how it functioned.

The effectiveness of the governance arrangements was observed on inspection at Strategy Deployment Review meetings. Each of the three leaders of each division owned and presented the data for their breakthrough objectives. They had interrogated the data to find root causes where the objectives were behind plan and had devised action plans based on this knowledge to bring the objective back on track.

The Chair of the Audit Committee explained that under the previous administration, assurance was not provided through reporting and they were not getting the information they needed. The new structures provided a joined-up approach that provided assurance on quality and delivery against the Patient First Strategy and breakthrough objectives and delivered quality improvement.

Quality was a ‘golden thread’ running through the trust Patient First Strategy. In all the interviews undertaken on inspection the golden thread of quality was evident in the use of data both quantitative and qualitative and how this was triangulated and reported through the Quality Steering Group to the Quality Assurance Committee and the trust board.

Non-executive and executive directors were clear about their areas of responsibility. Performance against the trust's patient first strategy, true north and breakthrough objectives was focused and reinforced through the trust's strategic deployment review approach. There was clear line of sight through daily performance huddles, weekly driver meetings, Divisional Strategy Deployment Review, executive level Strategy Deployment Review and the board.

The Chair of the Quality Assurance Committee gave an example of challenge and holding the executive directors to account when an action plan did not evidence sufficient learning to drive improvement and required further work to be undertaken.

The quality dashboard was aligned to the quality priorities along with the quality improvement plan with actions being taken and monitored at divisional, corporate and board level through the quality governance system, Quality Assurance Committee and board. The Audit Committee evaluated the effectiveness of the trust's structures and processes in relation to the management of risk, the management of performance and financial management and the management of quality and quality improvement.

Papers for board meetings and other committees were of a reasonable standard and contained the necessary relevant information. The Board Assurance Framework had only recently been revised as the last stage in the trust governance review. There was further work to be done to embed the revised Board Assurance Framework and ensure that the divisions clinical and corporate governance arrangements were informing and providing assurance for the Board Assurance Framework.

The chair of audit and the chief medical officer responsible director for governance stated that they had needed to revise and embed the trust Patient First strategy before they could revise the Board Assurance Framework. They both felt the revised Board Assurance Framework provided an
Effective tool for the board to review and receive assurance of the risks to delivery of the strategic themes. Twelve strategic risks had been identified. The chair of audit was confident that the revised Board Assurance Framework would change the nature of the discussion at the Audit Committee to focus on gaps in controls and assurance for these strategic risks. The Board Assurance Framework would inform the annual plan and agenda for the Audit Committee and the Internal audit programme.

Governance arrangements were in place in relation to Mental Health Act administration and compliance. Clinical site managers were made aware of the patients detained under the Mental Health Act and those awaiting psychiatric admissions. In incidences where there were more than four patients under a section of the Mental Health Act this was escalated to daily management meetings between clinical site managers, divisional leads and the mental health liaison team who provided support and assessed staffing requirements.

A clear framework set out the structure of ward/service team, division and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to act as needed. The trust management arrangements had been strengthened significantly since the management agreement with Western Sussex Hospitals Foundation Trust and NHS Improvement. These arrangements enabled all clinical and management staff to function in an effective and efficient manner through both line management arrangements and governance arrangements.

Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person. All staff we spoke with on inspection understood how they fit within the organisational structure and how their respective roles impacted on the achievement of objectives. Through the trust’s patient first strategy front line staff knew and understood their department objectives.

The trust was working with third party providers effectively to promote good patient care. The trust had Service Level Agreements with other NHS organisations where the trust was either a recipient or provider of clinical services and/or facilities to neighbouring NHS trusts. Many of these were long standing arrangements underpinned by formal Service Level Agreements and/or service specifications, such as the contract with Sussex Partnership NHS Trust to provide Mental Health services.

The trust also sub-contracted several services from third party providers including Renal Dialysis (for satellite services in Eastbourne and Crawley) and PET CT Scanning from Sussex University. Such agreements were subject to regular reviews. All of these specified within the Service level agreement the quality and access standards required which were designed to secure high quality care for patients.

The trust had established a structure for managing the contractual relationships with their key commissioning partners. Contracts with NHS England and Sussex Clinical Commissioning Groups for clinical services were underpinned by agreed process, regular meetings, governance structures and executive oversight. These regular meetings reviewed all aspects of activity, performance, quality and service. There was a collective and agreed shared responsibility to manage the relationships according to the principle of placing ‘the interests of the patients we collectively serve first’ within the context of contract management.

The trust had a range of other contracts for clinical services commissioned by other partners such as elective musco-skeletal and sexual health services. These were managed in accordance with a similar set of principles and governance structures to those of NHS England and the Clinical Commissioning Groups. Internal trust oversight and scrutiny of contract performance was managed through the Finance and Investment Committee, which was a sub-committee of the trust board.
A partnership arrangement with Sussex Partnership trust was in place for the provision of psychiatric liaison services with appropriate governance arrangements. The governance framework addressed the need to meet people’s mental health needs.

There was a mental health liaison team 24 hours, seven days a week at the Royal Sussex County Site and 8am to 8pm seven days a week at the Princess Royal Hospital with cover from Sussex Partnership Trust at night. The team worked collaboratively with BSUH to address any issues and support staff across the trust to provide therapeutic care for patients.

There was a Child and Adolescent Mental Health Liaison service for children, which included a perinatal mental health midwife, psychologists for neuro-rehabilitation and major trauma. There was a quarterly multi-agency Mental Health Steering Group which was chaired by the medical director. This group reported to the patient experience and engagement group.

A mental health lead trainer in the trust delivered Mental health act training and supports development of practice in the trust. The trust also had two learning disabilities nurses, employed by Sussex Partnership Foundation Trust who reported internally to the nurse director.

The nurse director and medical director were members of the Mental Health Crisis Board, which was city wide for Brighton and Hove.

There was a clear protocol for all patients that were detained under the Mental Health Act. Patients had section papers in their records, with originals kept by the Mental Health Act administrator’s office. The trust Mental Health Liaison Team was Psychiatric Liaison Accreditation Network (PLAN) accredited and followed their quality standard.

**Management of risk, issues and performance**

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. The governance team regularly reviewed the systems. The trust management team held responsibility for ensuring performance issues and risks were appropriately escalated through divisional management and Strategy Deployment Review to the Trust Executive Committee and through Finance and Investment Committee and Quality Assurance Committee to the board. The Strategy Deployment Review process provided the backbone of the trust’s performance management.

The chair of audit and the chief medical officer executive director responsible for governance and risk, were separately able to articulate the approach taken to risk management and the risk strategy and appetite in the trust. All were able to articulate the relationship between the Board Assurance Framework for the management of strategic risk and the corporate risk register for management of operational risks.

Observation of Strategic Deployment Reviews during inspection provided evidence of the focus on finance, performance and quality by the division. Reporting in each of these areas was provided in a directorate score card. The meetings focused on delivery against performance targets, financial targets and breakthrough objectives. The focus was on understanding the story the data was telling, interrogating the data when performance or delivery was off track, to understand why and put in place an action plan based on this intelligent understanding.

The trust board received monthly performance reports which described performance against key performance indicators, the Single Oversight Framework, wider qualitative, financial and workforce metrics. The board reviewed the assurances at board meetings, through the board committees.
The Audit Committee scrutinised the assurances provided that the trust's risk management and ensured assurances were effective, robust and accurate. The committee reviewed the effectiveness of the Risk Management systems and processes, including the Board Assurance Framework to ensure it was comprehensive and reflected the strategic risks the organisation faces. The Board Assurance Framework also identified gaps in controls, assurance and the actions being taken to address these.

The Audit Committee considered reports from internal and external audit in forming its view on the effectiveness of the trust's assurance systems and monitored actions taken to implement audit recommendations. The trust had reviewed its arrangements for the management of quality and refreshed the role and responsibilities of the Quality Assurance Committee.

Reporting on quality and the groups responsible for the management of quality had also been reviewed and aligned to the key areas of patient safety, clinical outcomes and effectiveness, patient experience and compliance. Standard agendas and reporting and escalation templates supported these groups to operate effectively and develop assurance.

Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance. The trust's Patient First Improvement Programme had enabled a clear and effective process for raising and managing risks, issues and performance. Where departments had implemented the Patient First Improvement System, patient safety and quality issues were raised daily at the daily improvement huddle and through a daily status sheet which the unit lead.

Supporting weekly escalation structures were being implemented because of divisional and directorate leaders completing the Strategy Deployment training. The Patient First Improvement System also enabled staff to escalate issues during their monthly Unit Leadership Meetings where they reviewed performance progress against their scorecard. At a divisional and directorate level, issues on performance were being identified, addressed and monitored openly through the weekly driver meeting.

Divisional risks scoring 12 and above were escalated and reviewed at the Trust Executive Committee and on to the relevant committees. The trust board also reviewed the Board Assurance Framework.

Strategic Deployment Reviews incorporated targets and a monthly review meeting chaired by the executive. These comprised of a Balanced scorecard of qualitative (patient safety, outcomes and experience), performance, financial and workforce metrics and corporate and divisional corporate projects agreed by the executive team in accordance with the trusts ‘True North’ principles with divisional clinical and managerial leads.

Using standard working approaches with defined triggers for review, divisions presented outlying performance metrics and project updates to the board, describing the challenge, stratifying reasons, and describing actions to drive improvement. This allowed board level visibility, risk assessment, formal escalation, ratification and challenge as part of a routine monthly performance and improvement cycle.

In addition, there were weekly meetings to review performance for cancer, referral to treatment times, diagnostic performance, and monthly LHE meetings (planned care and Local Area Emergency Delivery Board) to discuss acute and primary/community performance and planning.

The trust forecasted future anticipated recovery trajectories for any performance metrics below constitutional standards within the single oversight framework in accordance with NHS Improvement and NHS England requirements.
Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. Teams acted on results where needed. The trust ran an annual clinical audit cycle, which began in January with a review of the action plans from the previous year’s serious incidents. The review identified potential clinical audit projects for the forthcoming year that were relevant or clearly aligned to the clinical divisions. All mandatory audits were added to the plan as well as a list of all National Institute of clinical excellence (NICE) guidance pertinent to the divisions/subspecialties. Divisions had recently completed a progress assessment, against NICE guidelines and, national clinical audit. Divisions ensured that recommendations, arising from NICE gap analysis assessments and clinical audit were incorporated into their quality improvement programmes.

Identification and treatment of sepsis, and antibiotic review was audited quarterly through the Commissioning for Quality and Innovation (CQUIN) programme.

We saw fire safety precautions adopted by the clinical areas. All the wards we visited had identified fire wardens and ensured there was always a fire warden on duty at every clinical shift. We observed the fire procedures and found all fire doors were clearly marked, kept shut and free from obstacles. Fire safety equipment was available throughout the hospital and we saw evidence that fire equipment safety checks had been completed by an external specialist contractor.

In October 2017, we carried out an unannounced inspection focussed on the management of Control of Substances Hazardous to Health (COSHH) substances and found the management of COSHH substances were not robust. Since that inspection, the leadership team and staff had taken immediate actions to address our concerns.

At this inspection, we found the medical wards and units had systems to provide assurance that information relating to COSHH was available, complete and accurate, and staff understood it.

We reviewed COSHH folders containing information related to cleaning products on medical units in level eight A west, Baily, Bristol, Chichester, Donald Hall and Solomon and Jowers wards. On all wards and units, we found the COSHH folders had risk assessments and safety data sheets pertaining to all the cleaning chemicals found in the cleaning cupboards. All risk assessments and safety data sheets were in date and all had a review date. We saw all COSHH folders complied with COSHH regulations 2002. These regulations provide a framework to help protect people in the workplace against health risks from hazardous substances used directly in the workplace, for example cleaning chemicals.
Trust corporate risk register

Each division had a risk register in place and the chief medical officer, medical director and project manager for governance and risk management described the way in which the divisions used the corporate risk register as an active and dynamic tool to manage and reduce risk and improve quality of care. An example was given that the women and children’s directorate had asked for risks that were 10 and above to be included on the risk register where the risk score was driven by a consequence score of five. This was because of a risk on their divisional risk register for some years about the risk of intruders and abduction on the maternity unit due to a lack of security on the entrances. This has now resulted in investment in swipe card access to all areas of the unit.

The chair of the quality assurance committee the audit committee and the chief medical officer (responsible director for governance) all listed workforce, lack of capacity in A&E for the level of demand, the state of the estate and the size of the backlog maintenance programme impacting on delivery of care as the key operational risks to delivery.

The trust provided a document detailing their 14 highest profile risks. Each of these have a current gross risk rating of 16 or higher. The trust has provided the gross risk rating, when preventative measures fail, and net risk rating, when preventative measures are used successfully.

<table>
<thead>
<tr>
<th>Target</th>
<th>Risk</th>
<th>Gross risk rating</th>
<th>Net risk rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>To achieve Annual Control Total</td>
<td>Ability to manage financial pressures generated from additional demand, capture activity and code appropriately, maintain effective cost control and deliver cost improvement and productivity improvements as required.</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>To achieve a Staff Engagement Score – Top 20% in country (3.62 currently)</td>
<td>Staff at BSUH are currently less engaged than the average at this time. Capacity and focus to improve this position could be challenged in light of operational pressures.</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>Elective Flow - RTT – 92% incomplete &lt; 18 wks</td>
<td>Increased volumes, reduced flow, and non-delivery of activity volumes required lead to a poor patient experience / extended waiting times for elective treatment and failure to achieve the National RTT 18wk target. Impact on patient experience, staff morale, and organisational reputation.</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>Non-Elective Flow A&amp;E - 95% &lt; 4 hrs wait</td>
<td>Increased volumes and reduced flow within the A&amp;E units lead to a poor patient experience and failure to achieve the National A&amp;E 4hr Target. Impact on patient experience, staff morale, and organisational reputation.</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>Achieve the efficiency plan for 2017/18</td>
<td>Failure to achieve Efficiency Plan of £20m</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>Staff believe that Care is the top priority for the organisation</td>
<td>Fewer staff than NHS average feel that Care is the organisations top priority, potentially leading to poor staff satisfaction and poor experience for patients.</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td>Improvement in Sepsis recognition and timely response</td>
<td>Interventions do not result in improved recognition and the timely treatment of Sepsis to improve outcomes.</td>
<td></td>
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</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure no patients wait over 52 weeks for elective treatments.</td>
<td>Increased volumes, reduced flow, and non-delivery of activity volumes required lead to a poor patient experience / extended waiting times for elective treatment and failure to achieve the National RTT 18wk target. Impact on patient experience, staff morale, and organisational reputation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving Quality</td>
<td>Progress is not sufficient to demonstrate quality improvement to CQC as part of their inspection regime.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Sustainability</td>
<td>Failure to deliver key financial targets will impact on the Trust's ability to exit the Financial Special Measures regime. Further, the ability to take decisions/actions that support long-term sustainability may be affected.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient First Programme</td>
<td>Programme implementation - development of continuous improvement (Kaizen) Strategy that supports True North and Patient First objectives within the Trust fail to empower staff to solve problems and make improvements.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leadership, Culture and Workforce</td>
<td>Issues with Leadership, Culture and Workforce are cited as key reasons for CQC concerns and imposition of Special Measures. Time, resources and focus to change may be compromised by operational challenges and reinspection timescales.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3Ts</td>
<td>Successful delivery of the 3Ts programme is jeopardised by financial or capacity issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Six Facet survey covered; Physical Condition (including all external and internal building fabrics, fixtures and fittings; electrical and mechanical systems), Statutory Compliance, Space Utilisation, Functional Suitability, Quality of Environment and Environmental Management. There are extreme risks relating to two of these facets: Physical Condition and Statutory Compliance.</td>
<td>There is a risk that the identified 'extreme risks' are not sufficiently mitigated to the assurance of the Board.</td>
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</tbody>
</table>

(Source: Trust Corporate Risk Register / Board assurance framework)
Arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. Recorded risks were aligned with what staff said were on their ‘worry list’. The trust board had sight of the most significant risks and mitigating actions were clear.

The trust had recently updated and strengthened its Risk Management Strategy and Risk Management Policy. It had also reviewed and revised the Board Assurance Framework and all divisional and corporate directorate risk registers to ensure they accurately reflect the risks manifesting at all levels of the organisation from board to ward.

Divisions discussed new risks at their divisional governance meetings enabling risks to be identified and managed as appropriate by all staff. Strategic risks were agreed by the board as those risks regarding the delivery and achievement of strategic objectives. Actions required to address gaps in controls and assurance in the management of strategic risks were assigned to executive leads and progress was regularly reported to the board through the Board Assurance Framework.

Risk mitigations were actively managed and tracked and their impact on reducing risks assessed. Individual responsibility for implementing mitigating actions were assigned and entered into the risk management system. The Corporate Risk Register, including all risks rated 12 and above from the divisions, was reviewed by the Trust Executive Committee monthly. Risks were escalated to the committee through divisional reporting templates which allowed any concerns about the effectiveness of risk mitigation or newly emergent risks to be discussed and executive action taken if required.

A recent example would be the trust’s estate and the six-facet survey. A six-facet survey comprises a combination of six separate surveys and reviews, which are carried out by separate specialised facet survey teams and auditors, each experienced in their own field. The condition of the estate was recognised as being high risk by the executive team. A six-facet survey was therefore commissioned, the actions prioritised and then progress reviewed through the Trust Executive Committee.

Each year as part of the business planning process, divisions identified their key service developments for the coming year. These were assessed against the trust’s Patient First priorities and then are prioritised through the trust executive. This identified those service developments most required to address risks and issues, there was a focus on risks that related to quality.

**Finances Overview**

The trust’s financial position is reviewed at the finance and investment committee and the board. Financial information is submitted to NHS Improvement monthly. Board members expressed confidence in delivery of the financial control total for 2018/19 albeit this is a deficit of £55m including provider sustainability funding.

The trust has introduced and refined financial grip and control measures and has improved budgetary control; all posts and business cases for new service developments were reviewed to ensure inclusion in budgets where appropriate/approved. The trust was developing a medium term financial plan covering the next five years. This was expected to quantify the impacts and risks around the 3Ts new hospital building coming into operation. (The development is significant, accounting for approximately 30% of the hospital site area). This was work in progress at the time of the inspection and board oversight of the plan is in place.

Despite the trust’s challenging financial position, the trust did not make savings from budgets that were focused on patient care. The chief nurse explained that the trust had a ratio of 1:7 or less for registered: unregistered nursing. Working with her senior nursing team she had been able to provide evidence to the trust board of the benefits of these staffing levels through being in the top
20% of all trusts for the low falls rate and having a low rate of pressure ulcers. To support the financial recovery programme, the chief nurse and her senior nursing team had stopped using ‘Thornbury’ agency nurses. Examples of this were focusing on recruitment and retention, improvements to accessing training, continuous professional development and investing in leadership training for nurses with an application and selection approach. The trust was planning to set an ambition of no agency staff usage. This approach to safe staffing and the consequent improved outcomes for safety of care for patients is an example of exemplary practice.

The financial information received by the board was comprehensive. It included a balance of trust and divisional level analysis and covered both actual and forecast positions. Investment business cases include costs and consider financial and non-financial returns on investment. Where cost improvements were taking place, there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability. The trust had an efficiency plan focused on cost reduction, cost avoidance and income opportunities. Since April 2017, the programme management office had implemented and embedded a governance and assurance processes to identify, monitor and report delivery of the trusts efficiency plans in a consistent approach and format. The programme management office worked with directorates to develop schemes to inform in year opportunities, and to develop mitigation for schemes at risk.

Various sources of internal and external benchmarking material including ‘Model Hospital’(a nationally-available digital information system containing metrics relating to productivity, efficiency and quality of care) were used to focus directorates on potential efficiency opportunities.

Where cost improvements were taking place, they did not compromise patient care. Divisions were engaged in developing quality led efficiency schemes that recurrently reduce costs. Quality impact assessments were undertaken as part of development of the ‘Project Initiation Document’ for each scheme. These were signed off by a lead clinician at divisional level and were submitted to the chief medical officer and chief nurse for approval. All Quality Impact Assessments with a risk score of nine or above were submitted for review by the Quality Assurance Committee.

The trust had clear plans in place to manage adverse or unexpected changes in demand. The board had recently reviewed and strengthened the ‘Risk Strategy’ and ‘Risk Management’ Policy. The Quality Assurance Committee had recently approved the trust Quality Improvement Plan which contained the trust’s quality priorities for the year

The Clinical Commissioning Group also assessed the quality impacts through a monthly quality review group with the trust. There had been examples of efficiency schemes proposed which had been rejected on quality or safety grounds. We did not find any examples of care being compromised because of financial pressures.

At the start of the management contract in April 2017, the new board inherited a backlog of business cases. These were all reviewed, and a decision was made to invest £14m in quality. Recent examples of business cases approved despite having an adverse impact on the trust’s financial position included investment in the consultant medical workforce and Birth-rate Plus.

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th></th>
<th>Projections</th>
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</thead>
<tbody>
<tr>
<td>Income</td>
<td>£550.4m</td>
<td>£563.2m</td>
<td>£572.7m</td>
</tr>
<tr>
<td></td>
<td>Surplus (deficit)</td>
<td>Full Costs</td>
<td>Budget (or budget deficit)</td>
</tr>
<tr>
<td>------------------</td>
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<tr>
<td></td>
<td>£68.5m</td>
<td>£618.9m</td>
<td>£15.6m</td>
</tr>
<tr>
<td></td>
<td>£55.6m</td>
<td>£618.7m</td>
<td>£65.3m</td>
</tr>
<tr>
<td></td>
<td>£65.4m</td>
<td>£638.1m</td>
<td>£65.4m</td>
</tr>
<tr>
<td></td>
<td>Not available</td>
<td>Not available</td>
<td></td>
</tr>
</tbody>
</table>

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

There were plans in place for emergencies and other unexpected or expected events. For example, adverse weather, a flu outbreak or a disruption to business continuity. The trust had an operational planning process which included the development of detailed plans for all known specific events and/or expected fluctuations in demand.

Defined processes and procedures were in place to support the management of unexpected fluctuations in demand. These processes and procedures were designed to deliver flexibility in both the manpower and estates resource to respond effectively to changes in the demand profile. The annual planning process for 2018/19 included the development, in conjunction with system partners (through the Local Accident and Emergency Delivery Board) of specific demand plans for winter and the management of demand associated with the Brighton Pride Event. This included mitigating actions associated with both workforce and the trust estate.

The trust had a designated full-time head of resilience to support the executive lead for emergency preparedness in implementing the ‘Emergency Preparedness Policy’. The management of unexpected non-elective demand was co-ordinated through the site operations centre in accordance with the trust’s ‘Escalation Policy’ with all divisions and support services represented at three daily meetings. Where required the full capacity plan and/or business continuity would be invoked to support effective flow.

Individual workforce and estates issues were also managed through this forum. The trust maintained an up to date ‘Major Incident Plan’, which had recently been tested. Training for implementing the plan was given regularly.

Information management

Data quality and data management was evident throughout the inspection. The chair of the Audit Committee and the non-executive director advisor discussed the work that had been undertaken by the new management team to review, work on and improve data quality. The use of data was evident using quality improvement methodology to underpin delivery of the breakthrough objectives for each of the four strategic themes. This use of data to drive improvement was evident in the strategic deployment review meetings and safety huddles which we observed during inspection.

There was further work to be done to roll out quality improvement methodology across the whole organisation supported by data for measurement and improvement but there is a clear plan for this.

The board received holistic information on service quality and sustainability. Holistic performance management through a coaching style was witnessed in the strategic deployment meetings with the trust using data for performance targets and breakthrough objectives for ‘True North’. The trust used a systemic reporting of performance information at all levels using a structured problem-
solving approach (A3 thinking). This approach used information for improvement as well as providing assurance in how the problem was being tackled with an evidence base.

By using standard working approaches with defined triggers for review, divisions presented outlying performance metrics and project updates to the board, describing the challenge, the reasons for these challenges, and describing actions with timescales to drive improvement. This allowed board level visibility, risk assessment, formal escalation, ratification and challenge as part of a routine monthly performance and improvement cycle.

The trust also had a series of improvement projects at a ward and service level as part of the trust's Patient First Improvement System. Using this tool staff applied standard work processes to define a problem, determine root causes, structure improvement actions using project huddles (following a standard format) and to review and drive further incremental improvements.

Larger improvement projects were facilitated by the trust’s improvement team. The trust had utilised the Model Hospital tool and had held a range of seminars to discuss potential financial opportunities. These linked into the trust efficiency programme, and corporate project workstreams such as the theatre efficiency programme.

The trust also made use of benchmarking for improvement through the ‘Getting it right first-time programme’. The trust used a range of methodologies such as A3 thinking, fishbone diagrams and improvement huddles, which aimed to understand and improve performance through fully engaging with staff.

The trust was aware of its performance by using key performance indicators and other metrics. This data fed into a board assurance framework. Staff said they had access to all necessary information and were encouraged to challenge its reliability. The Safety and Quality Team generated monthly ‘Safety and Quality Dashboards’ for all five divisions (which included directorate information). This report was generated for the ward managers and included a report which was shared with ward staff.

The trust had a web-portal with controlled access which provided operational and performance reporting dashboards. There were routine reports sent daily, weekly and monthly which provided information about accident and emergency and emergency flow, referral to treatment time performance, performance against contract monitoring and other efficiency metrics.

The board and senior staff expressed confidence in the quality of the data and welcomed challenge. The trust had developed a data quality strategy and had introduced a framework tool for the assessment of data quality. The framework identified by exception, departments and staff groups where poor quality processes or outputs may affect patient safety risks for example, duplicate registration, misidentification, delay in recording a clinical event or inaccurate reporting due to inadequate data quality.

Information was in an accessible format, timely, accurate and identified areas for improvement. The trust recognised the importance of secure, robust and user focused IT systems and had recently written a strategy that reflected the clinical ambition of its users and patients. Nearly 1000 staff were engaged in creating the strategy, which was aligned with the trust Patient First strategy and describes IT systems that will demonstrably improve patient care.

The trust recognised an historic gap in funding related to IT clinical systems and had invested the capital to ensure the strategy could be delivered. This investment has ensured the key building blocks associated with industry leading IT would be put in place and has included investment in wireless infrastructure and cyber-security.
The trust was implementing a modern, flexible and extensive 'Patient Administration System'. The new system comes with features that would enable the trust to monitor and improve quality more effectively in the future. The new Patient Administration System and associated improved business intelligence programmes would improve performance and data quality reporting across the trust by providing information that was more accessible and contemporary.

The emergency care department had recently completed an upgrade of their primary information system and the new ‘Emergency Care Discharge Summary’ implementation was in the final stages whilst we were inspecting. New reporting software was being used to produce for more up to date operational reports for front line staff. The trust had developed a process for reviewing and correcting coded data involving clinician scrutiny and review.

Leaders submitted notifications to external bodies as required. The trust submitted central returns to NHS Improvement and NHS England in accordance with statutory and contractual requirements. These reports were compiled, validated and signed off at director level prior to submission. Any missing reports were identified by the system.

The trust submitted financial and workforce information as requested as part of NHS improvement monthly requirements. Internal and external validation of data was managed through the recently updated Corporate Data Policy and Strategy.

The trust learned from data security breaches. Data security breaches were actively managed through the trust's incident management system. They were triaged by the Information Governance Team to establish what actions were required and to establish if they required internal investigation or reporting to the Information Commissioners Office in line with 2018 NHS Digital guidance. Incidents trends and statistics were reported to the trust's Information Governance Steering Group.

The trust took its responsibilities seriously regarding the confidently and availability of patient and staff data. Information governance systems were in place including confidentiality of patient records. The trust had recently rewritten its 'Information Governance Policy' and management framework to ensure it reflected the new Data Protection Legislation. The trust had also published an 'Information Governance Staff Handbook'. This served as a standard operating procedure to ensure all staff were aware of their responsibilities. Internal and external validation of data was managed through the recently updated Corporate Data Policy and Strategy.

The trust had completed an Information Governance Toolkit assessment. In March 2018 the trust had submitted an internally audited 66% Level 2 Information Governance Toolkit score, as required by Department of Health and NHS Digital, and was actively working towards its replacement, the Data Security and Protection Toolkit.

Information Governance training had been attended by 92% of all trust staff.

Engagement

The trust had a structured and systematic approach to engaging with people who use services, those close to them and their representatives. The trust had a 'Patient and Public Design Panel' in place which was made up of representatives of patient groups and third party organisations with an interest in the redevelopment of the hospital.

Patient and Public Design Panel meetings had been running since 2010. These meetings were typically held at key points in the design and construction process.
Healthwatch conducted monthly visits assessing the patient environment and changes were made as a result. Examples included changing some of the signage across the trust, implemented new storage solutions on some wards in the Barry Building and offering heated blankets for patients experiencing cold in haemodialysis.

Engagement had also taken place with communities in the area surrounding the hospital and members of the public. These included engagements with communities concerning the redevelopment of the Royal County Hospital site and a consultation relating to the relocation of neurosurgery from Princess Royal Hospital to the Royal Sussex County Hospital.

The trust ‘Schools Liaison programme’ welcomed year seven children to the hospital site to show them the future of healthcare in their city and encourage them to think about jobs in healthcare and construction. The trust had also Presented to local resident community groups.

Hospital Liaison Group meetings were held every two months for local residents and patient representatives where they are updated on the 3Ts (Trauma, Teaching and Tertiary Care redevelopment), the wider Capital Development activities of the trust and given the opportunity to raise any queries. These meetings were chaired by local councillor and have been running since 2009.

The trust had engaged with stakeholders throughout the 3Ts development building programme. This included 131 events with more than 7,000 direct, face-to-face interactions with members of the public and other stakeholders, 26 events arranged as part of the formal application process for planning consent, 1,627 people/recorded contacts as part of planning application, more than 75 articles, adverts and broadcast pieces in local and regional media, a 3Ts Facebook page with 297 followers,140,368 hits across the suite of 3Ts webpages and announcements through the general trust twitter feed.

The trust commissioned a short public information video, available on the 3Ts website, Youtube7 and was played at public events. The trust had logged 705 formal requests, queries and suggestions including through freepost replies which had been handed out at public exhibitions. The trust had also directly contacted 1,416 individuals, groups and businesses who had registered an interest in the redevelopment and asked to be kept in touch with progress. These contacts had included 280 members of the Hospital Liaison Group and 319 groups or organisations, including members of Black & Minority Ethnic groups, Lesbian, Gay, Bisexual and Transgender and other disadvantaged and traditionally ‘harder to reach’ communities.

The trust had also mail-dropped over 84,000 hardcopy flyers/leaflets to 6,000 local residences within the immediate vicinity of the hospital. Contacted faith groups, across a spectrum of beliefs; heritage groups; business leaders and local business owners; environmental groups; and transport organisations. In addition, as part of the application for Full Planning Consent, nearly 80 statutory and national bodies were formally consulted.

The Hospital Liaison Group was re-established in October 2009 in discussion with the three East Brighton Local Councillors. The aim was to provide a forum for trust management and residents to work collaboratively to maximise the benefits and minimise the disruption associated with the 3Ts redevelopment.

The wards and divisions had access to feedback from patients, carers and staff and were using this to make improvements. A variety of methods are used to gather feedback from patients, their relatives and visitors to the trust. These included Friends and Family Test, trust website feedback, Patient Advice and Liaison Service feedback cards, NHS Choices, Patient Experience Panels, Patient Surveys and complaints.
Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used.

Patients, carers and staff had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The trust used Friends and Family Test which is delivered to patients via text, interactive voicemail or paper surveys. The trust had a breakthrough objective of receiving a Friends and Family test score of more than 96% of people recommending the trust.

All ward and department managers, senior nurses and some Allied Healthcare Practitioners had access to an online dashboard, which collected recommendation rates and comments, these were used to make improvements in patient experience.

Complaints were reported in detail monthly to the divisions and we saw examples where changes were made because of a complaint. A reduction in patient complaints about staff attitude was a Patient First project. The clinical infections unit had introduced a standardised way of introducing themselves and this has had a significant impact on complaints about staff attitude. These metrics are reported monthly at the Patient Experience and Engagement group.

The trust sought to actively engage with people and staff in a range of equality groups. The Trust’s Equalities Team had regular meetings with Possibility People who represent a range of people with disabilities. The group provided feedback about the trust and changes had been made because of this feedback, such as accessible signage and changes to the trust website. The trusts Patient Experience Panel was made up of diverse members of the community.

The trust worked closely with the Transgender Community, particularly in maternity, to ensure services were appropriate to their needs. Engagement processes were also in place involving people from a range of equality groups. For example, the trust has a Workforce Race Equality Standard working group and a Gender working group, both chaired by the chief executive.

From October 2018 the trust had plans in place for two additional Working Groups one relating to Disability and the other relating to Sexual Orientation and Gender Identity.

As a request from the LGBTQ+ Network the trust had entered the Stonewall Workplace Equality Index which is the definitive benchmarking tool for employers to measure their progress on lesbian, gay, bisexual and transgender inclusion in the workplace. This will enable the trust to benchmark itself with other entrants.

The trust had a structured and systematic approach to staff engagement. Staff were engaged in a variety of ways with the Patient First Improvement Programme being the most notable. As the programme is rolled out across the organisation every team member is involved in the programme and is therefore given the opportunity to make improvements to the service.

Where improvement opportunities are identified at a unit level and divisional level, staff are actively engaged in problem solving the issue and contributing to proposed solutions. Daily improvement huddles are attended by staff on Units where Patient First was delivered, where staff discussed improvement opportunities. Colleagues from other support functions and patients were encouraged to take part in discussions.

Workshops and ‘Rapid Improvement Events’ facilitated by the internal improvement team ensured stakeholders who were impacted by or drive processes were invited to participate in improving processes and services. There had been wide engagement with divisional staff in the refresh of the trust’s Clinical Strategy.
The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans. The trust had memorandums of understanding with Queen Victoria Hospital, Royal Surrey County Hospital and Sussex MSK Services. The trust regularly met and reviewed joint approaches with other Partners such as Sussex Community Services, Sussex Partnership NHS Trust and the Local Authority.

As a member of the Sustainability and Transformation plans, the trust was working in collaboration with both providers and commissioners across the wide local health economy. The trust engaged in several forums including Urgent and Emergency Care Network, Planned Care Network, Maternity Services Liaison Committee, A&E Delivery Board, Safeguarding Boards, Vascular and Trauma Networks, Hepatitis C Operational Delivery Network and the Mental Health Board.

External stakeholders said they received open and transparent feedback on performance from the trust. We were told by Stakeholders including MPs, Healthwatch, NHS Improvement, NHS England lead commissioners and the Chair of the trust single oversight committee that they received open and transparent feedback on performance from the trust.

**Learning, continuous improvement and innovation**

The trust’s Patient First Strategy sets out the overarching aim to put the patient at the top of all that they do. The Strategy and the Quality Improvement plan for 2018/19 is explicit in the way in which the trust has used improvement methodology and lean management to create a culture of continuous quality improvement where staff were facilitated to make small incremental changes at ward level to improve care with a golden thread of quality running from ‘floor to board’.

This approach was evident throughout the inspection where the approach to understanding challenges to performance or to quality of care was to have high quality reliable data to provide the True North metrics for improvement in line with the strategic themes that were monitored to track improvement. It was also evident at ward level at the safety briefings we observed and the focus on the ‘True North metrics’ and how these translated at ward level for example reducing pressure ulcers for critical care patients.

The strategic themes and the breakthrough metrics for True North were clearly identified from quality and performance data to improve quality and safety of care with a focus on identifying deteriorating patients and acting and reducing the number of complaints about negative attitude of staff. The golden thread of focus on improving quality and safety of care for patients and patient experience was evident through reporting and management at every level of the organisation.

The trust had invested in quality improvement expertise and training for staff and this was being rolled out across all clinical services and directorates. We saw clear evidence of understanding of this approach from the Strategic Deployment Review, safety briefings, and in interviews with trust staff, divisional leads and the Executive Team.

The approach to learning and improving together was evident in the management response to the challenges the women and children’s division was experiencing in addressing the financial deficit and referral to treatment performance specialties. There was ownership from the divisional lead of the targets and data and support and coaching from the executive management team.

The chair of audit and the non-executive director advisor discussed the work that had been undertaken to improve the quality of the data reported and were confident that this was now more
reliable to both provide data for quality improvement and assurance to the trust board sub-committees of the trust’s position for finance, performance and quality of care.

Lean management techniques were seen in the Strategic Deployment Review where there was no agenda and papers and the division scorecard for the True North breakthrough objectives and performance and finance data drove the agenda. The meeting was focused on what the data was saying and where there were challenges to performance or to achieving quality improvement from the True North metrics how this was being investigated to find the root cause analysis for solutions to improvement.

The trust infection control team, the senior nurse and infection control doctor both provided examples of how they had used data about infections to improve quality of care and provided leadership in this. The Infection Prevention and Control team identified the trust’s challenges with the estate and the numbers of single rooms but had been able to use the single rooms in the new infectious disease center to isolate patients. This had also led to a pathway where patients with infectious diseases were transferred to medical wards once they were well for example, for discharge planning which was good practice where they had complex health and care needs.

The Infection Prevention and Control team explained the recent Serious Incident that had been declared about a patient who had Tuberculosis that had required the trust to call back patients and staff who would have had contact with the patient. This had been identified through the new approaches to whole genome sequencing to type the Tuberculosis infection. The Infection Prevention and Control team had been working closely with Public Health England and had sought advice from the Tuberculosis Centre at the London School of Hygiene and Tropical Medicine who advised that the situation they were dealing with was unusual and they were breaking new ground. The trust demonstrated an open and transparent approach to this serious incident seeking external advice and support appropriately.

The infection control doctor was also employed as an infectious diseases doctor for the trust in the specialist unit and in acute medicine. This was an innovative role that enabled the infection control doctor to use her expertise in infection control in acute medicine to identify patients who may have an infectious disease or transmissible infection to be isolated and treated more swiftly.

Staff had training in improvement methodologies and used standard tools and methods. Leaders and staff built their knowledge and capability through support and attendance through the patient first improvement programme. This included patient first awareness sessions, training modules, and fundamentals training.

Larger improvement projects facilitated the cross departmental improvement and shared learning at the trust. This is particularly evident in improvement activities such as rapid improvement events and weekly project huddles.

Leaders and staff were empowered to raise and implement improvement opportunities (improvement tickets) through daily improvement huddles, strategy deployment and the associated review process. This enabled divisions to focus on key improvement objectives (driver metrics) which were cascaded to the frontline for continuous improvement.

Staff had time and support to consider opportunities for improvements and innovation and this led to changes. Staff regularly took time out to resolve problems through the Patient First Improvement System. As part of this, teams selected ‘driver metrics’ which were objectives aligned to the divisional and trust strategy of True North. Teams conducted a daily improvement huddle where improvements are raised to support the achievement of those objectives. The team met monthly to use the organisation’s structured improvement method (A3) to review barriers and gaps to improvement.
Staff were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented. On engagement events and inspection, we were shown multiple examples of service improvements that had been driven through this process. We found staff were engaged and enthusiastic about driving improvement within their departments and sharing learning from this improvement across the trust.

Staff told us that Patient First had given them a voice, had allowed them to drive improvement and had given them a framework by which they could do this. Staff told us that it felt like they were all speaking the same language from board to floor.

The trust had a planned approach to take part in national audits and accreditation schemes and shared learning.

**Accreditations**

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Medicine (including older people's care)</td>
</tr>
<tr>
<td>Imaging Services Accreditation Scheme (ISAS)</td>
<td>Diagnostic Imaging (additional service)</td>
</tr>
<tr>
<td>ISO 9001 Quality Management System Certification for Radiotherapy</td>
<td>N/A</td>
</tr>
<tr>
<td>Code of Practice for Disability Equipment, Wheelchair and Seating Services (CECOPS)</td>
<td>Trustwide</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).

The trust was actively participating in clinical research studies. Divisional staff were aware of research undertaken, particularly in areas which were highly active in research, such as HIV,
Cardiology, Cancer and Paediatrics. The trust had designed a role specification for a divisional lead for research to strengthen the link.

The trust’s Clinical Investigation and Research Unit forms part of the Clinical Outcomes and Effectiveness Group. Research, together with education, featured strongly as a theme in the Clinical Strategy refresh discussions with the divisions and will feature in the trust’s refreshed Clinical Strategy.

The trust’s Clinical Investigation and Research Unit had a monitoring group. This group reported through the Clinical Outcomes and Effectiveness Group to the Quality Steering Group. The trust recruited approximately 3,000 patients per annum to participate in research projects. Patients are recruited to trials on a targeted basis.

Effective systems were in place to identify and learn from unanticipated deaths. Reducing preventable mortality is a True North trust objective, with the underpinning breakthrough objective this year being an improvement in the recognition and responses to the deteriorating patient. Against this objective, specific developments included a business case approval for electronic observation tool, approval to expand Critical Care Outreach Team, revision of guidance and service for VTE, a review of the ‘Delirium Policy’ and a new cardiac handover system.

The trust had recently appointed seven new medical examiners and trained 51 staff to undertake ‘Structured Judgement Reviews’. The numbers of these reviews had increased monthly and contributed to the ‘Serious Incident report’ which was presented monthly to the Patient Safety Group and then by exception to the Quality Governance Steering Group Learning from all Structured Judgement Reviews was fed back to teams directly by the reviewer.

We reviewed the trust’s processes for learning from deaths during our inspection. The trust had a policy in place which had been approved by the board in November 2017. The policy gave a clear guidance for the mortality review process and set out the responsibilities, accountability and duties of the trust board.

Medical examiners discussed all adult deaths with the referring doctor, reviewed the case notes and spoke with relatives to understand any concerns. Reviews of children and young people’s deaths were reviewed by a specialist in child health using a national standardised mortality review tool.

We looked at six mortality reviews and found that they had been completed in line with the trust policy. Key learning points had been recorded along with how the learning would be disseminated appropriately.

Serious Incident learning was also presented at the Medical Grand Round. The outputs and learning from Structured Judgement Reviews were also reported through the learning from deaths report which was discussed quarterly by the trust board.

A whole trust safety related theme of the week, was communicated to all staff by email and used as one component of the daily, ward-based safety huddles.

The trust Mortality Review Group received all Regulation 28 communications where improvement was required and reported through the Clinical Effectiveness and Outcomes Quality Management Group into the Quality Governance Steering Group.
Departmental and divisional clinical governance meetings had a standardised agenda and present a monthly ‘hot spot’ report to the Quality Governance Steering Group. This included a summary of lessons and learning from moderate and serious incidents.

Complaints process overview

The trust had a process in place for managing complaints which had a personal approach with patients being contacted to understand the concerns they are raising. The divisions undertook complaints investigations and the complaints manager gave an example of a regular meeting with the chief nurse. In this meeting they went through outstanding complaints and identified any blocks to resolution and any actions already taken to learn from the complaint to include in the complaint response.

Complaints incidents and patient feedback were monitored through the Quality Assurance subcommittee of the board. The Chair of this Committee gave evidence of challenge to learning from incidents. The trust had a Patient Engagement Panel where patient feedback was reviewed. The panel met regularly with the local Healthwatch to understand patient feedback from their members and adjust the agenda accordingly. The trust chief executive also held a regular meeting with the Healthwatch chief officer to hear member concerns about the Trust. This is good practice and demonstrates a commitment to hearing patient feedback.

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

<table>
<thead>
<tr>
<th>Question</th>
<th>In working days</th>
<th>Target performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>N/A</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>40</td>
<td>46.8%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months? (April 2017 to March 2018)</td>
<td>4,364</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)
Number of complaints made to the trust

The trust received 450 complaints from April 2017 to March 2018. The surgery core service received the most complaints with 120 which accounted for 26.7% of the total complaints received.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>120</td>
<td>26.7%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>83</td>
<td>18.4%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>74</td>
<td>16.4%</td>
</tr>
<tr>
<td>Medical Care</td>
<td>44</td>
<td>9.8%</td>
</tr>
<tr>
<td>Other</td>
<td>43</td>
<td>9.6%</td>
</tr>
<tr>
<td>Maternity</td>
<td>31</td>
<td>6.9%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>18</td>
<td>4.0%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>11</td>
<td>2.4%</td>
</tr>
<tr>
<td>No core service assigned</td>
<td>10</td>
<td>2.2%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>10</td>
<td>2.2%</td>
</tr>
<tr>
<td>Critical Care</td>
<td>6</td>
<td>1.3%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>450</strong></td>
<td><strong>N/A</strong></td>
</tr>
</tbody>
</table>

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

Compliments

From April 2017 to March 2018, the trust received a total of 956 compliments. A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>259</td>
<td>27.1%</td>
</tr>
<tr>
<td>Other</td>
<td>241</td>
<td>25.2%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>229</td>
<td>24.0%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>89</td>
<td>9.3%</td>
</tr>
<tr>
<td>Medical Care</td>
<td>80</td>
<td>8.4%</td>
</tr>
<tr>
<td>Maternity</td>
<td>23</td>
<td>2.4%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>17</td>
<td>1.8%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>15</td>
<td>1.6%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>2</td>
<td>0.2%</td>
</tr>
<tr>
<td>Critical care</td>
<td>1</td>
<td>0.1%</td>
</tr>
</tbody>
</table>
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.

Acute services

Urgent and emergency Care

Facts and data about this service

Details of emergency departments and other services

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

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

Both hospitals provide many of the same acute services for the local populations. The Royal Sussex County hospital is the centre for emergency and tertiary care.
The emergency department at Royal Sussex County hospital sees approximately 86,000 patients each year.

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

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

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

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

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

Activity and patient throughput

Total number of attendances at Brighton and Sussex University Hospitals NHS Trust compared to all acute trusts in England, April 2016 to March 2017

From April 2016 to March 2017 there were 161,026 attendances at the trust’s services as indicated in the chart above.

(Source: NHS England)
The percentage of attendances at this trust that resulted in an admission remained similar in 2016/17 compared to 2015/16. In both years, the proportions were higher than the England averages.

(Source: NHS England)

Attendances by disposal method, from March 2017 to February 2018

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>34,965</td>
</tr>
<tr>
<td>Discharged*</td>
<td>93,879</td>
</tr>
<tr>
<td>Referred*</td>
<td>24,008</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>3,687</td>
</tr>
<tr>
<td>Died in department</td>
<td>161</td>
</tr>
<tr>
<td>Left department#</td>
<td>5,361</td>
</tr>
<tr>
<td>Other</td>
<td>128</td>
</tr>
<tr>
<td>Not known</td>
<td></td>
</tr>
</tbody>
</table>

* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

More up to date attendance figures provided to us by the trust showed between September 2017 and August 2018 there was 85,963 attendances to Royal Sussex County hospital. Of these approximately 29% resulted in admission to hospital. Children are treated at the Royal Alexandra Children’s hospital, occasionally a child is cared for in the adult resuscitation area whilst waiting a transfer to a specialist hospital.

Patients presented to the department either by walking into the reception area or arriving by ambulance via a dedicated ambulance-only entrance. Patients transporting themselves to the
department are seen initially at the reception desk and booked in prior to being seen by a triage nurse. (Triage is the process of determining the priority of patients’ treatments based on the severity of their condition). Patients are directed from triage to the most appropriate areas.

We inspected the department over a two-day period. During this inspection, we spoke with 15 patients, four relatives, over 30 members of staff and reviewed 26 sets of patient records and 20 medication charts. We also reviewed information from a range of sources, including information provided by the trust before, during and after the site visit.

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

Mandatory training completion rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data at core service level.

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

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Mandatory and statutory training completion was recorded electronically on a matrix. Each band 7 nurse had a team of staff and was responsible for monitoring mandatory training for their team. There was a colour rated system for monitoring training completion; red indicated that mandatory training was out of date, yellow indicated that mandatory training would shortly be out of date and green indicated that staff had completed their training.

The practice educators had oversight of mandatory and statutory training completion and produced a weekly report of compliance rates which was shared with the matron who monitored completion rates against the trust target.

The service provided mandatory training to staff, training was a mixture of on-line and face to face. Staff reported that it was easy to access mandatory and statutory training and had dedicated time to complete it. There were 19 different modules which made up the mandatory and statutory training programme. Data given to us showed that of these 19 modules 15 had met the trust compliance target of 90%.

There was an improvement on compliance with mandatory and statutory training amongst the nursing staff but a decline in compliance amongst medical staff. The last inspection compliance rate reported for the healthcare assistant group was 69%, 76% for nursing staff and 84% for medical staff.

Data supplied to us showed the Acute Floor Directorate were 91% compliant in mandatory and statutory training. This was better than the trust target of 90%.

Data supplied to us showed that 91% (equal to trust target) of nursing staff at Royal Sussex County hospital and 77% (below trust target) of medical staff were compliant with mandatory training.
Clinical staff received mandatory training on how to recognise and provide a first response to patients with mental health needs, learning disabilities, autism or dementia. The training was included in the safeguarding module which included the Mental Capacity Act and deprivation of liberty safeguards training. All staff received this training on induction and was repeated yearly, the safeguarding and Mental Capacity Act leads delivered the training.

The dementia training module ‘forget me not’ was led by the dementia team and all staff undertook yearly training.

**Safeguarding**

**Safeguarding training completion rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data at core service level.

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

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. All staffed undertook Safeguarding Adults at Risk training and either level 1 or 3 Safeguarding Children and Young People training.

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

Data supplied to us showed that 92% of all staff were compliant with Safeguarding Adults at Risk training. This was better than the trust target of 90%. Compliance amongst medical staff at Royal Sussex County hospital was below the trust target (81%) and compliance was 94% amongst nursing staff at Royal Sussex County hospital.

Ninety-eight percent of all relevant staff had completed level 1 Safeguarding Children and Young People training. Eighty-one percent (worse than trust target) of medical staff at Royal Sussex County hospital had completed level 3 Safeguarding Children and Young People training. Ninety-four percent of nursing staff at Royal Sussex County hospital had completed level 3 Safeguarding Children and Young People training. Compliance with safeguarding training had improved since our last inspection.

Staff did or arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff ensured that patients were placed on enhanced levels of observation in accordance with their assessed risk to manage patient and ward safety.

The emergency floor department held morning multi-disciplinary meetings which included a review of patients’ risks. Staff could be sourced from departments within the emergency floor to provide increased level of observation to manage patient and department safety.

The consultant and staff we spoke with were aware of Mental Health Act holding power. Staff gained advice and support from the mental health liaison team and safeguarding team in relation to the Mental Health Act if required. Staff were aware of Section 136 requirements (two police officer escorts were with a patient at all times while they were in department receiving emergency medical treatment. We observed this during our inspection.

Staff followed trust policies and procedures for supervision and the restraint of patients if needed. The department had adjusted their observation and restraint policy to take patient frailty into account. This ensured that appropriate techniques were used dependant on patient size, weight and age. All staff were trained to use de-escalation techniques, using calm talk and distraction
interventions, as a first resort and on occasion they offered oral short acting sedation to manage patient and department safety.

Children attending the Sussex eye hospital who were on the Child Protection Register were identified on the computer system. All children under the age of 18 had a green assessment form completed which included the details of the patient, brief history including past medical history and medication. These were uploaded to the computer system which generated the number of previous attendances and if the child was on the Child Protection Register.

Although children were not treated within the department staff were aware of their responsibilities to protect vulnerable children and were clear about how to raise concerns. They were knowledgeable about safeguarding procedures and were able to give examples of when they had made safeguarding referrals.

There was no Child Protection Information Sharing system although the department was working with the Royal Alexandra Children's hospital and clinical commissioning group to implement this. In the interim, the department contacted the Children's hospital for advice and support along with the safeguarding policy to escalate concerns such as physical injuries or neglect.

The Child Protection Information Sharing project is a NHS England sponsored work programme dedicated to developing an information sharing solution that will deliver a higher level of protection to children who visit unscheduled care settings such as accident and emergency departments, minor injury units, paediatric assessment and walk-in centres.

Staff told us that feedback from reporting safeguarding concerns was varied and they usually had proactively sought feedback.

Staff knew how to make a Multi-Agency Safeguarding Hub referral. The Multi-Agency Safeguarding Hub brings together a team of multi-disciplinary professionals from partner agencies into the same room to deal with all safeguarding concerns, where someone is concerned about the safety or well-being of a child.

Staff knew how to make a Multi-Agency Risk Assessment Conference referral. A Multi-Agency Risk Assessment Conference is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors, probation and other specialists from the statutory and voluntary sectors.

Staff could tell us about female genital mutilation and had a good knowledge about this issue. This was part of the safeguarding level 3 training, that all staff in the department undertook. There was a female genital mutilation pathway available however, there was not any posters or prompts to remind staff to consider this.

The service had devised ways of ensuring those subjected to domestic violence could access a phone number without their abuser being aware.

**Cleanliness, infection control and hygiene**

Staff kept themselves, equipment and the premises clean. They used control measures available to prevent the spread of infection.

Staff received mandatory training which ensured they knew how to prevent and minimise the risk of infection. Data showed that 94% of clinical staff had undertaken Infection Prevention training and 100% of non-clinical staff had undertaken training.
Staff in the department were compliant with the National Institute for Health and Care Excellence, Quality Statement 3: Hand Decontamination, “People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care”.

We observed staff followed the trust policy for hand washing and ‘bare below the elbows’ guidance in clinical areas.

Hand washing guides were visible in the department with the appropriate World Health Organisation’s My five moments for hand hygiene procedures visible above all sinks. The posters clearly defined the key moments of hand hygiene.

There were adequate hand washing facilities throughout the department and hand alcohol gel dispensers were available in each cubicle, on the corridors and next to the entry and exit doors.

We observed staff cleaned their hands in line with national guidelines (five moments of hand hygiene). Departmental hand hygiene audits undertaken between week commencing 18/9/17 and week commencing 10/9/18 and average score of 85% for returned audits. The most recent audit score was displayed on the noticeboard in the department.

Staff adhered to the infection control policy and used personal protective equipment correctly when delivering care.

There were side rooms available for patients requiring isolation. Signage was used to advise staff not to enter without appropriate protective clothing, and visitors to speak to a member of staff.

The departments were clean, tidy and uncluttered. Cleaning services were provided by staff employed by the trust. The same housekeepers worked in the department to provide cleaning services. Dedicated housekeeper cover was available from 7am until 11pm seven days a week. This provided continuity of cleaning and ensured a good relationship between the housekeepers staff and emergency department staff. Staff we spoke to knew the names of the domestic staff responsible for the cleaning of the department and were embedded as part of the acute floor team.

Cleaning was undertaken in line with the national specifications for cleanliness in the NHS” a framework for setting and measuring performance outcomes”. A domestic supervisor undertook monthly audits to ensure compliance with the framework. For example, a score of 98% was achieved in August 2018. Patients and service users were aware of hand hygiene and cleaning audits as the most recent audits were displayed in the departments.

Equipment in cubicles and bays such as suction tubing and oxygen masks were checked daily to ensure they were clean. We saw records which confirmed this. During the inspection, one of the domestic staff showed us cleaning schedules which were fully completed.

We observed staff cleaning equipment after use to minimise the spread of infection. For example, we saw staff cleaning the patient trolleys, which was done thoroughly. The mattress was removed and inspected for any holes in the material and cleaned.

We saw all yellow sharps bins had been correctly assembled and labelled. This was in line with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

We saw all waste was segregated and stored correctly in line with national guidance. We saw domestic staff regularly changed waste bags to ensure they did not overflow.

We saw staff inserting vascular access (inserting a small tube into a vein) minimised the risk of infection by completing specified procedures during insertion. For example, we saw staff cleaned the skin before inserting the device. This was in line with the National Institute for Health and Care
Excellence guideline QS61. A proforma was completed by the staff member, which confirmed the specified procedures had been undertaken.

Due to limited space within the department the risk of infection was not always controlled well during busy periods. We observed during busy periods patients were on trolleys next to each other in the ‘cohort area’ which did not minimise the risk of the spread of infection. This was consistent with our last inspection however, we observed it happening less frequently during this inspection.

Environment and equipment

Due to the increase in attendances and lack of hospital flow the service did not always have suitable premises for the patients it cared for. There were periods when the number of patients in the departments was greater than the space available. When this occurred, patients were cared for in a non-clinical area ‘the cohort area’ or doubled up in assessment bays. This was consistent with our previous inspection findings.

We observe equipment was easy to locate, clearly organised, labelled and sufficient to meet the needs of patients.

Since our last inspection the room used for assessing patients with mental health needs had been refurbished. The room was now compliant with the Psychiatric Liaison Accreditation Network standard. This was a quality standard for liaison psychiatry services awarded by the Royal College of Psychiatrists.

An inspection undertaken at Royal Sussex County hospital in October 2017 highlighted issues with the safe use and storage of products subject to Control of Substances Hazardous to Health and under the Control of Substances Hazardous to Health Regulations 2002. During this inspection we saw all substances subject to these regulations were stored securely, with swipe access to the cleaning cupboards. Portable trolleys used by domestic staff had a locked section where these substances were stored, we checked four trolleys which were locked.

Staff were able to show us where information relating to substances subject to Control of Substances Hazardous to Health was located. This information was complete and accurate, and staff understood it. Staff were aware of the regulations and their responsibilities with regard to safe storage and use of Control of Substances Hazardous to Health products.

Staff regularly serviced all equipment in accordance with manufacturer guidance and electrical equipment was tested. Records we viewed demonstrated routine electrical testing, calibration and maintenance of medical equipment was completed as per hospital policy. During our inspection which checked 20 items of electrical equipment which had stickers on which confirmed they had undergone electrical safety testing in the last 12 months.

Resuscitation equipment was readily available and staff sealed all crash trolleys with a red tag. However, we noted that the resuscitation trolley in majors 2a was missing the defibrillator from the top of the trolley. We asked the matron where it was and was told it had probably gone with a patient on a transfer. This meant staff would not know where it was if they needed it in an emergency. However, other defibrillators were available for use in the department. When we returned the following day, we saw that all the resuscitation trolleys now had a laminated poster where staff could record where the defibrillator had gone and where the nearest alternative one was.

Resuscitation equipment was checked daily and weekly and we saw two months of records which confirmed this, this was an improvement since our last inspection. Equipment on top of the trolley such as suction and oxygen was checked daily and the drawers opened and a full check
undertaken weekly. We checked more than 20 items on the trolley in 2a all were in date and fit for use.

A team of technicians were responsible for the equipment and supplied within the department. We saw records which confirmed each area or bay was checked daily to ensure equipment was available and fit for use. The technicians worked closely with the electrical engineering department to ensure the equipment was maintained and safe for use. The technicians attended trauma calls within the department to ensure timely access to specialist equipment.

Point of care testing equipment in the department included glucose meters, urine testing sticks and a blood gas machine. There was an ultrasound machine available in the resuscitation room for emergency use.

There was a fully equipped child resuscitation bay and resuscitation trolley with all sizes of equipment. This was checked on a daily basis to ensure they were ready for use and we saw records, which confirmed this. Occasionally this area was used by very sick children awaiting transfer to another hospital.

The adult waiting areas had separate male, female and disabled toilets. We identified potential ligature points in the toilets, which could be used by mental health patients. Staff told us that this risk was reduced as all mental health patients would be escorted to a toilet and a member of staff would wait outside. Each toilet had a panic button or pull cord to alert staff if help was needed.

The urgent care centre had been refurbished and re-designed since our last inspection which meant the department ran more efficiently and safely. For example, previously in the urgent care centre staff did not have oversight of the patients in the waiting. Since the area had been redesigned staff were able to monitor patients for signs of deteriorate as they could see them. We saw there was a dedicated waiting area and seven assessment/treatment bays. The treatment chairs used in this department were on wheels and could be laid flat if a patient suddenly deteriorated.

The department was located near the x-ray department and CT scanner to allow for easy access.

The department had effective processes for managing fire risk assessments. We saw the department had six actions following the last fire risk assessment all of which had been completed. All doors were unobstructed and fire escapes were clear.

There was simulation suite in the department, this was used to improve training quality and the opportunities available to staff.

**Assessing and responding to patient risk**

Data provided to us after the inspection showed there was regular delays in assessing the risk for patients who brought themselves to the emergency department. The median time patients waited for assessment at Royal Sussex County hospital was 25 minutes therefore their condition was at risk of deteriorating during this time. During our inspection we did not observe patients waiting significant lengths of time for initial assessment. Patients who presented themselves to the department with a minor injury where treated in the urgent care centre. Staff had oversight of patients waiting in the waiting area and therefore could monitor any deterioration in a patients condition. The computer system tracked the length of time a patient was in the department, so staff knew had been waiting the longest.

More recent data supplied to us showed an improvement in the initial assessment of patients at Royal Sussex County hospital. Between 01 July 2018 and 09 September 2018 93% of patients
had an initial assessment within 15 minutes of ambulance arrival between. This was similar to the national target of 95%.

**Emergency Department Survey 2017**

The trust scored about the same as other trusts for all five Emergency Department Survey questions relevant to safety.

*(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)*

**Median time from arrival to initial assessment (emergency ambulance cases only)**

Adult patients arriving by ambulance were rapidly assessed by the nurse in charge of the department. This assessment was required to determine the seriousness of the patient’s condition and to make immediate plans for their on-going care. This is often known as triage. Standards set by the Royal College of Emergency Medicine states that this should take place within 15 minutes.

The median time from arrival to initial assessment was not reported by the trust from July 2017 to June 2018.

*(Source: NHS Digital - A&E quality indicators)*

**Percentage of ambulance journeys with turnaround times over 30 minutes for this trust**

**Royal Sussex County Hospital**

From July 2017 to June 2018 there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Royal Sussex County Hospital.

**Ambulance: Number of journeys with turnaround times over 30 minutes - Royal Sussex County Hospital**

![Bar graph showing the number of ambulance journeys with turnaround times over 30 minutes from July 2017 to June 2018 at Royal Sussex County Hospital.](image)

**Ambulance: Percentage of journeys with turnaround times over 30 minutes - Royal Sussex County Hospital**

![Line graph showing the percentage of ambulance journeys with turnaround times over 30 minutes from July 2017 to June 2018 at Royal Sussex County Hospital.](image)

*(Source: National Ambulance Information Group)*
Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From June 2017 to May 2018 the trust reported 1,068 “black breaches”.

[Graph showing number of black breaches]

The trust has had fluctuating performance in terms of black breaches which it accounted for by challenges with hospital capacity and flow. The highest number was 63 in week commencing 22 October 2017 and the lowest number was 3 in week commencing 27 August 2017.

(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

More up to data provided to us by the trust showed there was 902 black breaches at Royal Sussex County hospital between September 2017 and August 2018.

The department was effectively using a system to monitor acutely ill patients.

Since our last inspection, staff had embedded and strengthened the systems and processes relating to the management of deteriorating patients. Every patient had a safety checklist completed whilst in the department. The safety checklist was broken down into three sections; checks undertaken within one hour, two hours and three hours of arrival in the department. The checklist included a variety of checks, which included but were not limited to; vital signs measured, identification wristband on patient, suspected sepsis (infection), blood tests and pain score.

However, this document was very comprehensive, and staff told us took a long time to complete and was therefore not always fully completed. We reviewed 22 patient records and found that four of these were not fully completed. For example, the checks and risk assessments meant to be done within the first hour were not completed. Staff told us that this documentation had been implemented without any consultation with staff on the length or content. The leadership team told us that this document was under review jointly by the nursing and medical team to ensure it was streamlined and quicker for staff to complete. We saw the two teams had decided on the essential safety aspects of the documentation which should be included. The leadership team told us they would consult with staff before re-issuing a modified version.
Level of risk was identified using standard Red Amber Green rated risk assessment at triage. We saw the level of risk was documented on the four patient records we reviewed that were at risk of self-harm or suicide.

The department had recently changed to using the National Early Warning Score 2 in line with NHS England and NHS Improvement recommendations. It is the early warning system for identifying acutely ill patients - including those with sepsis - in hospitals in England.

The National Early Warning Score 2 is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, such as blood pressure and heart rate which are already recorded in routine practice, when patients present to, or are being monitored in hospital. Six simple physiological parameters form the basis of the scoring system:

- respiration rate
- oxygen saturation
- systolic blood pressure
- pulse rate
- level of consciousness or new confusion
- temperature.

The National Early Warning Score 2 score prompted staff to take further action. For example, increasing the frequency of monitoring vital signs and informing medical staff so they could review patients and escalate treatment if required. The escalation pathway was readily available on the observation records for staff to easily refer to. There were processes to ensure that staff reported elevated National Early Warning Score 2 scores to a medical practitioner and patients had access to necessary medical reviews.

We observed National Early Warning Score 2 being performed and concerns escalated through appropriate channels. Data provided to us by the trust confirmed our observations during the inspection. Between January 2018 and September 2018 100% of patients had a National Early Warning Score 2 on admission to the department. The same data showed an improvement in vital signs being measured hourly. Compliance with this varied between 0% in January 2018 and 95% in August 2018. The trust set a target to achieve 85% compliance, this was achieved six times in the nine months.

Although ‘the cohort area’ was not the ideal environment for patients to receive care the service ensured the risk to patients was monitored. Data supplied to us by the trust showed that in July 2018, 82% (14 out of 17) of patients in ‘the cohort area’ had a National Early Warning Score 2 score calculated within 15 minutes of arrival. The same data showed that between January 2018 and July 2018 no patient with a National Early Warning Score 2 of more than five was cared for in this area.

‘The cohort area’ had enough staff allocated which ensured patients in this area were monitored for signs of deterioration. During our inspection we saw a nurse was always in the area. We saw an audit of the area which confirmed between January 2018 and July 2018 staff were allocated to this area.

The mental health liaison service provided around the clock access to mental health liaison and/or other specialist mental health support if staff were concerned about risks associated with a patient’s mental health. The mental health liaison team had a one-hour response time to respond to requests for assessment and support. Staff described a positive relationship with the mental health liaison team and found advise and support easily accessible.
Five hospitals in Sussex provided a place of safety, which the service could access. The Mental Health Act gives police powers to take people who appear to be suffering from a mental health disorder to a place of safety for assessment for up to 72 hours - in the interests of the health or safety of the person, or the protection of the public. All 136 suites have additional staff in the ward numbers to nurse admissions as required. The suites are frequently in use, so patients were nursed in the department or ward environment until a place suitable for their needs became available for their onward admission.

There were risk assessments in place in relation to mental health needs or behaviour. A safeguarding and managing risk tool was used to assess the level of danger to self or others. The tool assessed whether they were a red (highest level of risk), amber, yellow or green risk. The level of risk set out a management plan for the patient. The assessment tool included a description of the patient in the vent they absconded staff could give a description of the patient to the police or security. In the four patient records we reviewed we saw the risk assessments had been completed.

At the time of our last inspection all patients were triaged, and a category assigned one to five depending on their condition. Triage is the process of determining the priority of patient’s treatments based on the severity of their condition.

Since our last inspection the service had started using a streaming process. This is the assessment and allocation of patients to the most appropriate physical areas of a hospital, and the most appropriate clinical pathways. The service had now changed to new model which was based on national guidance. This model was based on the streaming and priority assessment and treatment of patients. The purpose of streaming is to quickly determine the most appropriate place for a patient who walks through the front door of an urgent and emergency care department.

This includes sending the patient to the right department within the hospital or redirecting them offsite to a more appropriate setting.

Priority assessment and treatment involves a senior doctor seeing and assessing patients as soon as possible after their arrival. The senior doctor can make decisions about that patient’s care and condition rapidly. This should enable time-critical conditions to be identified and treatment delivered rapidly.

If a patient had been streamed and had a National Early Warning Score 2 score of three in one single observation such as low blood pressure or had a total National Early Warning Score 2 of five or over then priority assessment and treatment would be undertaken by a senior doctor.

We saw patients being assessed in line with this model during our inspection, it was particularly useful during busy periods as doctors could order any investigations that might be required early in the patient journey. This also improved efficiency within the department. We saw all patients had their observations as part of this assessment and a National Early Warning Score 2 recorded.

Feedback from staff was mixed on the new assessment process, although the majority felt it was quicker and more efficient than the Manchester triage system. The new process required time to embed and for staff to become familiar with it. Only band 6 and 7 nurses who had completed a competency could stream patients. Senior band 5’s could on completion of the competency and authorisation from a band 7.

There were excellent awareness of sepsis (severe blood infection) was embedded in the department with continuous monitoring for improvement. Up to date and evidence-based guidelines for the management of sepsis were visible in all areas in the department. During our
inspection the weekly trust focus was on sepsis, this raised awareness amongst staff and ensured staff knew the most up to date treatment guidelines.

Sepsis screening was a mandatory process within the department on the computer system any patient with a National Early Warning Score 2 of five or more on arrival to the department the system triggered a ‘red flag sepsis alert’ and prompted users to get an immediate senior review and early diagnosis.

The sepsis screening tool was based on Sepsis Six. The Sepsis Six is the name given to a bundle of medical therapies designed to reduce deaths and serious illness associated with sepsis. The Sepsis Six consists of three diagnostic and three therapeutic steps – all to be delivered within one hour of the initial diagnosis of sepsis.

We reviewed the patient records of five patients who had attended with sepsis or suspected sepsis. We saw that the screening tool had been completed and the patients had received treatment in line with evidence-based guidelines. For example, patients received antibiotics within an hour from when sepsis was diagnosed or suspected.

Trust wide data showed that 100% of patients within the emergency department were screened for sepsis between April 2017 and March 2018. The same data showed in quarter one 84%, quarter two 83% and quarter three 90% of patients received antibiotics within one hour of diagnosis or suspicion of sepsis.

There was a trust wide sepsis improvement plan which was last updated in July 2018 and was due the next update in October 2018. We saw the improvement plan was up to date and had individuals allocated to each action.

During our inspection we saw some of the improvements had been made. For example, a Sepsis Clinical Lead for the department had been appointed to support staff and patients alike through education, promotion of early diagnosis with the screening tool and rapid treatment with the sepsis trolley.

Part of the improvement plan was also to ensure all staff were trained in using the sepsis tool. Training had been on-going, with more than 1000 staff completing the sepsis screening tool session, which encouraged individuals to ‘think sepsis’ as early as possible using the tool, considering patients at risk and promoting awareness.

Sepsis trolleys were in use in the department, these provided the staff with all the equipment they needed to deliver the ‘Sepsis Six’ without distractions.

Since our last inspection, the department had imbedded the single clerking assessment process. Single clerking had a positive effect on the patient journey and medical staff resources. Clerking is when one doctor takes a comprehensive history and full examination of a patient and avoids repetition. Single clerking brings together all the different specialities into the department.

A recognised assessment tool was used to identify patients at risk of developing a pressure ulcer and preventative measures could be implemented. A repositioning chart and management plan were put in place for those patients identified as being at high risk.

However, we reviewed the records of one patient who had been identified as a high risk of developing a pressure ulcer and had been in the department for eight hours and had not been placed on a pressure relieving mattress.

Patients attending the emergency department were routinely assessed for venous thromboembolism and patient records showed they received appropriate preventative treatment.
There were laminated flow charts displayed for a variety of different emergency conditions such as major haemorrhage for staff to refer to.

The department had a simulation suite, this allowed staff to have practical experience of managing emergency situations which were then followed up with a de-brief of the exercise, so staff received feedback and could identify any learning.

Staff used body maps to document injuries to patients, this helped with assessment of injuries or in cases of unexplained bruising or injuries where there was a safeguarding concern. The body maps were all used to document and pressure areas or pressure ulcers a patient had. This meant a record of a patients pressure areas where recorded when they first admitted, and any new areas were easily identified.

**Nurse staffing**

The trust has reported their staffing numbers below for two different times; March 2017 and April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>As at 31 March 2017</th>
<th>As at 30 April 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>All sites</td>
<td>225.1</td>
<td>242.5</td>
</tr>
</tbody>
</table>

In March 2017 the trust reported they had filled 93% of their planned staffing. This increased to 94% in April 2018.

No site breakdown is available as the trust did not report the data at site level.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From May 2017 to April 2018, the trust reported a vacancy rate of 3.7% for qualified nursing staff in. This was lower than the trust target of 10.5% in March 2018, reducing incrementally to 9.0% by March 2019.

The breakdown by site was as follows:

- Royal Sussex County Hospital emergency department: 4.1% over establishment.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

The service invested in the recruitment and retention of staff. Since our last inspection the service had recruited a dedicated band 7 recruitment and retention nurse. This enabled the band 7 to oversee the whole recruitment process provide the ‘personal touch’ and identify any delays. The band 7 supported the practice educators in the development and education of staff to encourage them to stay working for the service.
Turnover rates

From May 2017 to April 2018, the trust reported no staff turnover in urgent and emergency care services. This was better than the trust’s overall target turnover rate of 14% in March 2018 reducing incrementally to 11% by March 2019.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From May 2017 to April 2018, the trust reported a sickness rate of 3.9% in in urgent and emergency care services. This was better than the trust overall target sickness rate of 4.20% in March 2018 reducing incrementally to 3.50% by March 2019;

A site level breakdown is shown below:

- Royal Sussex County Hospital: 4.0%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

Staffing levels were at times a challenge with staff being moved to different areas of the department to cover busier periods. Staff told us that they sometimes found this difficult.

The nursing team was led by a senior matron (grade 8b) and at the time of our inspection the service was advertising for another matron (grade 8a). The matron in post at the time of our last inspection had left and a new matron had been appointed. There was a total of 14 band 7 nurses, 36 band 6 nurses and 48 band 5 nurses of 72 to cover the majors area, resuscitation area, urgent care centre and the clinical decision unit. Data provided to us showed vacancy rates for Royal Sussex County hospital were 1.6 whole time equivalent for band 5 nurses, 4.6 whole time equivalent for band 6 nurses and 7.2 whole time equivalent for health care assistants. There were 17 nurses working in the department on the day shift and seven health care assistants. There were 18 nurses staff working in the department on the night shift and six health care assistants.

If the demand and capacity increased numbers were adjusted accordingly. The band 7 nurses reviewed the roster in advance and used a red, amber green scoring system to identify shortfalls in the number of staff and the skill mix of staff on duty. We saw there was a tool used for calculating the score and clear escalation plans to address shifts scored as red or amber. Records showed action had been taken to address any shortfalls in staffing.

The staff had recently started to take turns to work in the different areas within the urgent and emergency care department. This ensured staff were multi skilled and worked where a need was identified. We saw staff rotate between areas during the inspection to meet individual care needs.

Staffing was reviewed twice a day at handovers in the department and three times a day at the site management meetings. If the department was short staffed, the staffing across the whole hospital was reviewed and additional staff sought from other areas in order to support the department.
The department's escalation plan and the trust's business continuity plans managed variations and increased demand.

Staff were easily identifiable by the patients and visitors as their job role was printed on the back of their uniform top.

Band 6 and 7 nurses were given the knowledge and skills to support the leadership of the service they all undertook NHS Leadership training.

**Bank and agency staff usage**

Please note that the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff in all cases. Therefore, we have been unable to analyse bank and agency usage as a proportion of the total shifts needing to be filled.

The table below shows the numbers of shifts in this core service from June 2017 to May 2018 that were covered by qualified nursing and nursing assistant bank and agency staff or left unfilled.

For qualified nurses, 1,465 shifts were filled by bank staff and 1,475 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses. In addition, 1,100 shifts were not filled by either bank or agency staff.

For nursing assistants, 1,823 shifts were filled by bank staff and four shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants. In the same period, 628 shifts were not filled by either bank or agency staff.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Qualified nurses</th>
<th>Healthcare assistants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>1,465</td>
<td>1,823</td>
<td>3,288</td>
</tr>
<tr>
<td>Agency</td>
<td>1,475</td>
<td>4</td>
<td>1,479</td>
</tr>
<tr>
<td>Not filled</td>
<td>1,100</td>
<td>628</td>
<td>1,728</td>
</tr>
</tbody>
</table>

Of the 1,100 unfilled qualified nursing shifts 794 of these were in emergency department at Royal Sussex County hospital in nursing and three were in the resuscitation area. In addition, there was 32 unfilled qualified nursing shifts reported for Emergency Nurse Practitioner which were non-site specific.

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

**Medical staffing**

The trust has reported their staffing numbers below for two different times; March 2017 and April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>As at 31 March 2017</th>
<th></th>
<th>As at 30 April 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
</tr>
<tr>
<td>All sites</td>
<td>104.3</td>
<td>109.9</td>
<td>95%</td>
<td>117.2</td>
</tr>
</tbody>
</table>

In March 2017 the trust reported they had filled 95% of their planned staffing. This decreased to 87% in April 2018.

No site breakdown is available as the trust did not report the data at site level.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)
Vacancy rates

From May 2017 to April 2018, the trust reported a vacancy rate of 4% for medical staff in in urgent and emergency care services. This was lower than the trust target of 10.5% in March 2018, reducing incrementally to 9.0% by March 2019.

This data is at trust level as it was not reported with site level detail.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From May 2017 to April 2018, the trust reported no staff turnover in in urgent and emergency care services. This was better than the trust’s overall target turnover rate of 14% in March 2018 reducing incrementally to 11% by March 2019.

This data is at trust level as it was not reported with site level detail.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From May 2017 to April 2018, the trust reported a sickness rate of 0.4% in in urgent and emergency care services.

This was better than the trust overall target sickness rate of 4.20% in March 2018 reducing incrementally to 3.50% by March 2019.

This data is at trust level as it was not reported with site level detail.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

From April 2017 to March 2018, the trust reported that 101 shifts within this core service trust-wide were filled by bank staff and no shifts were filled by locum staff. There were 62 shifts which were not filled by either bank or locum staff. A breakdown of bank and locum usage by staff type at the trust is shown below.

Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
<th>Unfilled shifts</th>
<th>Total shifts (bank + locum + unfilled)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>24</td>
<td>0</td>
<td>0</td>
<td>24</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>68</td>
<td>0</td>
<td>60</td>
<td>128</td>
</tr>
<tr>
<td>Junior</td>
<td>9</td>
<td>0</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>101</td>
<td>0</td>
<td>62</td>
<td>163</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)
Staffing skill mix

From December 2017 to December 2017, the proportion of consultant staff reported to be working at the trust were lower than the England average and the proportion of junior (foundation year 1-2) staff was also lower.

Staffing skill mix for the 101-whole time equivalent staff working in at Brighton and Sussex University Hospitals NHS Trust.

<table>
<thead>
<tr>
<th></th>
<th>This trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>20%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>9%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>58%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>13%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Medical staffing provided twenty-four-hour consultant cover, this met the Royal College of Emergency Medicine guidelines.

There had been an increase in the medical staffing establishment since our last inspection from 109.9 whole time equivalent to 134.1 whole time equivalent which provided 24-hour resident consultant cover.

Consultants had the skills knowledge and experience needed to work across both hospital sites. With the exception of one consultant, all consultants worked between Royal Sussex County hospital and Princess Royal hospital. This allowed continuity for both sites, consultants maintained their skills and consultants could cover either site when required. For example, to cover last minute sickness.

There was the correct amount and experience of doctors to meet the needs of the department 24-hours a day. There were two consultants who worked 8am until 3:30pm, two from 3:30pm until 10:30pm and one from 10pm until 8am.There were three junior doctors who worked 8am until 5pm, one from 12pm until 9pm, four from 3pm until 12pm and four between 10pm and 8am. There were two middle grade doctors who worked between 8am and 6pm, two from 12pm until 10pm and one from 10pm until 8am. On each shift there was one or two float doctors of different grades to cover last minute sickness or surges in demand.

The GP’s worked three different shifts; 9am until 3pm, 11am until 7pm and 7pm and midnight.

Different grades of medical staff were easily identifiable by the coloured uniform they wore. Consultants wore red, middle grade doctors wore green and junior doctors wore lime green.
Urgent and emergency care did not use locum doctors to cover shifts. Any limited shortfalls in staffing were covered by their own staff. This was an unusual inspection finding and represented a successful approach to self-rostering and allocation of staff.

The service offered a clinical fellow programme. This allowed the opportunity for doctors to work in a part clinical (75%) and part research (25%) role for one year. This had created a flexible workforce to cover the needs of the service and provided the opportunity for the service to gain research and innovation projects. The clinical fellow programme had been replicated by other hospitals nationwide. The programme had also been awarded highly commended in November 2017, Health Service Journal awards and the May 2018, British Medical Journal awards.

We observed a medical handover during the inspection and found it to be effective, structured and fit for purpose. After the initial handover the consultant in charge visited all the different areas within the department and received a more detailed handover of each area. We observed this during our inspection and saw a staff member asking the consultant to review a patient they were concerned about.

**Records**

The majority of records were clear, up-to-date and available to all staff providing care. We reviewed 22 sets of patient records and found four were incomplete. For example, not fully completed safety checklists or falls risk assessment. In all cases the incomplete documentation occurred during a night shift. Senior staff told us that it had been an extremely busy night and it had therefore been overlooked. In addition, we noted there was extensive amounts of paperwork which was not achievable for staff to complete due to the demand on the service. Data supplied to us showed that in July 71% had a documented nursing assessment, in August 95% and September 89%.

We reviewed some further patient records the following day from the previous night and found all were fully completed.

The department used paper records for patient notes and assessments and an electronic system for tracking lengths of stay, x-rays and tests. The electronic system was used to document the initial National Early Warning Score 2 which when certain score was met triggered a reminder for staff to consider sepsis. A paper based casualty card was used to record any treatments and procedures undertaken whilst the patient was in the department.

Patient records were kept securely and confidentially this was an improvement since our last inspection. At our last inspection patient records were not kept securely in the “cohort area”. At this inspection we saw a lockable cabinet was used to store patient records in this area.

At our last inspection there was an electronic display screen at the department hub/desk which displayed reading confidential patient information. During this inspection we saw the screen no longer displayed patient identifiable information.

Assessment tools within patient records reflected best practice. Patients conditions were reviewed and treatment plans were followed. Documentation showed evidence that observations were regularly undertaken, monitored and al National Early Warning Score 2 calculated and recorded.

The casualty cards were kept in the department for 48 hours in case the patient returned to the department, this enabled them to be found quickly and easily.

Staff could access the patient’s full medical notes if required. Administration staff had authorisation to request a patient’s full medical notes if required, out of hours this could be done via the site manager. Staff told us they arrived quickly.
Discharge summaries were generated and sent to the patients GP by or emailed over if urgent. Patients with pre-existing physical or mental health illnesses were easily identifiable on the electronic patient system. The electronic patient system allowed alerts to be added to patients, there was a symbol next to the patient name.

Patient records contained when it was necessary, details of patients a patient’s mental health needs, learning disability needs, autism needs and dementia needs. We saw this recorded in four patient files.

A drug and alcohol worker from a local substance misuse service attended the department daily and reviewed the electronic patient system to identify patients with drug and alcohol support needs. Staff demonstrated to us how this would be identified on the electronic patient system.

Mental health and physical health records were shared effectively to avoid unnecessary admissions. The mental health liaison team recorded a summary of their assessment in the electronic patient system.

Data supplied to us showed that between March 2018 and September 2018 for six of the seven months 100% of patient records had a documented review of the patients electrocardiogram.

**Medicines**

The service prescribed, gave, recorded and stored medicines in line with best practice and guidance. Patients received the right medication at the right dose at the right time.

Monitoring of fridge and room temperature readings where medicines were being stored was carried out regularly and in line with guidance. This was an improvement since our last inspection when we found an inconsistent approach to medicine fridge temperature checks.

There was an effective process for the safe management and storage of patients own medicines. This was an improvement since our last inspection when we found they were not being handled in line with trust policy. As part of the trust wide Patient First Improvement System the problems associated with patients’ own medicines was identified. Following the Patient First framework, a process was implemented. As part of their first hour checks on the safety checklist, staff confirmed if patients had bought any of their own medicines into the department. These where then recorded and stored safely. A green sticker was added to the patients notes to act as a reminder to staff that the patient had medicines which needed to be returned to the patient at discharge or transferred with the patient to the ward. This process also improved efficiency as it reduced the amount of medicines becoming lost between the emergency department and the wards.

Doctors did not always prescribe intravenous (into a vein) fluids in line with trust policy. We reviewed twelve medicine charts and found seven had the intravenous fluid prescribe in the once only section of the chart. Prescriptions for intravenous fluid should have the length of time the fluid should be given over documented, so staff administering it ensure it was given over the correct time. The intravenous fluids prescribed on the once only section did not have the length of time documented or the traceability batch number of the intravenous fluids. Giving intravenous fluid to a patient too quickly or too slowly could cause harm to a patient. In addition, if the patient had an adverse reaction to the intravenous fluid the batch number could not be identified.

The process for ensuring medicines stocked in the department were within date was not effective. We checked 20 different medicines were past the expiry date. Staff told us that it was the responsibility of the pharmacy technician to check expiry dates when they undertook stock checks.

Patients received their medicines as intended and medicines were recorded appropriately. We reviewed 12 medicines charts and saw that allergies were documented for all patients. One
The medicine chart did not state a reason why the medicines had not been given, this could cause confusion for staff looking after the patient as they would not know the reason it was not given. We saw medical gas cylinders were correctly stored and the correct signage was in place in line with legislation. This was an improvement since our last inspection when cylinders were stored incorrectly.

Medicines and controlled drugs were stored in a secure room with swipe card access. All staff had access to the room, so they could replenish items such as dressings and bandages. Only authorised staff had access to the medicine cupboards. Two members of staff were required to access the controlled drug cupboard. This ensured they were stored and dispensed in line with The Misuse of Drugs Regulations 2001. We checked the controlled drug records, which were fully completed, with no omissions. This was an improvement from our last inspection when we found missing signatures in the records. Controlled drugs are medicines liable for misuse that required special management.

All incidents involving controlled drugs were investigated. Three monthly reports were made to the NHS England controlled drugs officer and the Controlled Drug Local Intelligence Network meetings were attended.

A pharmacy technician would top up the store of medicines and intravenous fluids in the department daily, staff did not report any problems with the supply of medicines.

Patient group directions had recently been re-introduced for paracetamol, ibuprofen and codeine (mixture of paracetamol and codeine). Nurses were required to complete the training day and competency which was based on The National Institute for Health and Care Excellence guidelines before they could issue a patient group direction. We saw evidence of the training day and competency which confirmed this. Nurses had to complete their triage competency before they could undertake patient group direction training.

Nurses working under these directions could administer a set list of pain medications to patients without waiting for a doctor’s prescription. This reduced the time new patients had to wait for pain medicines.

Patient group directions are written instructions which allow specified healthcare professionals to supply or administer a medicine in the absence of a patient specific prescription.

A safe and secure medicines audit had been completed (September 2018). An action plan from previous audit (May 2018) had been reviewed and new actions noted for each area as appropriate.

Patients received the information they needed to understand how to take their medicines and what they medicines were for. On the medicine administration round on the short stay/clinical decision unit we observed the nurse explained to the patients what their medicines were for. There was a medicine information line for patients to phone if they have queries about their medicines after discharge.

Nurses checked the discharge medicines and discussed them with patients. Patients were given a copy of their discharge summary.

There was one nurse prescriber within the urgent care centre. The urgent care centre only stocked simple medicines and no controlled drugs due to the nature of the injuries they were treating.

FP10 prescriptions were available in the Sussex Eye hospital and the NHS Counter Fraud Authority Management and control of prescription forms: A guide for prescribers and health organisations, March 2018, was being followed in regard to the security of these prescriptions. The
stationary was stored securely and a tracking system was in place. The emergency department at Royal Sussex County hospital did not stock FP10 prescriptions. If patients required a prescription they could get one from the GP’s in the urgent care centre or get issued a hospital prescription and get the medicines from the main pharmacy in the hospital.

FP10s are prescription forms that can be issued by a GP or nurse, pharmacist prescribers and hospital doctors.

The department had a restricted list of pre-packed medicines available to support a quick and easy discharge process.

Staff had access to an electronic database number and a support line for patients who had taken an overdose was available. There was also an up to date best practice pathway to follow. We saw there were posters in the department with details on how to contact the database.

Incidents

There was an open culture for reporting medicines incidents, these were investigated and were reported to the medicines safety committee. Learning from incidents was identified and the information disseminated across the organisation.

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 2017 to May 2018, the trust reported no incidents classified as never events for in urgent and emergency care services.

(Source: NHS Improvement - STEIS)

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 26 serious incidents (SIs) in urgent and emergency care services at Royal Sussex County Hospital which met the reporting criteria set by NHS England from June 2017 to May 2018.

These most common incident type was commissioning incidents meeting Serious Incident criteria (24 reported).

(Source: NHS Improvement - STEIS (01/06/2017 - 31/05/2018)

All but one of the serious incidents reported were 12-hour breaches. A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. Senior staff told us that they were awaiting instruction from the Clinical Commissioning Group with regard to investigating these. The remaining serious incident was a patient fall in the department resulting in harm. We reviewed the serious incident investigation when a patient fell in the department and saw it was investigated using a root cause analysis approach.

Data supplied to us by the trust showed that between September 2017 and August 2018 the service reported 668 incidents. Of these incidents one resulted in death, five in moderate harm, 97 in low harm and 486 in no harm. The top three categories of incident were: regarding medication
(96), staffing, facilities and environment (90), and implementation of care and ongoing monitoring / review (64).

The service managed patient safety incidents well. Staff recognised incidents and reported them in with trust policy. One band seven investigated the majority of incidents rather than the wider team of band 7’s. There were plans to change this so that band 7’s investigated and managed the incidents. Lessons learned with the whole team and the wider service were shared. Learning was shared via a range of methods including directly through email, morning handovers, a social media application and at daily huddles. Information was also shared via a folder that summarised the incident and identified good practice, areas for improvement and learning points for sharing. We saw there was three incident report investigations in the folder for staff to review.

There was a dedicated computer system for reporting incidents and there were clear policies and procedures for staff to follow.

When things went wrong, staff apologised and gave patients honest information and suitable support.

The division of the acute floor held weekly emergency department rounds meeting and quarterly medicine directorate emergency department rounds meetings. Emergency rounds included individual case studies and were multidisciplinary and the purpose was to increase awareness, seek consensus on system changes and disseminate learning to multitude of professionals, including senior management.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke with had a good knowledge of duty of candour and, senior staff were very clear about their responsibilities in relation to the guidance. We saw examples of when the regulation had been applied.

Safety thermometer

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 ten days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, one fall with harm and two new urinary tract infections in patients with a catheter from May 2017 to May 2018 within urgent and emergency care services.

The Medicine Safety Thermometer was completed on a monthly basis. This provided information on medicines reconciliation rates, completion of Venous thromboembolism risk assessments, recording of allergy status, omissions in recording administration of medicines and prescribing of high risk medicines. Medicine reconciliation is the process of creating the most accurate list possible of all medications a patient is taking.

(Source: Safety thermometer - Safety Thermometer)
**Evidence-based care and treatment**
The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

We looked at a range of clinical policies and guidelines available within the department and on the trust intranet. We saw policies were based on National Institute for Health and Care Excellence and best practice guidelines. Staff showed us how they would access the local guidelines on the trust intranet.

Local audit information was displayed for staff on an audit noticeboard and was used to highlight areas of good practice and areas where improvement was needed.

There was a clinical audit lead with oversight of the local and national audit programme. Audit results were shared with the department at handovers, huddles emergency department rounds and governance meetings.

Governance meeting minutes showed that National Institute for Health and Care Excellence guidelines were discussed. This enabled changes to guidance could be applied to systems and processes within the department.

We observed staff worked in accordance with national best practice guidance. For example, they followed National Institute for Health and Care Excellence Head injury: assessment and early management Clinical guideline (CG56).

There were a variety of up to date, evidence based pathways used such as the management of: sepsis, asthma, alcohol abuse, mental health referrals, resuscitation, fractured neck hip, stroke and diabetes.

Care and treatment was given in line with ‘Clinical Standards for Emergency Departments’ guidelines. Staff used a standardised safety checklist adapted from Royal College of Emergency Medicine (RCEM) guidelines, when assessing patients.

The service introduced emergency prompt cards in April 2017 they allowed the essentials of clinical practice and safety to be readily available to all. The emergency prompt cards were based on national guidance and local guidance. The emergency prompt cards set out a standardised approach to undertaking certain procedures such as inserting a chest drain.

The service to part in national audits requested by the Royal College of Emergency Medicine; others were based on the National Institute for Health and Care Excellence guidance and the department contributed to the Trauma, Audit and Research Network.

We saw the service had undertaken a repeat audit in October 2017 (previous audit 2016) in relation to the management of head injuries. The purpose of the audit was to identify if improvements had been made in line with National Institute for Health and Care Excellence Head injury guidelines. The audit showed some improvements had been made. For example, a target of 90% compliance with Standard 2 of the guideline states: Discharged patients should receive written advice on discharge. The 2016 audit showed 31% compliance and the 2017 audit showed 84% compliance.

The latest Trauma, Audit and Research Network data showed (Quarter 4 2017/18) showed 100% of patients which met the national guideline criteria had a CT scan undertaken within 60 minutes of arrival. The national average was 91%.
Skin vulnerability assessments were completed on arrival for frail and elderly patients. The patient records we reviewed showed this was completed in line with Royal College for Emergency Medicine guidance.

Sepsis screening and management was carried out effectively in line with national guidance such as the Sepsis Six. Trust wide data showed that 100% of patients within the emergency department were screened for sepsis between April 2017 and March 2018. Patient records we reviewed showed that staff delivered care in line with national and best practice guidance.

Patient records we reviewed showed that patients were routinely assessed for venous thromboembolism and preventative treatment offered in accordance with National Institute for Health and Care Excellence guidance. Thromboembolism is a condition where a blood clot forms in the vein which can travel to the lungs.

The service used the frailty Rockwood score as part of the assessment of patients over the age of 75. Rockwood is a clinical frailty scale that is used to measure severity of frailty as part of a comprehensive assessment and is recommended by the British Geriatric Society.

**Nutrition and hydration**

**Emergency Department Survey 2017**

In the CQC Emergency Department Survey, the trust scored 7.0 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

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 made adjustments for patients’ religious, cultural and other preferences.

Snack boxes were available for patients which included a choice of sandwich a drink and fruit. Staff telephoned the canteen to request these and they were then delivered to the department. We observed a member of staff requesting a snack box during our inspection and it arrived within five minutes.

There was a vending machine in the main waiting area. This offered hot and cold drinks and a selection of snacks such as biscuits, crisps and confectionery. During our inspection the vending machines were stocked and in use.

The hospital also had a large canteen, café and shop all close to the department.

All the patients we spoke to said they had been offered an adequate amount of food or drink

**Pain relief**

**Emergency Department Survey 2017**

In the CQC Emergency Department Survey, the trust scored 6.0 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was about the same as other trusts.

The trust scored 7.4 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)
Assessing and offering pain relief within 30 minutes of a patient's arrival has been one of the department's priorities for the last few months. This was being delivered via the trust wide Patient First Improvement System. The departments target was to achieve this at least 75% of all patients. The pain relief audit was done every day, on five sets of notes, usually allocated to a team member at morning handover.

Audit data showed that in July, August and September over 50% patients had their pain score assessed and pain relief offered within 30 minutes. This was an improvement from April 2018 when it was 11% We saw measures had been taken to improve performance such as cupboards containing painkillers had been moved in to the areas that needed them the most alongside water fountains to help patients take their painkillers on time.

The adult pain tool score used was a score between 0 and 10, zero being no pain and 10 being the worst pain a patient had ever experienced. We saw pain scores were recorded in the records we reviewed. The Abbey Pain score was used for the assessment of pain in patients who could not verbalise for example patients living with dementia or patients with communication difficulties.

Patients told us they were regularly asked if they were in pain or required pain relief and it administered quickly when it was required. We saw a patient in severe pain and the nurse quickly administered painkillers and then reassessed them to ensure the pain killers had been effective.

Patient outcomes

We saw that the trust had participated in national audits such as those identified by the Royal College of Emergency Medicine (RCEM). The results were used to benchmark and compare with other trusts nationally. There was a clinical audit lead in place for the department and they would lead on audit completion and compliance.

Senior staff monitored the effectiveness of care and treatment and used the findings to improve them. The department took part in national audits in order to compare treatment results with other hospitals. However, some of their data was amalgamated with that of the Princess Royal Hospital and so it was not possible to be specific about the effectiveness of treatment at the Royal Sussex County Hospital.

Royal College of Emergency Medicine Audit: Moderate and acute severe asthma 2016/17 – Royal Sussex County Hospital

Comparing this hospital to other hospitals on the 2016/17 Moderate and Acute Severe Asthma Audit (Adult and Paediatrics), performance was better in two metrics, worse in three metrics and similar in two metrics. In this context, 'similar' means that the hospital's performance fell within the middle 50% of results. The Royal College of Emergency Medicine standard of 100% was met in none of the metrics.

Trust performed worse in the following:

- Standard 4: Add nebulised Ipratropium to nebulised β2 agonist bronchodilator therapy
- Standard 5a: If not already given before arrival to the ED, steroids should be given as soon as possible: within one hour of arrival (acute severe)
- Standard 5b: If not already given before arrival to the ED, steroids should be given as soon as possible: within four hours of arrival (moderate)
Royal College of Emergency Medicine Audit: Consultant sign-off 2016/17 – Royal Sussex County Hospital

Comparing this hospital to other hospitals on the 2016/17 Consultant Sign-off Audit, performance was similar in the two-reported metrics (atraumatic chest pain in patients aged 30 and over, and abdominal pain in patients aged 70 and over). In this context, ‘similar’ means that the hospital’s performance fell within the middle 50% of results. The Royal College of Emergency Medicine standard of 100% was not met for these metrics.

RCEM Audit: Severe sepsis and septic shock 2016/17 – Royal Sussex County Hospital

Comparing this provider to other trusts on the 2016/17 Severe Sepsis and Septic Shock Audit, performance was better in two metrics, worse in two metrics and similar in four metrics. In this context, ‘similar’ means that the trust’s performance fell within the middle 50% of results. The national standard was met in none of the relevant metrics.

Trust performed worse in the following:
- Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to): Within one hour of arrival
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival

(Source: Royal College of Emergency Medicine)

More recent audit data showed an improvement in performance against national guidelines for the management of sepsis. Trust wide data showed that 100% of patients within the emergency department were screened for sepsis between April 2017 and March 2018. The same data showed in quarter one 84%, quarter two 83% and quarter three 90% of patients received antibiotics within one hour of diagnosis or suspicion of sepsis.

Unplanned re-attendance rate within seven days

From July 2017 and June 2018, the trust’s unplanned re-attendance rate to urgent and emergency care services within seven days was worse than the national standard of 5% and worse than the England average.

Unplanned re-attendance rate within seven days - Brighton and Sussex University Hospitals NHS Trust

(Source: NHS Digital - A&E quality)
We saw in 2017 the department undertook a re-audit (original audit 2013/14 of the national paracetamol overdose audit and benchmarked performance against the original audit. Compliance with the Royal College of Emergency Medicine standards for the management of paracetamol overdose was varied as was the performance against the original audits. Compliance in some standards had improved since the last audit and some had got worse. Performance against the national median from 2013 was also varied compliance against some standards was better and some worse. The department had made six recommendations following the audit to improve compliance and planned to re-audit in six months time.

Daily audits were undertaken on completeness of the safety check list, National Early Warning Score 2 and administering pain relief within 30 minutes.

We reviewed four patient records that were undergoing treatment for sepsis. All had all six tests and interventions undertaken within the hour.

The department provided thrombolysis onsite 24 hours a day, seven days a week as part of the stroke pathway.

Thrombolysis is a treatment to dissolve dangerous clots in blood vessels, improve blood flow, and prevent damage to tissues and organs. During our inspection we observed a patient undergoing treatment for a stroke. The consultant was helping to transport the patient to the CT scanner which ensured essential imaging was undertaken quickly.

There were nursing audits undertaken by the department that fed into monitoring patient outcomes, such as a pain audit and national early warning score audits.

The department contributed to the Trauma, Audit and Research Network. Data supplied to us by the trust showed that Royal Sussex County hospital was in the top quartile for against the major trauma standards and better than the national average.

The latest Trauma, Audit and Research Network data showed (Quarter 4 2017/18) that they delivered a consultant led trauma team within 30 minutes for triage positive patients 98% of the time. The national mean was 92%.

The same data showed that they delivered a consultant led trauma team on arrival for patients with an injury severity score greater than five 77% of the time. The national mean average was 66%.

Staff handovers staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. A member of the Mental Health Liaison team attended shift handovers to ensure patients requiring additional mental health support received this and to support staff in care and risk planning to meet patients mental health needs.

**Competent staff**

The service made sure staff were competent for their roles. However, some staff had not received additional life or trauma support training. Thirty-eight nursing staff out of 98 had undertaken intermediate life support training and a further 28 staff had completed advanced life support training. Therefore 67% of nursing staff had completed additional life support training.

Nurses did not complete trauma intermediate life support training they completed a trauma course called Sussex Trauma Course at level 1 or level 2. Sixty-five percent of nurses had either level 1 or level 2 qualification. One-hundred percent of nurses who worked in the resuscitation area had either level 1 or level 2 training. One-hundred percent of band 7 nurses had level 2 qualification.
The funding for this course had been lost and the service planned to ensure all nurses completed the trauma intermediate life support training.

Advanced life support training completion for junior doctors was monitored via their e-portfolio system. For non-training doctors it was monitored as part of their appraisal process.

The service employed staff with the correct skills and knowledge to develop and support their staff. Since our last inspection the service had employed two practice educators. They shared the role and made one whole time equivalent. They provided support and training to enable staff to develop and improve their skills and knowledge in a structured educational pathway.

Nurses new to the department received a three or four-day induction programme, depending on their previous experience. They then worked on a supernumery basis for four weeks and worked closely with the department’s practice educators.

Newly qualified nurses were placed on a preceptorship programme. Preceptorship is a period of structured transition for newly qualified healthcare professionals lasting up to one year, during which support is given by a preceptor who provides supervision, mentoring and support to develop confidence and refine skills.

There was an extensive teaching and assessment programme which included competencies required for nurses working in emergency departments. These reflected the Royal College of Nursing’s National Curriculum and Competency Framework for Emergency Nursing published in July 2017. The competency framework was used by nurses and their managers to help identify when they were ready for increased levels of responsibility.

The practice educators supported healthcare assistants to complete the national care certificate, which established their skills and competencies against national best practice.

The service was committed to developing its staff. Since our last inspection the service had introduced a band 4 assistant practitioner role in the urgent care centre. Three members of staff were currently undertaking the training and when successfully completed would provide support to the emergency nurse practitioners.

In-house education and teaching was undertaken weekly and we saw evidence of this and an attendance list was kept.

One of the consultants led the training of junior doctors and the professional development of senior doctors. All the consultants took part in the training programme. There was a multidisciplinary approach to training opportunities.

If the need for improvements in clinical practice had been identified, a consultant would lead a simulation of the practice with the involvement of all types of staff from the department. A discussion about the learning points from the simulation took place at the end of each session.

Staff told us that there was a learning and teaching culture which was inclusive to all staff. Staff also told us that development opportunities and teaching had improved since our last inspection and there was a focus on education.

We looked at a sample of three staff appraisals. In each case staff had established structured objectives for the year ahead to progress their professional development. The senior member of staff involved in the appraisal had documented how they would support the individual to achieve this and there was a clear, constructive review of the individual’s performance to date.

Bank and agency staff were used in the department, competencies of bank and agency staff were monitored by the agency, induction for agency staff was undertaken in the department by a
permanent qualified member of staff. This was documented and kept in the department records we saw these during the inspection.

Staff had the skills to sensitively manage any difficult behaviours that patients displayed. We observed an interaction with a patient caring for a patient living with dementia who was able to calm the patient down gently and persuaded them to go back to their bed space.

Staff had the skills, knowledge and experience to identify and manage issues arising from patients with mental health conditions, learning difficulties, autism and dementia. Staff received mandatory training in relation to mental health, dementia and learning difficulties. The Mental Health Liaison team delivered training at induction to staff on the needs of mental health patients. The Mental Health Liaison team included a registered mental health nurse, who delivered Mental Capacity, Mental Health Act and deprivation of liberty training.

**Appraisal rates**

From May 2017 to May 2018, 61% of staff within this core service at the trust received an appraisal compared to a trust target of 78%. The trust target is correct at March 2018 as they have commented that the target will increase incrementally to 90% by June 2018. Below is a split of appraisal completion rate by staff group.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Appraisals completed</th>
<th>Appraisals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>9.0</td>
<td>9.0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>49.0</td>
<td>73.0</td>
<td>67%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>75.0</td>
<td>131.0</td>
<td>57%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>8.0</td>
<td>16.0</td>
<td>50.0%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>0.0</td>
<td>1.0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>141.0</strong></td>
<td><strong>230.0</strong></td>
<td><strong>61%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Appraisal tab)

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. More recent data given to us showed that 91% of staff within the acute floor directorate had received an annual appraisal. This was above the trust target of 85% and was an improvement from our last inspection when 78% of staff had received an annual appraisal. The service did not provide appraisal data by hospital site.

**Multidisciplinary working**

Staff of different professions worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Staff worked across health care disciplines and with other agencies when required to care for patients. These included but were not limited to: district nurses, community services, physiotherapists, occupational therapists, social workers, mental health services, learning disability services, police and GPs.
Patients received a multidisciplinary assessment of their needs prior to being discharged to ensure they were safe to be discharged home. A multidisciplinary Rapid Discharge Team were based within the department. The team included social workers, occupational therapists and physiotherapists who coordinated care with the emergency department clinical team. The team and staff were very positive about the service they delivered and had established links to resources in the community to provide assistance and rehabilitation.

There was a positive working relationship with the local ambulance service. Comments from ambulance crew that we spoke to said, “staff do a brilliant job under very difficult circumstances” and “it can get very busy and frustrating but it’s not within their control”.

The service held regular meetings with Clinical Commissioning Groups, local ambulance service, safeguarding team, mental health liaison team and emergency department staff. These meetings developed care plans for frequently attending patients. Established pathways and interventions diverted patients who did not need the emergency department from attending unnecessarily. We saw meeting minutes which confirmed these meetings took place.

There was a strong working relationships with community drug, homeless charities and alcohol teams and community mental health teams. These teams reviewed patients within the department several times a day to identify patients who might need their support.

When a patient was admitted to the department under a Section 136 of the Mental Health Act an Approved Mental Health Professional and/or external agency could come to the department to manage risks and attempt to prevent admission to inpatient setting.

Staff told us that relationships with other specialties had improved since our last inspection due to single clerking which brings the specialities to the department to review their patients. There was a daily morning meeting which brought all the specialties in a room to discuss treatment plans.

The stroke service was highlighted by staff as an exemplar of excellent multi-disciplinary working. Time is critical in the management of stroke and effective multi-disciplinary working was the key to a good outcome for patients. We saw a consultant helping to transport a patient to the CT scanner quickly rather than waiting for a porter to help.

Senior nurses attended a daily trust wide multidisciplinary team meeting to support access and flow across all services. This was a cross-site meeting to enable staff to strategise with colleagues at the Princess Royal hospital to ensure challenges were addressed by the wider team.

The mental health liaison team facilitated communication with the mental health teams based within the community and made referrals to the home-based treatment team, where appropriate. This enabled patients to be discharged from hospital with more intensive mental health support provided.

The security team worked with nursing staff to identify strategies to reduce the risk of harm amongst patients who presented with a mental health need, including those at risk of self-harm. For example, security staff and department staff were trained in de-escalation techniques. We saw security staff providing support for staff during our inspection.

Staff told us that the culture of working together to achieve the best patient experience and outcome had changed since our last inspection. Staff told us that there was a ‘can do attitude now’ and staff ‘all pulled together’. We observed staff interact with each other in a very positive and professional manner. Their interactions demonstrated strong and positive working
Seven-day services

The service was compliant with the NHS Seven Day Services Clinical Standards. For example, mental health liaison services were available to respond to referrals and provide urgent and emergency mental health care 24 hours a day, seven days a week.

There was an on-call pharmacy service outside of normal working hours.

The department had access to radiology support 24 hours each day, with rapid access to computerised tomography (CT) scanning when indicated. There was always a senior radiology doctor available within the hospital.

The rapid discharge team were available seven days a week in order to ensure that it was safe to discharge patients who were frail or had mobility problems.

Health promotion

After-care leaflets were provided to patients once discharged from the department. We saw there was a wide variety of visual information and advice cards displayed in the waiting rooms.

Staff on the unit would advise patients about stopping smoking, obesity and alcohol use where necessary.

There was a wide variety of health promotion available for patients and visitors for example advise on healthy eating and preventive vaccinations.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Staff were able to obtain advice from the mental health liaison team 24 hours if a patient was self-discharging or refusing treatment. Staff told us that they could not detain informal patients, however could work with the team and patients to encourage them to stay and engage in treatment.

We observed a nursing team discussing a patient’s capacity to consent to treatment with members of the older people mental health team during out inspection. We also reviewed patient care records which documented staff discussions around patient consent for treatment in liaison with the mental health liaison team.

Two patients held section 136 of the Mental Health Act were in the emergency department during our inspection. Staff were able to get advice from the mental health liaison team and safeguarding team if required.

Data supplied to us by the trust showed 92% of staff working at Royal Sussex County hospital had completed Mental Capacity Act training which was better than the trust target. Seventy-two percent of doctors had undertaken the training which was below the trust target. The training included deprivation of liberty training.
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Comments from patients we spoke to included “more than happy, felt amazingly safe and “A star treatment”.

Friends and Family test performance

The trust’s Friends and Family Test performance (% recommended) was about the same as the England average from July 2017 to June 2018.

A&E Friends and Family Test performance - Brighton and Sussex University Hospitals NHS Trust

(Source: NHS England Friends and Family Test)

The Royal Sussex County hospital Friends and Family Test performance (% recommended) was about the same as the England average (86%) October 2017 to September 2018.

In April and May 2018 87% of patients said they would recommend the hospital as a place to be treated. Quotes from the friends and family test included: “A fabulous, friendly service, well done. Friendly staff, very efficient, nothing too much trouble, great all-round service, keep doing what you’re doing”

In the 2016/17 staff survey 58% of staff recommended the trust to a friend/relative needing treatment this was an improvement of 6% on the previous year.

In busy times, it appeared an impossible task for staff to prevent mixed sex breaches due to the layout and lack of capacity in the department. There were screens available to promote dignity when patients were in ‘the cohort area’

The service undertook comfort rounds and we saw this during the inspection. These checked if
the patient was comfortable, in pain or needed anything to eat and drink. Patients records demonstrated staff completed these in line with the department policy.

Staff were very positive and compassionate towards the people they cared for. Staff at reception were very respectful and responsive to presenting patients.

Staff introduced themselves to patients and explained what was going to happen before carrying out a procedure, such as taking their blood pressure, temperatures and weighing them.

We observed staff maintaining patient’s privacy and dignity at all times by keeping them covered and drawing curtains during examinations and procedures. We observed staff asking for permission to enter patient bed areas when the curtains were closed.

We saw ‘stop do not enter’ signs and privacy signs in use. However, we did not see any signs advising patients of their right to have a chaperone.

Patients told us they felt safe and that if they asked for something, staff would do their best to get it.

Compliments cards were on display and included comments such as: “A fabulous, friendly service, well done. Friendly staff, very efficient, nothing too much trouble, great all-round service, keep doing what you’re doing”

At medical and nursing handovers we heard staff talk about patients in a caring and professional manner.

Staff showed understanding and a non-judgmental attitude when caring for or talking about patients with mental health needs, learning disabilities, autism or dementia. We observed this during numerous discussions nursing staff had in their own teams and with various members of the mental health teams.

**Emotional support**

Staff provided emotional support to patients to minimise their distress. We saw a member of staff sensitively trying to calm a patient down and return to their bed.

There were packs of information for relatives to read about what to do when a loved one had died. This included information about what to expect, advice leaflets, support groups and legal requirements.

There was a multi-faith chaplaincy service available in the hospital which provided a multi-faith service for patients and their families. Information regarding these and a time table of activities were displayed within the department.

Staff we spoke with demonstrated understanding of how to provide emotional support to patients with mental health needs and those in crisis. They also understood how mental health challenges could manifest themselves and how they could tailor care and treatment to the patient’s needs.

Staff demonstrated understanding of the importance of providing emotional support to patients living with dementia in an environment that could be hectic and confusing.

Patients who attended with a mental health illness, living with dementia diagnoses received advice about their condition, its treatments and useful coping strategies supplemented with written information.

There was a rapid access for older people to return home or back to GP/community. The service could refer to a patient’s GP if early dementia diagnoses required. Written information is accessed on the internet printed off and given to patients and their families.

There was access to frailty mental health specialists who could offer guidance and support to nursing staff and patients’ carers and family members.
**Understanding and involvement of patients and those close to them**

Staff were polite, professional and communicated clearly with patients regarding their procedures, investigations and outcomes and ensured that patients and relatives understood their plan of care. Patients told us staff explained their condition and treatment in a way they could understand.

**Emergency Department Survey 2017**

The trust scored about the same as other trusts for all the 24 Emergency Department Survey questions relevant to the caring domain.

*(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)*

Data given to us by the trust showed that in September 2018 85% of patients relatives/next of kin were informed within two hours of arriving in the department. We spoke to a patient who told us staff had asked him if he wanted staff to contact his son.

Healthwatch Brighton and Hove undertook a survey at Royal Sussex County hospital in January 2018. The report showed that most people seemed to be well advised on ‘what’s happening next’ after they arrived in the department. Seventy-one percent of patients and relatives waiting in the majors area had been told what was happening next and why they were waiting. In the urgent care centre 81% had been advised what to expect next.

Visitors, patients and staff could easily identify the nurse in charge, as they wore a large red badge. The names of staff allocated to different area was displayed on notice boards within the department. Visitors, patients and staff could identify the different roles staff undertook as it was printed on the back of their uniform top.

Patients told us they felt involved in planning their care and we observed this during our inspection.

Staff had access to communication aids to help patients become partners in their care and treatment. Communication aids were available online for staff to print off and use with patients to support their communication needs and include patients in the planning and delivery of their care.

During our inspection we observed a patient who was moved to a private room in the department to maintain their privacy and dignity as they were becoming distressed and staff wanted to ensure the patient had a private area to be cared in.

**Is the service responsive?**

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

The trust planned and provided services in a way that met the needs of local people.

The department had regular meetings to discuss any patients who were classed as ‘frequent attenders.’ Patients were identified by the service and were discussed at the multidisciplinary meeting with the department staff, mental health team, police, ambulance and substance abuse staff. This enabled them to put a care management plan in place. hen a frequent attender visited the emergency department, staff could access a care plan on the patient's records and ensure they were treated appropriately.
Information on a range of subjects was on display in the majors waiting area, including dementia awareness, domestic abuse, fit to sit, and waiting times.

Individual patient crisis risk plans were developed by the mental health liaison team for use across the emergency department for those patients who needed it. This meant that staff had an engagement protocol for that patient which had already been approved by the mental health liaison team to meet their needs quickly and help avoid long emergency department admission.

There was large range of information within the department which gave patients and visitors information about services provided in the local community. For example, centre for HIV and sexual health and Brighton and Hove adult Lesbian Gay Bisexual Transgender drug and alcohol service.

The department was close to car parks and had a drop off area for police and ambulances.

Staff told us that funding had been made available to secure the building of a new acute floor, which was expected to provide additional capacity to cope with the increased volume of patients who attend the department. Building work was due to commence within the next couple of months.

The service worked in collaboration with a local homeless charity as Brighton has a large homeless population. On request the charity would provide transport to a hostel, warm clothing sleeping bags and tents for patients attending the department. The charity telephoned the department every day to check if their services were required.

Staff were able to identify if community care was available. Daily multi agency telephone calls identified what community support was available.

The department did not have a separate viewing room for family to see their relative’s body if they had died. The Royal College of Emergency Medicine: End of life care for adults in the emergency department 2015 recommends this as good practice. The department had only one relatives room, which met the criteria set out in the same guideline, which staff told us was not sufficient. During a safety huddle we observed during the inspection we heard another room had been identified and was awaiting conversion to another relative’s room.

In the reception area, we saw that there were easy clean chairs for patients to use whilst waiting for treatment and there appeared to be sufficient seating in the waiting areas. However, staff told us that during very busy periods there was not sufficient seating.

GP streaming was used in the department for patients that self-presented and were streamed to the GP on triage if they were deemed suitable. Patients who were triaged and deemed unsuitable for GP streaming were either seen in the major’s or minor’s area, depending on their condition. Therefore, the most appropriate clinician could see all patients more quickly.

The department saw a significant number of patients with needs relating to frailty. To ensure they received appropriate care, a frailty lead and team of frailty practitioners were in post to support discharge packages and reduce the risk of readmission.

Meeting people’s individual needs

The service took account of patients’ individual needs but was not always successful in meeting them. During busy times it was not always possible to manage individual needs if patients were cared for in ‘the cohort area.’ This was the same as our last inspection. For example, both male and female patients were within this area although we saw staff used privacy screens. We saw staff took into account patients individual needs before placing them in this area. For example, we saw patients living with additional needs such as living with dementia were not placed in this area.

Waiting times to see a nurse or doctor were continuously displayed in the waiting room.
Although there was wheelchair access to all clinical areas there was no lowered reception desk to allow patients in wheelchairs to register in comfort. However, in the Sussex Eye hospital there was a wheelchair accessible reception desk for wheelchair users.

The mental health liaison team, provided service 24 hours a day, seven days a week. Staff were aware of the service and how to access it.

When a patient was admitted to the department under a Section 136 of the Mental Health Act an Approved Mental Health Professional and/or external agency can come to the department and manage risk and attempt to prevent admission to inpatient setting.

The department had discharge arrangements for people with complex health and social care needs. For example, if a patient presented at the emergency department with self-harm concerns, however was not known to services the outpatient ‘self-harm’ clinic contacted them post discharge. Patients were seen at home or in a local polyclinic to address their self-harm support needs to attempt to avoid admission to an inpatient setting.

The service had access to the older people mental health team to assess their physical and mental health needs, care plan and offer advice for this patient group. We observed discussions between ward staff and the older people mental health where an initial care plan was agreed to support a new patient on the ward.

Patients who were suspected to be experiencing depression were referred for a mental health assessment.

If patients with a mental health condition attempted to discharge themselves, staff reported they would talk to the individuals and encourage them to stay on the unit. If there were significant concerns, staff would call security who would offer one to one supervision. Staff told us that security staff had received training in caring for people living with dementia.

The department had access to interpreting and translation services for those who did not speak English. This included face-to-face interpreters, British Sign Language, telephone interpreting and translation services. Staff were positive about the responsiveness of the translation services and gave examples of when translators had arrived in the department within 30 minutes.

There was a wide range of written patient information available. The service had researched the top five different languages spoken within the local area and information leaflets were available in these languages.

There were domestic abuse link nurses and several posters visible in the department to support patients of domestic abuse. Contactable phone numbers, help lines and internet sites were available to patients and relatives to support their needs.

There was a relatives’ room available near the majors triage area where confidential conversations could take place.

The department had a campaign in place regarding patients that were ‘fit to sit’ on a chair rather than stay on a trolley. This helped staff make decisions to aid patient flow when patients arrived in the department on an ambulance trolley. The service was currently trialling different locations for the chairs to assess the most appropriate area within the department. At the time of our inspection the chairs were near ‘the cohort area’ which staff told us did not work well as relatives and visitors accompanying relatives in this area sat on the chairs.

There was an effective pathway for assessing patients who were alcohol dependant. Medicines to reduce anxiety were commenced in the department and patients were promptly referred to the alcohol abuse service.
There were no facilities that were conducive to the care of people with dementia. However, we did however, see twiddle muffs, old postcards and old newspapers.

The Forget Me Not scheme for managing and supporting the needs of patients living with dementia was embedded into the department. Staff placed laminated symbols beside patient names on their bed and the electronic recording system symbolising whether suspected or assessed dementia support needs had been identified for that patient. The relevant symbol was also placed onto a patient’s wrist band to alert staff to the patient’s additional support needs.

Autism support resource support was available from Royal Alexandra children’s hospital.

The Learning Disabilities team developed health passports for patients with support needs. This ensured their needs, for example what and how the patient ate and drank, was shared with staff to better meet patient need.

The service told us that comfort rounds were undertaken within two hours of the patient being within the department. The comfort rounds checked whether the patient wanted anything to eat or drink, needed the toilet, if the patient was in pain and monitoring of any pressure areas. We saw comfort rounds were undertaken during our inspection Data provided to us by the trust showed that the comfort rounds were not always undertaken within two hours. For example, in June 2018 76% of patients received a comfort round check within two hours.

**Emergency Department Survey 2017**

The trust scored about the same as other trusts for all three of the Emergency Department Survey questions relevant to the responsive domain.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

**Access and flow**

The service took account of patients’ individual needs but was not always successful in meeting them. During busy times it was not always possible to manage individual needs if patients were cared for in ‘the cohort area.’ This was the same as our last inspection. Issues around the departments inability to meet surges during demand remained a concern. The service had undertaken a number of changes since our last inspection to improve efficiency and the performance against national standards. However, performance against national targets still required improvement.

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust met the standard for 11 months over the 12-month period from July 2017 to June 2018.

From July 2017 to June 2018 performance against this standard was better than the England average for 10 of the 12 months within this period.

More up to data provided to us by the trust showed between 01 July 2018 and 09 September 2018 91% of patients met the Royal College of Emergency Medicine guidelines at Royal Sussex County hospital.
Median time from arrival to treatment from July 2017 to June 2018 at Brighton and Sussex University Hospitals NHS Trust

(Source: NHS Digital - A&E quality indicators)

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. From August 2017 to July 2018 the trust was consistently worse than the standard and performed worse than the England average.

Four-hour target performance - Brighton and Sussex University Hospitals NHS Trust

(Source: NHS England - A&E Waiting times)

Percentage of patients waiting more than four hours from the decision to admit until being admitted

From August 2017 to July 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average. From August 2017 to July 2018 performance against this metric showed a peak of approximately 40% in January 2018 before ending with an improved figure at the end of the reporting figure of approximately 24%
Additional data supplied to us by the trust showed that on average between September 2017 and August 2018 43% waited more than four hours after decision to admit at Royal Sussex County hospital. This was compared to 6.5% at Princess Royal hospital.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted - Brighton and Sussex University Hospitals NHS Trust**

![Graph showing percentage of patients waiting more than four hours](image)


**Number of patients waiting more than 12 hours from the decision to admit until being admitted**

Over the 12 months from August 2017 to July 2018, 153 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in December 2017, (51), March 2018 (35) and January 2018 (27).

Data supplied to us by the trust showed between September 2018 and August 2018 on average 0.58% of patients waited more than 12 hours from the decision to admit until being admitted at Royal Sussex County hospital.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2017</td>
<td>637</td>
<td>7</td>
</tr>
<tr>
<td>September 2017</td>
<td>731</td>
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<td>0</td>
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<tr>
<td>July 2018</td>
<td>797</td>
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</tr>
</tbody>
</table>

(Source: NHS England - A&E Waiting times)
Percentage of patients that left the trust’s services before being seen for treatment

From July 2017 to June 2018 the monthly percentage of patients that left the trust’s services before being seen for treatment was similar to the England average. From July 2017 to June 2018 performance against this metric showed a sign of improvement.

Percentage of patient that left the trust’s services without being seen - Brighton and Sussex University Hospitals NHS Trust

(Source: NHS Digital - A&E quality indicators)

Median total time in urgent and emergency care unit per patient (all patients)

From August 2017 to July 2018 the trust’s monthly median total time in urgent and emergency care unit for all patients was higher than the England average. From August 2017 to July 2018 performance against this metric showed a stable trend.
People could access the service when they needed it. However, patient sometimes experienced extended waiting times in the short stay word or clinical decision unit awaiting admission to the ward.

We saw that service had built upon the significant achievements highlighted at our previous inspection and had made improvements to address our concerns. However, despite these improvements, the department continued to struggle to meet the demands placed upon it, because of the lack of capacity elsewhere in the hospital. This meant that during busy times patients were care for in environment not designed to be used for patients.

During this inspection staff told us that there had been a change in culture regarding the targets. Ownership of the targets were now shared across the whole multidisciplinary and executive leadership team and was not just the responsibility of the emergency department. Staff told us that this had a positive impact and had improved staff morale and encouraged better communication teamwork. Staff displayed a ‘can do attitude’ and this culture was driven by the leadership team, staff told us they felt empowered to make improvements.

We saw improvements in access and flow with less patients waiting in ‘the cohort area.’ Improvements to access and flow had been facilitated by the trust wide Patient First Improvement System. It was hoped that once the new streaming, patient assessment and treatment and ‘fit to sit’ processes had become embedded access and flow through the department would improve.

As part of the trust wide Patient First Improvement System the service was aiming to undertake all ambulance handovers within 15 minutes. Data showed that on week commencing 03 September this was achieved 44% of the time and week commencing 10 September this was achieved 41% of the time.

We saw the single clerking process was working well. Patients received one medical clerking from the most senior decision maker reducing time and duplication.

The service identified how unwell patients were quickly especially during busy periods when a consultant greeted and assessed patients as they arrived by ambulance.
Between June 2018 and September 2018, the median referral time to be seen specialist review varied. The shortest time was 5 minutes (orthopaedics) and the longest was three hours six minutes (acute and general medicine). Patients received a review by a senior doctor promptly who could make decisions about their care. The overall median time for specialities from arrival to senior specialist review was 3 hours 42 minutes. Patients were referred quickly for a specialist review and within the four-hour standard. The overall median time for all specialities from arrival to specialist referral was 1 hour 36 minutes.

The service had access to services in order to make discharge arrangements for people with complex health and social care needs. Staff told us that there was positive flow for patients to the community, however there were challenges admitting to inpatient mental health beds due to lack of availability.

Department leads met regularly with the local mental health trust to review system pressures and explored alternative pathways to deliver patient care in the community. The service only referred patients to out of area mental health inpatient beds only where necessary.

A project was being undertaken by two clinical fellows to explore alternative discharge pathways for both mental health patients and patients with drug and alcohol support needs. This was to explore if routine pathways could be avoided to reduce existing pressures and create alternatives within the community.

Staff and the care systems they followed helped to provide good care to patients in need of additional support. Staff could access the mental health liaison team, perinatal team, paediatric team, dementia team, trauma psychologist, access to learning disability team to obtain support and guidance.

The staff in the emergency department sent a bleep alert to the dementia team as soon as a distressed patient with suspected dementia needs was admitted. This ensured that the team identified a bed for the patient to move them through and meet their needs appropriately.

The service had arrangements, known to all staff on duty, to meet patients’ urgent or emergency mental health care needs at all times, including outside office hours and in an emergency. There was a service level agreement between the trust and the mental health liaison team which set out those patients with urgent mental health needs would be reviewed within one hour. Staff told us patients were always reviewed within one hour and this was consistent with our observations. The mental health liaison team developed crisis care plans for patients who attended frequently in crisis. This enabled triage and nursing staff to quickly meet the needs of the presenting patient to avoid a long stay in the department or an inappropriate admission.

Emergency department staff call the mental health liaison team when a mental health patient had been identified and was referred as matter of urgency. The mental health liaison team could also see the departments electronic board listing incoming and triaged patients, so they could plan for new admissions.

Patients could self-refer to the via the mental health liaison team the emergency department, however they have to undergo a triage assessment first.
Learning from complaints and concerns

Summary of complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

From March 2017 to April 2018 there were 74 complaints about services. The trust took an average of 45 working days to investigate and close complaints. The trust worked towards a 25-working day timescale for complaints and, when acknowledging complaints with the complainant, the trust agreed a timescale with them dependent upon the complexity of the concerns raised.

The four most common subjects of complaints are shown in the table below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to treatment or drugs</td>
<td>41</td>
</tr>
<tr>
<td>Values and Behaviours (staff)</td>
<td>9</td>
</tr>
<tr>
<td>Admission and Discharges (not including delay due to no care package)</td>
<td>8</td>
</tr>
<tr>
<td>Communication</td>
<td>7</td>
</tr>
</tbody>
</table>

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of complaints</th>
<th>Days taken to close</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Sussex County Hospital</td>
<td>51</td>
<td>47</td>
</tr>
</tbody>
</table>

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

Number of compliments made to the trust

From March 2017 to April 2018 there were 229 compliments in.

The breakdown by site is below:

1. Royal Sussex County Hospital: 140 compliments

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

Sixty-nine percent of the trust wide complaints related to Royal Sussex County hospital.

There were leaflets and posters in the waiting area with contact details for the trust’s Patient Advisory Liaison Service for patients and relatives to raise concerns or make a complaint. A consultant and the quality risk lead that had overall responsibility to review and respond to complaints. However, there was a plan for the band 7 nurses to receive complaint response training in order to respond to complaints which would allow them to have better oversight of complaints.

Staff told us that if a patient made a verbal complaint to them they would try and resolve the concern at the time and record the details on the electronic system if there were opportunities for learning. We reviewed three formal complaints that had taken place in the department in the last year. We saw the complaints were investigated thoroughly and in a timely manner, opportunities for learning identified and action taken when required.

 Replies to the complaint were courteous and displayed understanding of how the complainant felt.
Is the service well-led?

Leadership

The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

The leadership structure had changed since our last inspection, as had the directorate and divisional structure. Urgent and emergency services including the short stay ward and clinical decision unit were within the acute floor directorate and within the medicine division.

The acute floor leadership team was made up of Divisional Director of Operations, Chief or Service and Head of Nursing and covered across the different hospital sites. At the Royal Sussex hospital, they were supported by a senior matron, a clinical director (an emergency department consultant) and a directorate manager. The post of junior matron was vacant and being advertised at the time of the inspection,

A team of band 7’s, a managed by the senior matron, were responsible for the day-to-day running and co-ordination of the different departments. The band 7’s managed band 6 nurses, band 5 nurses, health care assistants and associate practitioners. The urgent care centre was managed by a Nurse Consultant who was supported by Emergency Nurse Practitioners but were not managed by the senior matron. At the time of our inspection there was not a specific medical lead for the urgent care centre however there were plans to appoint one.

The nursing team was established with experienced staff that provided clinical and professional leadership by supporting and appraising junior staff. A new, experienced senior matron with major trauma centre experience had been in post for three months.

Staff commented that the senior matron was a dynamic leader who had a clear understanding of the challenges the service faced and a vision of how to overcome these. Comments from staff about the senior matron included “we have a direction now, matron is very positive, focussed and has a definite pathway to achieve goals.”

It was hoped that the service would appoint a junior matron quickly to provide support to the senior matron in delivering the departments goals.

The leadership team had a good knowledge of how services were provided and were quick to address any shortcomings that we identified during the inspection. They accepted full responsibility and ownership of the quality of care and treatment within their department and encouraged their staff to have a similar sense of pride.

We saw strong leadership, commitment and support from the leadership team. They were responsive, accessible and available to support staff during challenging situations. They had introduced a clearer escalation process, which aimed to provide a consistent approach in times of pressure.

All staff told us clearly about their lines of reporting to the leadership team and told us they felt valued, supported and respected in their roles. Staff said that the organisation of the department and staff morale had improved dramatically since our last inspection and since the local and executive leadership team had been in post.

Staff told us that the leadership team were always willing to help out pushing beds, transferring patients to other wards and departments or undertaking any task, which supported the staff, and the care and treatment patients received.
Consultant leadership in the department was committed and consultants demonstrated clinical ownership of the patients in the department. Consultants had oversight of the patients in the department and had an awareness of who was the most unwell or had the potential to deteriorate.

The clinical fellows who worked in the department were appreciated by staff and provided stability in the medical rota. Doctors in training felt well supported by senior clinicians and felt they could approach them for advice and support. We observed this several times during our inspection.

Clinicians and the leadership team we spoke with were knowledgeable about their patient’s needs, as well as their staff needs. They were dedicated, experienced leaders and committed to their roles and responsibilities.

There was a multi-disciplinary mental health clinical steering group, chaired by nursing director with the mental health trust’s medical director. The group meetings identified patient and ward activity, pressures, issues for escalation and to shared learnings. The steering group was implemented to improve safety and patient flow following a series of behavioural incidents on an acute nursing ward. There had been three meetings to date.

The mental health liaison team had the expertise to lead the mental health service within the department.

Staff told us that leaders were visible and were aware of the local challenges the department faced. Comments from staff included “we are a centre of excellence and the executive team want to put Brighton on the map”

**Vision and strategy**

There continued to be confusion about the strategy for the Emergency department.

The trust provided accident and emergency services at both the Royal Sussex County hospital and the Princess Royal hospital. A trust board paper in March 2018 confirmed its commitment to continue to do so for at least the next five years. There were common themes in terms of how the two departments worked and were developing; such as improving ambulatory care provision and ensuring early consultant review of patients, and the trust was in discussions with Commissioners regarding the co-location of Urgent Treatment Centres with both of the trust’s accident and emergency services Departments.

The wider strategy for each hospital differed significantly however; Princess Royal Hospital was and would continue to be a Local Emergency Hospital, which saw acutely unwell medical patients and patients with minor injuries and ailments. However, during our inspection at Princess Royal hospital, we saw patients with significant injuries and ailments. The needs of these patients do not appear to have been considered when developing a strategy.

The Royal Sussex County hospital was the main tertiary site for Sussex and for the past five years had been a designated at a Major Trauma Centre, with the necessary supporting infrastructure that this entailed. The Brighton site also contains the Royal Alexandra Children’s Hospital, which had a full paediatric urgent and emergency department and was a specialist paediatric and neonatal hospital for Sussex. The trust was committed to continuing and strengthening the trust Major Trauma Centre services.

When we spoke to staff and leaders about the strategy they told us they wanted to develop a generic workforce for the acute floor. This meant all staff including doctors would have the skills and knowledge to work in any area and emergency admissions would be managed on the acute floor and discharged within 48 hours. Their strategy was not consistent with what the trust told us was the strategy for urgent and emergency care.
The service had a mental health strategy appropriate for patients with mental illness that the trust board approved and reviewed annually. The trust board included a clinical lead responsible for the mental health strategy and developing clear, measurable health outcomes.

A positive trajectory for improvement had been plotted to meet national standards, where targets were not currently being met by the trust wide Patient First System. For example, patients receiving pain relief within 30 minutes 75% of the time.

The service had effective strategies in place to address capacity and flow challenges. However, they were dependant on building work completion to create more capacity within the department and the creation of additional bed capacity within the hospital.

The service had improved on many of the issues highlighted in the previous inspection

**Culture**

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

We observed interactions between staff that were cooperative, supportive and appreciative. They worked collaboratively and shared responsibility where necessary.

We observed positive working relationships between staff and a non-hierarchical culture where everyone felt comfortable to approach anyone for advice.

Staff told us that there had been a change in culture, it was a ‘can do’ and pressures in the department were now seen as a trust wide responsibility.

There was a strong culture of openness and transparency, leaders actively encouraged staff to raise concerns.

Staff felt safe undertaking their role and felt there was a strong emphasis on the safety and well-being of staff. One nurse told us “It felt much safer to come to work now for me and my patients.”

There was strong collaboration and support across all aspects of the service and there was a common focus on improving quality of care and people’s experiences. For example, the culture of using ‘the cohort area’ had changed and it was not normalised practice to place patients in this area. Patients were only placed there when absolutely necessary and were moved as quickly as possible.

Patients attending the department with a mental health illness were treated exactly the same as patients attending with physical health needs. Improvements in the mental health provision had been made since our last inspection. For example, the refurbishment of the mental health assessment room, which ensured it, was safe for the patients who used it.

Staff felt supported in their work and there were opportunities to develop their skills and competencies, which were encouraged by leaders and practice educators. Staff also felt that they could raise ideas that could be potential solutions to the departments issues and they would be taken seriously, and their ideas considered by the leadership team. For example, the introduction of green stickers on patients notes to remind staff the patient has their own medicines with them.

Staff we spoke to were not aware of who the Freedom to Speak Up Guardian was but had an understanding of their role and how to contact them if required.
The clinicians and leadership team promoted a culture of parity of care between patients who attended with either mental health or physical health needs.

**Governance**

The department used a systematic approach to continually improve the quality of its services and safeguarding high standards of care.

Governance and performance management arrangements were proactively reviewed and reflected best practice. They were discussed at quarterly governance meetings and was used to demonstrate effectiveness and progress. Governance meetings were usually cross-site so that learning could be shared. They were chaired by the department governance lead and were well attended by all levels of clinical staff. Issues discussed included new clinical guidelines, the results of incident investigations, complaints and updates to the risk register. Mortality and morbidity reviews were well-established and were also discussed. A briefing document was distributed afterwards so that all staff were aware of learning and the actions that needed to be taken.

There were short, weekly governance meetings which looked at recent incidents and complaints. A difficult case history from the previous week was discussed in detail. Options were considered that could avoid the problems that had been encountered.

Staff told us they were clear about their roles and felt supported by their clinical leads and senior managers.

There was regular engagement and communication with partners and third partner parties such as the local mental health trust who were responsible for providing mental health services.

**Management of risk, issues and performance**

The department had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The department maintained a risk register, which defined the severity and likelihood of risks in the department causing harm to patients or staff. It was displayed on a staff noticeboard and documented the measures to be taken to reduce the risk. We saw that the risks described accurately reflected the concerns described by staff in the department. The risk register was reviewed at least quarterly by the leadership team and severe risks were escalated to the board when necessary.

The leadership team were clear about the challenges the departments faced and they were all committed to improving the patients’ journey and experience. Where national audits had demonstrated a weakness in clinical practice the senior clinical team ensured that action plans were developed.

There was a major incident plan which was up-to-date and detailed. Since our last inspection major incident and chemical, biological, radiological and nuclear defence leads had reviewed all equipment and processes. The local ambulance service peer reviewed the departments plans and supplies. The department achieved a “green” full compliant rating across all areas. The major incident plan provided clinical guidance and support to staff on treating patients of all age groups and included information on the triaging and management of patients suffering a range of injuries. These included injuries caused by burns, blasts or chemical contamination.
The service had undertaken four major incident simulation days to test processes and systems following national incidents.

The service had participated in a regional desktop exercises and completed the first trust wide major incident practice, exercise ‘Galileo’ on 18 September 2018. Learning from the joint exercises were being incorporated into a new version of the major incident plan.

Processes to assess, monitor and improve quality and safety of the service had become embedded since our last inspection. The safety checklist, streaming and patient assessment and treatment of patients had enabled this.

During our inspection, despite the department being busy and utilising ‘the cohort area’ the department calm, well organised and more resilient in their ability to deal with increased demand.

There was a nursing and medical lead in the department who oversaw sepsis management within the department.

The leadership team told us that the escalation process was effective; issues were now escalated for action rather than for information and action was taken promptly to rectify the issue.

Potential risks were considered when planning services or improvements to improve efficiency. For example, the expansion of the acute floor had been delayed whilst a plan for where the ambulances would arrive was finalised.

### Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Staff received helpful data on a daily basis, which supported them to adjust and improve performance as necessary. There was a computer link to the local ambulance services which informed staff of the number of ambulances en-route to the department. It gave details of the patient’s condition and an estimated time of arrival. This allowed staff to make space in an appropriate treatment area.

The departmental computer system displayed useful patient information such as the risk of their condition deteriorating and whether they were vulnerable, either physically or psychologically. The system was refreshed every 15 minutes and allowed senior staff to have an up-to-date overview of all patients in the department.

Information from the system provided information for performance monitoring and management.

Computer systems ensured staff identified patients suffering from sepsis. There was a Mandatory sepsis screening was triggered on the computer system if a patient had an Early Warning Score of three in one observation or a total score of five.

Patients confidentiality was protected at all times. During our inspection we observed computer stations around the department were left locked, this meant that unauthorised persons could not gain access to patient records.

### Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
The 2017/8 staff survey highlighted the need for effective communication from senior management and acting on staff feedback. The trust wide Patient First Improvement System had improved communication and staff engagement with daily huddles and provided the opportunity for staff to give feedback and put new ideas forward. For example, we observed a huddle and a member of staff had identified the need for a second relatives room. During the huddle it was confirmed that a room had been identified and it would be converted into another relatives room. This was as a result of direct feedback from staff.

In the 2017/18 survey 47% of staff recommended the trust as a place to work this was up 9% from the 2016 survey and 58% of staff recommended the trust to a friend/relative needing treatment this was an improvement of 6% from the 2016 survey. Responses from the staff survey increased by an average of 18% in the 2017/18 survey.

Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture. For example, the leadership team had established the 2018/19 Patient Winter Planning Group which included staff participation from all cross-party groups to enable staff to give great patient care.

There was a focus on education and developing the staff, which was different from our last inspection. It had been driven by the practice educators who had been employed since our last inspection. There were clear development and career progression pathways for all grades of staff. Staff told us that they now felt invested in and appreciated.

There were a number of ways patients and visitors could provide feedback. They could fill in an online patient survey, complete a ‘thank you’ form, raise a complaint or concern, rate the trust on the National Health Service Choices website or complete the Friends and Family Survey.

We reviewed comments on the National Health Service choices website regarding the hospital, the hospital was rated as five stars out of five by service users. There were many positive comments about the emergency department. For example, “I just wanted to thank the staff in the A and E department for the outstanding care for myself when I arrived with a burn to my hand. I was seen promptly, and the Charge Nurse was extremely caring and rapidly treated me and my excruciating pain. I really appreciated all the care and consideration of the staff. They do a wonderful job. Thank you.”

The trust interacted on social media via a variety of social media networks. Effective utilisation of social media can engage patients and was another way patients effectively communicated with the trust. This demonstrated that the trust was committed to communication and listening to feedback from social media users.

We saw information regarding the Friends and Family Survey throughout the department, feedback could be given in person, in writing or online.

The hospital and urgent and emergency care worked in collaboration with the local Healthwatch group. In January 2018 Healthwatch undertook an observation of care delivered in urgent and emergency care departments. Healthwatch gave feedback to the hospital and the department of their observations, which provided a useful insight.

Staff felt that the care they delivered co-ordinated care when patients had both physical and mental health needs, this was achieved by effective communication with the mental health liaison team. Patients who attended with mental health needs also had their physical health needs assessed.

Staff counselling was available and the number to contact for support was visible in the department.
The trust had annual “star of the year awards,” staff nominated staff members for award such as patients champion and leader of the year.

**Learning, continuous improvement and innovation**

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. Staff were very positive about the trust wide Patient First Improvement System which had empowered staff to make meaningful changes. The trust wide Patient First Improvement System was embedded into the daily working in the emergency departments. Staff said it had made changes to the way they all worked and had improved safety for patients.

As part of the trust wide Patient First Improvement plan staff identified there was a high haemolysis rate of blood samples. This resulted in a delay as the blood sample had to be taken from the patient again. Haemolysis of blood samples occurs when the red blood cells get damaged and therefore the results of the blood tests are inaccurate and need to be repeated. The service researched the best way to prevent haemolysis. For example, by mixing the blood tubes with anticoagulant additives gently first. Prior to making the changes in the process there was a haemolysis rate of 12% which has now reduced to 2% (the national average is 8%).

As part of the trust wide Patient First Improvement plan staff identified that medicines that patients bring into the department with them get lost incurring extra cost to the hospital to replace them. A new process had been implemented where details of medicines were recorded on the safety checklist and a green sticker added to the patients notes to act as a reminder that the patient had their own medicines.

The service had developed Staff Recruitment and Retention Initiatives since our last inspection, one was the development and education of staff. The service had also employed a dedicated band 7 recruitment and retention nurse. The role gave new staff the ‘personal touch’ as they band 7 contacted the new staff member several times before they started and identified their learning needs and development pathway. The role also allowed for continuous, centrally co-ordinated and fast-tracked recruitment of staff.

In October 2017, the service was the winner of Royal College of Emergency Medicine (RCEM) Quality Improvement Project, Award in celebrating 50 years of Emergency Medicine.

In November 2017, the service was highly commended in the Health Services Journal within the workforce category for work on innovative staffing solutions for medical staffing (clinical fellows) May 2018.

In May 2018, the service achieved British Medical Journal (BMJ) Award highly commended for Innovation team of the year for staffing solutions to emergency departments.

In May 2018, the service was the winner for Health Services Journal Award, acute service redesign, single clerking project.

In July 2018, the service was Highly Commended in the Patient Safety Awards, Prompt Cards in the Emergency Department.
Brighton and Sussex University Hospitals (BSUH) is an acute teaching trust operating on two main sites. The Brighton campus includes Royal Sussex County Hospital (centre for emergency and tertiary care), the Royal Alexandra Children’s Hospital and the Sussex Eye Hospital. The second site is the Princess Royal Hospital in Haywards Heath (centre for elective surgery).

The trust provides healthcare services to around 750,000 people living in and around the City of Brighton and Hove, Mid Sussex and the western part of East Sussex. In addition, more specialised clinical and trauma services are available to the wider community in the south east of England.

Medical care services at Royal Sussex County Hospital (RSCH) was last inspected in April 2017 and rated as ‘requires improvement’. Prior to this, the trust had been rated as inadequate and was placed into special measures by NHS Improvement. The trust remains in special measures due to the fact that the ‘Well Led’ domain was not inspected at an organisational level during 2017. This was done to allow a new Board to effect the changes required.

Facts and data about this service

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

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

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

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

(Sources: Statement of Purpose and Routine Provider Information Request AC1 - Acute context)

There are 371 medical inpatient beds located across 24 wards.

A site breakdown can be found below:

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

(Source: Routine Provider Information Request – Sites tab)

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

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

(Source: Hospital Episode Statistics)

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

**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 harm.

**Mandatory training**

Royal Sussex County Hospital (RSCH) medical services provided mandatory training in key skills to all staff and made sure everyone completed it.

Managers and staff showed us how they accessed training using computer facilities provided by the trust.

Some training topics were offered ‘on-line’ through the internet-based learning management system, which could be securely accessed by staff from any computer connected to the internet. This meant staff could complete these topics after hours or at home if desired. Staff and managers gave examples of when they used this facility from home and liked the flexibility it gave them.

Other subjects required attendance at a classroom session.

Subjects covered by all staff included child and adult safeguarding, information governance, infection prevention and control, health and safety and fire safety. Clinical and therapeutic staff had additional mandatory training which included more advanced safeguarding training, responding to deteriorating patients, record keeping and detailed infection prevention and control.
training. We also found that staff received training to help make them aware of the potential needs of people with mental health conditions, learning disability and dementia.

There was an induction process for all new starters and nurses we spoke with described the induction as helpful. They reported it covered an example of topics such as a tour of the ward, fire evacuation procedures, use of equipment, safeguarding and emergency contact telephone numbers.

The trust had employed practice educators to help improve compliance to all mandatory training. The practice educator we spoke with told us that they regularly monitored training compliance and contacted staff promptly to ensure alternative attendance dates were scheduled. All staff told us they welcomed the support they receive from the practice educators.

Staff we interviewed said they received sufficient training to ensure they had the skills to do their jobs. Staff reported they had protected time to allow them to complete training and attend trust courses. All the staff we spoke with ranging from doctors, nurses and healthcare assistants reported they had completed the annual updates.

We heard good examples of occasions when team colleagues and managers worked to ensure colleagues could attend training despite changes in staffing levels and increased demand. This included the use of closed social media groups that facilitated informal requests among staff and managers for work cover and other support.

**Mandatory training completion rates**

According to the trust, compliance targets were set at 75% for 2017 and these were met. This year, the trust set a compliance rate of 83% with a stretch target set of 90% commencing in June 2018.

Trust data as at September 2018 showed the overall compliance to mandatory training in this service was 89%. This had significantly improved from 72% in the 2017 inspection. In particular, adult basic life support training compliance had improved from 44% to 80%.

We found evidence of training reflected the compliance rate on this visit. Managers acknowledged that rates in some topics had been lower than target, but showed us evidence of action undertaken to remedy the shortfall included a refocus on training, methods of delivery for training and performance management along with peer recognition. For example, we saw training status posters displayed prominently on staff noticeboards and staff told us about the practice educators who identified areas of non-compliance and worked with them to explore alternative methods of delivery for training in work areas. We saw this was reflected in a trust’s project initiation document improvement plan to address the shortfall.

In each manager’s office we visited, we also saw staff lists on display that indicated individual training compliance. Where we saw gaps against names these had dates of the course booking that had been made.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The trust had clear systems and processes to help staff identify and report concerns to protect their patients.
Patients and relatives we spoke with said they felt safe on the ward and were always treated respectfully by staff.

Staff we spoke with had safeguarding training at the correct levels for their roles and were alerted to any potential issues with adults or children.

Female genital mutilation and sex exploitation awareness was incorporated into safeguarding training which was delivered as part of the statutory and mandatory training programme as well as induction courses for new staff.

**Safeguarding training completion rates**

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

Trust data as at September 2018 at this site showed the overall completion rate of 90% by medical and nursing staff in this service for Safeguarding Adults at Risk training had met the trust target.

The overall completion of 92% by medical and nursing staff for Safeguarding Children and Young People Level One training had also met the trust target.

However, the overall compliance for Safeguarding Children and Young People Level Two of 86% and Level Three of 87% had not met the trust target, but we saw training dates scheduled to address the small gaps.

On the wards and units we visited, we saw the overall safeguarding training compliance rates had improved since the 2017 inspection.

The trust had up to date safeguarding policies for adults at risk and children and young people. Staff we spoke with showed us where to locate the policies and they described how they identified a safeguarding concern and the processes used to report a concern or incident. We observed staff routinely discussed safeguarding concerns at the regular safety huddles which had been introduced throughout the medical division. Safety huddles were introduced to reduce potential patient harm. We saw examples of safeguarding referrals and we noted the investigation documentation also included learning points following the investigation. Staff knew who the safeguarding lead was to obtain support and advice. This showed that staff recognised the risks of abuse and were actively reporting it through correct channels.

**Cleanliness, infection control and hygiene**

Since our last inspection, the trust had improved the internal décor and cleanliness of the Barry building. This was the oldest structure on the site and had been a cause for concern. On this occasion, the medical division controlled infection risks well. Staff kept themselves, equipment and the premises clean. The areas we inspected attained the standard required in their risk category according to the national specification of cleanliness in the NHS.

We visited 15 wards or units across the site. Beds, trolleys and medical equipment were clean and stored correctly. Clinical consumables were kept off the floor in purpose-built racking. In therapy rooms and clinical equipment stores, there was wide-use of ‘I am clean’ stickers. These showed the date and time the item was cleaned along with the name of the person who cleaned it. We saw these details had been completed in all cases, which enabled staff to quickly identify items that were ready for use.
This service had adhered to the Health and Social Care Act 2008: Code of practice for health and adult social care on the prevention and control of infections and associated guidance. We saw a significant improvement compared with the 2017 inspection when the code of practice was not met. Managers reported there was daily housekeeping support provided to each area and we saw housekeepers working throughout the day. The wards and units including housekeepers had routine cleaning schedules to follow and kept account of their progress by completing daily cleaning audits and quality monitoring. We saw records of these on the wards and cleaning trolleys, and we noted housekeepers changing the colour-coded mops and cloths to suit the cleaning task.

This service had infection prevention and control policies which were in-date and readily available for staff to access on the trust intranet. Staff were aware of the policies and knew how to locate them. These included waste management policies, which were monitored through regular environmental audits. We saw clinical and domestic waste bins were available and clearly marked in coloured bins for disposal in the correct manner. Staff followed correct waste segregation which helped to prevent bacterial contamination or unsafe disposal of clinical waste.

This service reported three incidences of hospital acquired Meticillin-Resistant Staphylococcus Aureus (MRSA) in the last six months. This remained the same from the three incidences the trust reported from 1 April 2016 to 31 March 2017. MRSA is a type of bacterial infection which is resistant to many antibiotics and is capable of causing harm to patients. A care plan was implemented if a positive result was obtained and we saw examples documented in the patient plans we reviewed.

There were adequate numbers of side rooms to allow any patient who presented a risk of cross infection to others to be isolated to reduce the risk. These rooms were clearly identified using a system of signs that helped inform visitors and staff about any special precautions needed. Similarly, posters about infection control were prominently displayed at ward entranceways to encourage visitors to help in reducing the risk of cross infection by maintaining good hand hygiene and not visiting if they are unwell.

All staff we observed during the inspection were ‘bare below the elbows’ and dressed in line with trust policy. We saw sufficient supplies of personal protective equipment such as aprons and gloves in dispensers on walls and we saw staff used these items. Gloves were readily available in the full range of sizes. This gave staff convenient access to correctly fitting gloves, which consequently reduced the chance of accidental tearing. We saw body fluid spillage kits were also readily available.

The trust’s hand decontamination policy was current and described when staff should wash their hands. We saw staff followed the policy and adhered to the World Health Organisations “Five moments for hand hygiene”. Antimicrobial hand-rub dispensers were mounted on the walls at strategic points throughout the hospital as well as outside each room or bay. These contained gel and we observed staff using the product as they moved around the hospital. At each ward entrance, we saw prominent signage designed to alert staff and visitors to the placement of the hand dispensers. We observed these acted as an effective prompt to remind visitors to clean their hands and we saw visitors to the wards and units we visited consistently used the hand gel.

We saw non-disposable curtains in use throughout the medical wards and these were marked with the dates cleaned and changed. We saw these matched with the dates documented on the cleaning schedules. This complied with Hospital Building Note 00-09: Infection control in the built environment and indicated curtains were routinely cleaned/changed to help reduce the chances of germs passing from one person or object to another.
Sharps were managed in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 (the Sharps Regulations). Clearly marked and secure containers were placed close to the areas where medical sharps were used. Instructions for staff on the safe disposal of sharps were displayed in clinical areas and the sluices. We saw clear guidance for staff on the action to take in the event of a needle stick injury. This was displayed in treatment rooms and other clinical areas.

Each of the medical wards and units we inspected displayed their infection prevention and control audit results, so patients, visitors and staff had current infection control information available.

The endoscopy unit had been accredited by the Joint Advisory Group (JAG) for gastrointestinal endoscopy. This accreditation is a formal recognition that an endoscopy service has demonstrated it meets criteria set out in the JAG standards. The scheme was developed for all endoscopy services and providers across the UK in the NHS and independent sector.

We observed staff working in the endoscopy suite and we saw that they carried out decontamination of endoscopes in line with the Health Technical Memorandum 01-06: Decontamination of flexible endoscopes and Safety Executive (HSE) Standards and recommended processes for endoscope reprocessing units.

The trust had arrangements to support the management of infection prevention and control. This included the use of ward ‘champions’ and infection prevention team with qualified infection control nurses. The team worked across all hospital departments coordinating with other health-care professionals, patients and visitors to prevent and control infections. The team’s responsibilities included giving advice, providing education and training, monitoring infection rates and auditing infection prevention and control practice.

Our observations were consistent with local audits and the 2017 patient-led assessment of the care environment (PLACE) survey. This showed the trust scored 98.7% for cleanliness, which was better than the England average of 98%.

**Environment and equipment**

Most of the medical wards were in the Barry Building at the Royal Sussex County Hospital site. In our previous 2016 and 2017 inspections, we identified that the fabric of Barry Building was poor and posed a risk to patients with regards to the management of fire safety, crowding and infection prevention and control. While most of the medical wards was still located in the Barry Building at this inspection, we found the trust had taken immediate actions to reduce the risks and plans for the wards to move to a new purpose-built building were on schedule (due by end 2020). We saw building works were well underway and staff we spoke with were excited by the prospects. They told us they had not been complacent in ensuring the risks we found in the previous inspection were reduced while located in the Barry Building.

We saw robust fire safety precautions adopted by the clinical areas. All the wards we visited had identified fire wardens and ensured there was always a fire warden on duty at every clinical shift. We observed the fire procedures and found all fire doors were clearly marked, kept shut and free from obstacles. Fire safety equipment was available throughout the hospital and we saw evidence that fire equipment safety checks had been completed by an external specialist contractor.

We saw all medical wards had undergone fire risk assessments. We reviewed three fire safety risk assessments on Jowers, Chichester and Bristol wards. These were fully completed and all actions that were identified were complete for Jowers and Chichester wards. Bristol ward had eight
actions identified by the fire risk assessment; five were complete with three that remained outstanding and were actions for either the Estates or project's team.

Each ward participated in regular fire drills and we saw all the wards we visited kept a stock of red fire warden tabards in a range of sizes for use when required. Staff told us they participated in fire drills simulation which involved staff in evacuation scenarios using the external fire escapes. We saw one aspect of the daily safety risk checklist entailed a full examination of the fire ski sheets which facilitated the safe and prompt evacuation of non-ambulant patients. We observed staff checked the fire ski sheets daily and reported it at the staff safety huddles. New staff also completed specific training relevant to their ward fire safety during their induction period.

The removal of beds from the balcony on Jowers (now converted to the Small Acts of Friendship area), Vallance (now converted to a dining area) and Chichester wards helped mitigate the impact of crowding on the wards.

The rest of the medical wards and units located in other buildings at the Royal Sussex County Hospital site had suitable premises and equipment, and they were looked after well. The areas we observed supported the safe delivery of care. Rooms were well-lit and supplied with sufficient equipment and furnishings. Corridors, treatment rooms and toilets were spacious with doors wide enough to fit wheelchairs.

In October 2017, we carried out an unannounced inspection focussed on the management of Control of Substances Hazardous to Health (COSHH) substances and found the management of COSHH substances were not robust. Since that inspection, the leadership team and staff had taken immediate actions to address our concerns.

At this inspection, we found the medical wards and units had systems to provide assurance that information relating to COSHH was available, complete and accurate, and staff understood it.

We reviewed COSHH folders containing information related to cleaning products on medical units in level eight A west, Baily, Bristol, Chichester, Donald Hall and Solomon and Jowers wards. On all wards and units, we found the COSHH folders had risk assessments and safety data sheets pertaining to all the cleaning chemicals found in the cleaning cupboards. All risk assessments and safety data sheets were in date and all had a review date. We saw all COSHH folders complied with COSHH regulations 2002. These regulations provide a framework to help protect people in the workplace against health risks from hazardous substances used directly in the workplace, for example cleaning chemicals.

We spoke with 12 housekeepers and 17 nursing staff about their understanding of the COSHH regulations. All 29 staff had an understanding relevant to their roles and all said they had received training in COSHH. This had improved since 2017 inspection when we found staff lacked the knowledge. COSHH regulations provide a framework to help protect people in the workplace against health risks from hazardous substances. The substances may be used directly in the workplace, for example cleaning chemicals.

We saw staff ensured all products subject to COSHH were stored securely, unlike what we found in the 2017 inspection. The trust told us that the cleaning products had been rationalised and every cleaning cupboard had a pictorial sign of all the chemicals used. We were also told that a significant investment of money had been allocated to put electronic swipe card access on all cleaning cupboards and in high risk areas, the cleaning trolleys had lockable compartments. We found all cleaning cupboards in the wards and units we visited had swipe card access and were locked at the time of inspection. All cleaning cupboards had the pictorial signs showing the
chemicals in use. We also saw the cleaning trolleys had lockable compartments and we observed they were all locked at the time of inspection. We found systems and staff practices had markedly improved since the 2017 inspection.

All staff knew how to locate emergency equipment in clinical areas, including portable oxygen, suction and automated defibrillators stored on purpose-built trolleys. We reviewed seven resuscitation trolleys in the medical wards and units we visited. We found all the trolleys were stocked and checked daily in accordance with guide sheets attached to each trolley, which were collected by managers and audited monthly. Actions identified by daily checks were complete, for example replacing equipment that had been used or monitoring those that were near their expiry dates. All bays and rooms we visited had piped oxygen and suction and every device we checked functioned correctly. This was consistent with the emergency equipment checklists maintained by staff and indicated staff had active focus on ensuring these items were ready for immediate use should an emergency occur.

Beds, furniture and electrical equipment were labelled with asset numbers and labels showing service dates. Staff told us that the medical equipment was well maintained centrally by the engineering service and none cited any problems in obtaining sufficient items for use. The ward stores we visited appeared visibly clean and well-organised, with plentiful shelving and items clearly labelled.

We saw clear segregation and safe disposal of clinical waste, and correct storage of clean and dirty equipment.

We found patients no longer had to travel to London to receive iodine treatment. At this inspection, we saw the replaced iodine room now located within the building where cancer services are provided. This had replaced the iodine room that was knocked down within the Jubilee Building in 2017.

The 2017 patient-led assessment of the care environment survey showed the trust scored 90.7% for condition, appearance and maintenance, which was worse than the England average of 94%. However, the leadership team and clinical areas had made significant improvements within their control to enhance this since the 2017 inspection, and we saw the service had completed risk assessments where required.

Assessing and responding to patient risk

This service had comprehensive screening tools to help staff recognise the early signs of emerging sepsis (bacterial contamination of blood). We saw a newly designed sepsis bundle contained those tools which the medical division had put considerable effort into, to support staff identify and manage patients with those conditions. Staff we spoke with said they all had training. We observed sepsis was the theme of the month and this was discussed at the safety huddles.

We saw nursing staff had carried out comprehensive risk assessments on patient admissions which were kept in the patient records. This included assessing the patient against the risk of falls, nutrition status, skin integrity and pain. We reviewed eight sets patient records and saw nursing staff had reviewed and repeated risk assessments within suitable and recommended timescales.

The trust had introduced the updated version of the National Early Warning Score (now known as NEWS2) monitoring tool. It is based on a simple scoring system in which a score is allocated to physiological measurements, for example blood pressure and pulse. The scoring system enabled
staff to identify patients who were becoming increasing unwell and provide them with increased support.

In the eight sets of patient records we reviewed, we found NEWS scores for all eight patients had been calculated consistently and accurately. The record entries we checked in all the patient records were completed legibly and accurately. The patient records also showed nursing staff escalated any concerns about deteriorating health and those decisions about changes to care or treatment plans were made by staff competent to do so. Nursing staff told us they had good support from the doctors and the outreach support team whenever a patient’s deterioration was observed.

We reviewed 20 patient records related consultant assessments, and all showed a consultant assessed patients who were urgent or unplanned medical admissions. The records also showed patients were seen within 12 hours of admission or within 14 hours of the time of arrival at hospital.

This service had on-site access to level two and three critical care (high dependency and intensive care) units for patients if required.

Staff held two multi-disciplinary safety huddles daily where each patient was risk assessed. This enabled them to share information and act on any risks in a timely way. We observed three safety huddles and one board round meeting which involved multidisciplinary staff including doctors, nursing and therapy staff and social workers. We saw effective risk-based discussions and decisions about staffing levels, safety incidents, infection prevention and control issues that supported what we had been told.

On some wards, we saw printed copies of the NEWS2 and sepsis risk assessment sections in the care bundle showed different trigger scores for escalation. The sepsis section showed a score of three or more and the NEWS2 section showed a score of five or more. Ward managers we spoke with explained the new bundle forms had recently been introduced and the trust were in the phase of reviewing and replacing with new versions. We observed this was reported at the safety huddles. Our review of patient records and staff we spoke with provided assurance that patients were not meanwhile put at risk as staff had escalated issues at the lower trigger score.

**Nurse staffing**

This service had staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

The trust monitored staffing levels, sickness and vacancy rates and use of bank and agency staff. The trust did not use a patient acuity tool to determine levels of staffing. The leadership team used an algorithm to quantify the extent of nursing care to be provided based on the size of population, mix of patients, and type of service and relating it to the activities undertaken by different members of the team.

There were sufficient staff to meet the patients’ needs based on our observations during the inspection. We saw that actual staff on duty matched staffing templates used and this information was clearly displayed on performance boards at ward entrances and on staff notice boards.

However, a lack of registered nurses remained a concern since the 2017 inspection. The concern was raised and acknowledged by staff and managers, and we saw the service and corporate risk registers included this. The trust had taken various actions to address the shortfall in staffing such as introducing a band five rotational programme and recruiting overseas nurses. We were told that
overseas recruitment drives were now continuous. Senior managers stated the trust offered overseas qualified nurses to enrol in international English language tests and structured clinical examinations to enable them to register with the nursing and midwifery council. The trust actively supported recruitment by providing employment as healthcare assistants to the overseas qualified staff.

Managers explained that planned staffing was generally met, although bank and agency staff were required to fill vacant shifts. Bank use was encouraged as permanent staff taking on extra 'bank' work were familiar with the ward processes and environment. Where agency staff were used, we were told that shifts were block booked whenever possible. This provided consistency in cover, ensured agency staff were familiar with the processes used and they felt like a team member. Agency staff had orientation packs delivered on their first shift and we saw completed examples matching staff names on rosters.

We saw arrangements for nursing staff to hand over the care of patients between shifts and we noted the use of printed handover communication sheets. We looked at these sheets and found they contained relevant information on the specific needs and risks of patients that supported the delivery of safe care.

Planned vs actual

The trust reported the following qualified nursing staff numbers in medical care for two snapshots in time; 31 March 2017 and 30 April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>As at 31/03/2017</th>
<th></th>
<th>As at 30/04/2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
</tr>
<tr>
<td>All sites</td>
<td>411.3</td>
<td>465.9</td>
<td>88.3%</td>
<td>391.8</td>
</tr>
</tbody>
</table>

The trust fill rate for qualified nursing staff in medicine at 30 April 2018 is lower than the trust fill rate at 31 March 2017 (81.7% compared to 88.3%). At 30 April 2018, the trust had 87.9 fewer members of qualified nursing staff in medicine (WTE) than they had planned.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From May 2017 to April 2018, the trust reported an overall vacancy rate of 13.7% for qualified nursing staff in medicine. The trust has set a vacancy target of 10.5% as at March 2018 reducing incrementally to 9% by March 2019. A site breakdown can be seen below;

- Royal Sussex County Hospital medical department: a vacancy rate of 10.9%.
- Princess Royal Hospital medical department: a vacancy rate of 24.7%.
- Staff assigned to ‘other’ sites within medical care at the trust: a vacancy rate of 7.5%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From May 2017 to April 2018, the trust reported a turnover rate of 8.9% for qualified nursing staff in medicine, which is better than the trust target. The trust has set a turnover target of 10.5% as at March 2018 reducing incrementally to 9% by March 2019. A site breakdown can be seen below;
• Royal Sussex County Hospital medical department: a turnover rate of 3.7%.
• Princess Royal Hospital medical department: a turnover rate of 0.0%.
• Staff assigned to ‘other’ sites within medical care at the trust: a turnover rate of 11.8%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From May 2017 to April 2018, the trust reported a sickness rate of 4.0% for qualified nursing staff in medicine. The trust has set a sickness target of 4.2% as at March 2018 reducing incrementally to 3.5% by March 2019. A breakdown of sickness rates by site is found below:

• Royal Sussex County Hospital: a sickness rate of 3.6%
• Princess Royal Hospital: a sickness rate of 4.1%
• Staff assigned to ‘other’ sites within medical care: a sickness rate of 5.5%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

Please note that the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff in all cases. Therefore, we have been unable to analyse bank and agency usage as a proportion of the total shifts needing to be filled.

The table below shows the numbers of shifts in medicine at a trust wide level from April 2017 to March 2018 that were covered by qualified nursing and nursing assistant bank and agency staff or left unfilled.

For qualified nurses, 12,623 shifts were filled by bank staff and 4,587 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses. In addition, 7,000 shifts were not filled by either bank or agency staff.

For nursing assistants, 19,240 shifts were filled by bank staff and 14 shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants. In the same period, 7,007 shifts were not filled by either bank or agency staff.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Qualified nurses</th>
<th>Healthcare assistants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>12,623</td>
<td>19,240</td>
<td>31,863</td>
</tr>
<tr>
<td>Agency</td>
<td>4,587</td>
<td>14</td>
<td>4,601</td>
</tr>
<tr>
<td>Not filled</td>
<td>7,000</td>
<td>7,007</td>
<td>14,007</td>
</tr>
</tbody>
</table>

Unfortunately, we are unable to provide a site-specific breakdown of nursing bank and agency usage in the medical care core service, due to the format of the data provided by the trust.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

Overall, we found that numbers of doctors at the right grades were suitable to meet the needs of patients. While vacancy rates and turnover was better than trust averages, medical staff told us they struggled at times due to shortage of middle grade doctors but found this service a good place to work. The medical division had created a lead specialist registrar to act as a conduit for middle grade trainees to raise any training issues direct with the senior leadership team.
Additionally, we saw the division had improved middle grade rotas and improved the quality of their training. To enhance this, the trust had also approved (September 2018) to expand the medical consultant workforce.

We saw newly admitted patients received a timely review by a consultant trained in general medicine and we saw ward rounds taking place. A consultant on-call system operated and junior medical staff we spoke to told us they could access advice from a consultant and generally felt well-supported.

However, we found that the clinical director for specialty medicine in this division had been vacant for seven months. We raised this with the trust who acknowledged they are trying to attract a consultant into this key role. We were told new consultants had been appointed and the trust hoped this would assist in recruitment. Ward managers we spoke with told us of a consultant commencing in October 2018.

**Planned vs actual**

The trust reported the following medical staffing numbers in medical care for two snapshots in time; 31 March 2017 and 30 April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>As at 31/03/2017</th>
<th>As at 30/04/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>All sites</td>
<td>249.0</td>
<td>235.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fill rate</td>
</tr>
<tr>
<td></td>
<td>105.9%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>All sites</td>
<td>248.5</td>
<td>243.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fill rate</td>
</tr>
<tr>
<td></td>
<td>102.1%</td>
<td></td>
</tr>
</tbody>
</table>

The trust fill rate for medical staff in medicine at 30 April 2018 is lower than the trust fill rate at 31 March 2017 (102.1% compared to 105.9%), although at both snapshots in time the trust reported a fill rate of over a 100%. At 30 April 2018, the trust had 5.2 extra members of medical staff in medicine (WTE) than they had planned.

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

**Vacancy rates**

From May 2017 to April 2018, the trust reported an overall vacancy rate of 1.1% for medical and dental staff in medicine. The trust has set a vacancy target of 10.5% as at March 2018 reducing incrementally to 9% by March 2019. A site breakdown can be seen below;

- Royal Sussex County Hospital medical department: an over-establishment of 3.3%.
- Princess Royal Hospital medical department: an over-establishment of 509.1%. The detail of this is cited in a separate Medical care (including older people’s care) service report specific to that location.
- Staff assigned to ‘other’ sites within medical care at the trust: a vacancy rate of 10.2%.

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

**Turnover rates**

From May 2017 to April 2018, the trust reported a turnover rate of 5.6% for medical and dental staff in medicine. This is better than the trust turnover target of 14% that was set for March 2018 (the trust has said that they are aiming to reduce this target incrementally to 11.0% by March 2019). The trust was unable to provide turnover rates for medical staff by site.

*(Source: Routine Provider Information Request (RPIR) – Turnover tab)*
Sickness rates

From May 2017 to April 2018, the trust reported a sickness rate of 0.9% for medical and dental staff in medicine. The trust has set a sickness target of 4.2% as at March 2018 reducing incrementally to 3.5% by March 2019. A breakdown of sickness rates by site is found below:

- Royal Sussex County Hospital: 1.5%
- Princess Royal Hospital: 0.3%
- Staff assigned to ‘other’ sites within medical care: 0.7%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

Trust wide

From April 2017 to March 2018, the trust reported that 1,122 shifts within medical care trust-wide were filled by bank staff and 864 shifts were filled by locum staff. There were 483 shifts which were not filled by either bank or locum staff. A breakdown of bank and locum usage by staff type at the trust is shown below.

Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff. Due to the format of the data provided, no site breakdown is available.

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
<th>Unfilled shifts</th>
<th>Total shifts (bank + locum + unfilled)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>141</td>
<td>698</td>
<td>163</td>
<td>1,002</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>836</td>
<td>166</td>
<td>283</td>
<td>1,285</td>
</tr>
<tr>
<td>Junior</td>
<td>145</td>
<td>0</td>
<td>37</td>
<td>182</td>
</tr>
<tr>
<td>Total</td>
<td>1,122</td>
<td>864</td>
<td>483</td>
<td>2,469</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix

In March 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was slightly higher.
Staffing skill mix for the 396 whole time equivalent staff working in medicine at Brighton and Sussex University Hospitals NHS Trust

This Trust | England average
--- | ---
Consultant | 35% | 43%
Middle career^ | 2% | 6%
Registrar group~ | 40% | 29%
Junior* | 23% | 22%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

Source: NHS Digital - Workforce Statistics - Medical (01/03/2018 - 31/03/2018)

Records

Staff managed and kept records of patients’ care and treatment in a way that kept people safe. Records were clear, up-to-date and available to all staff providing care. The trust had a clear policy which described how records should be completed and stored. Staff we spoke with told us they had clear guidance to follow on how information should be recorded and which sections had to be filled in, for example patient’s personal and discharge details.

We reviewed 27 sets of patient records which included records of the patient’s journey in the emergency, outpatient and inpatient areas. In all the notes we reviewed, we found a good standard of record keeping. Records were clear and up-to-date. We saw staff had completed records in full, were concise, legible and signed. The records contained all required information such as admission details, signature list and consent to treatment. The care records included multidisciplinary input where required for example, entries made by physiotherapist, occupational therapist and dementia nurse specialist. We saw care plans focussed on individual needs of patients and their families, and included clear instructions and review dates.

Patients’ records were readily accessible to those who needed them and we found they were stored securely in locked purpose-built trolleys.

Medicines

The trust had current medicines management policies, together with protocols for high-risk procedures involving medicines such as the intravenous administration of antibiotics. These were readily available for staff to access. Prescribers also had access to relevant resources on medicines management such as electronic and printed copies of the current British National Formulary.

This service had systems to ensure the safe supply, administration and disposal of medicines in accordance with ‘NICE NG5 Medicines optimisation: the safe and effective use of medicines’.
In the 2017 inspection, we found staff had not monitored the ambient room temperature in medicine storage areas. During this inspection, we saw staff recorded and monitored daily ambient room temperatures in all the clinical areas we visited. The temperature records included actions taken when staff had identified an out of range temperature, for example switching on fans to cool the area when it was above the recommended temperature.

We saw all medicines, including emergency medicines, were within the expiry date and were stored securely behind locked doors in locked cupboards, and in fridges where applicable, with access restricted to appropriate staff. Staff recorded and monitored fridge temperatures daily to ensure medicines were kept in optimal conditions.

Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored securely. We saw two qualified nurses checked the quantities weekly and any discrepancies were reported. All stock levels we reviewed were correct.

Emergency medicines were available on emergency trolleys which were secure, sealed and checked regularly. All the medicines we reviewed within the emergency trolleys were within the expiry date.

Medicine related alerts and recalls were communicated via email to the nurse in charge of the ward. The pharmacy staff also delivered a paper copy and these were cascaded to all staff.

Staff had clinical pharmacy support with access to a regular ward based pharmacist and technician. Access to pharmacy during opening hours was by designated pharmacy staff only. In addition, there were specific procedures for other named staff to gain emergency access out of hours. This process ensured there was no unauthorised access.

A Patient Group Directions (PGD) is a legal framework which allows some registered health professionals to supply and administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor. All the PGDs we reviewed were in date and reviewed in accordance with local and national guidance.

We reviewed 10 patient medicines charts. All entries were legible and staff had recorded allergies where applicable. However, we noted the medication record forms contained more than one space for the prescriber to record the date of each prescription, which was a potential source of confusion. In some cases, it was not clear that the medication order had been correctly signed by the prescriber. When we raised this with senior managers, the trust responded immediately. The forms and last audit results were reviewed by the drugs and therapy committee, who recommended a change in the layout of the chart to help eliminate any confusion that may exist. The new layout forms were being rolled out before the end of the year.

Incidents

The service managed patient safety incidents well. Staff understood what constituted an incident and reported them. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Staff told us they received feedback after reporting incidents and described how they took learning and recommendations from a recent serious incident.

Staff reported incidents using an electronic incident reporting system. Some staff showed us how they accessed the online system. All staff we spoke with confirmed they had received training and felt confident about using the system.

The Duty of Candour is a regulatory duty that relates to openness and transparency, and requires providers of health and social care services to notify patients (or other relevant person) of certain notifiable safety incidents and provide reasonable support to that person. Staff we spoke with had good knowledge and said they had received this as part of the mandatory training. Staff also
described they apologised to patients and gave patients honest information and suitable support when things go wrong.

We reviewed three recent investigation reports and saw evidence of learning from that was shared across the trust through email alerts and announcements on the trust intranet. We saw staff discussed them at local level during safety huddles, team and divisional meetings.

Staff completed a safety handover form every 12 hours for each shift. They followed a pattern of ‘SAFETY’; Staffing, Acuity, Falls, Environment and Equipment, Trust and Ward issues, and Yourselves (how was your shift). We observed staff used this in the safety huddles we attended during inspection.

On the wards we saw team communication folders containing the minutes of team and divisional meetings that also detailed lessons learned and actions taken. We saw that the wards had good control mechanisms in place to record the names of staff reading the announcements.

**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 2017 to May 2018, the trust reported one incident classified as a never event for medicine. This occurred at Princess Royal Hospital and related to the misplacement of a nasogastric tube into the right main bronchus contributing to the death of a patient from respiratory failure. Detail of this had been described in a separate Medical care (including older people’s care) service report specific to that location.

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

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported nine serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from June 2017 to May 2018.

![Incident Breakdown Chart]

Of these, the most common types of incident reported were:

- Slips/trips/falls meeting SI criteria with six (67% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with one (11% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (11% of total incidents).
- Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria with one (11% of total incidents).
incidents). Site specific information can be found below:

- Royal Sussex County Hospital: four incidents
- Princess Royal Hospital: five incidents

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

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 10 new pressure ulcers, 19 falls with harm and 31 new urinary tract infections in patients with a catheter from June 2017 to June 2018 for medical services, and not site-specific.

Two of the three categories had improved from the 2017 inspection, which showed 13 new pressure ulcers and 48 new urinary tract infections in patients with a catheter from February 2016 to February 2017. This is testament that staff had used the information to drive improvements in safety care. While there were 19 falls with harm (15 reported from February 2016 to February 2017), four of the care of the elderly wards at Royal Sussex County Hospital had shown a reduction in fall numbers because of a project called the ‘blanket project’. We saw staff used individual ‘blankets’ for each patient which acted as a bed spread on each bed. This protected patients from falls as they could recognise their own bed space.

In the 2017 inspection, we found safety thermometer information was not visibly displayed in patient areas. However, we saw staff had clearly displayed these on patient information boards located within the ward and unit corridors. We observed safety performance charts displayed in staff meeting rooms. These showed current ‘safety thermometer’ information about key indicators such as falls and staffing levels. The charts helped staff understand what the trust was monitoring and how each ward was performing against the targets set by the trust.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls with harm and new urinary tract infections at Brighton and Sussex University Hospitals NHS Trust

![Graph of prevalence rate](image)
### Total Falls (19)

- 1 Pressure ulcers levels 2, 3 and 4
- 2 Falls with harm levels 3 to 6
- 3 Catheter acquired urinary tract infection level 3 only

### Total CUTIs (31)

Source: NHS Digital - Safety Thermometer

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**Is the service effective?**

#### Evidence-based care and treatment

This service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. New and updated guidance was evaluated and shared with staff.

Staff told us they had easy access to national and local guidelines through the trust’s intranet. Staff described examples of guidance they had access to, based on National Institute for Health Care Excellence (NICE), Royal Colleges guidelines, UK Resuscitation Council and British Dietetic Association. In addition, they reported they could access the Royal Marsden Manual of clinical nursing procedures online which the trust hosted. There were sufficient computer terminals provided on the wards we visited and we saw staff using the resources. We noted there were links on the trust intranet to help access national guidelines if needed. We saw wards and units we visited had developed policy folders for quick reference.

We saw staff used standardised care pathways that were based on current best practice and NICE guidance. For example, the acute heart failure and stroke pathways.

The trust routinely reviewed the effectiveness of care and treatment by using performance dashboards, local and national audits.

This service had been awarded the Joint Advisory Group on GI Endoscopy (JAG) accreditation. This showed the service used evidence based practice.

#### 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. This service adjusted for patients’ religious, cultural, and other preferences.
The trust used nationally recognised tools to assess patients' nutrition and hydration needs. Staff screened all patients admitted using the Malnutrition Universal Screening Tool (MUST). This enabled staff to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. We saw all MUST assessments in the 10 patient records we reviewed showed fully completed assessments and were up to date. All the nutrition and fluid balance charts we reviewed were complete and additional dietetic advice were provided if required. We observed staff had discussed the dietetic needs of vulnerable patients at safety huddles. This showed patients received adequate intake of food and fluids.

Staff and patients had access to dietitians who were accessible from Monday to Friday 9am to 5pm. Out of hours, there was a telephone service for advice. Dietitians contributed to patient care plans and recorded instructions for other members of the multi-disciplinary team. Staff advised us that dietitians and speech and language therapists (SALT) supported them to look after patient's nutritional needs. We observed a SALT trained a senior nurse about the required number of scoops of thickener required to thicken fluids.

Staff explained that dieticians monitored patients who received nutrition through a nasogastric or parenteral feeding tube. Parenteral feeding is the process by which a patient receives nutrients intravenously by passing the usual process of eating and digestion. We did not see any patients who required this therapy on the wards or units we visited.

Staff offered patients three main meals daily and snacks were available if required. There was a choice of food and the hospital also catered to suit cultural, religious and therapeutic diets. The trust used a system of ‘pictograms’ to represent food or fluid restrictions as well as special dietary needs. These were displayed on the wall next to each bed or on the door of separate rooms. These provided visiting staff and therapists with a visual reminder that the patient had a special requirement or need.

We observed staff supported patients to eat independently and placed drinks within their reach. Nurses, family members and volunteers assisted patients to eat when required.

The 2017 patient-led assessment of the care environment survey showed the trust scored 95.3% for food and hydration, which was significantly better than the England average (89%).

Pain relief

Since the 2017 inspection, this service had placed emphasis to improving pain management. This was part of the trust wide ‘Patient First’ initiative with an aspiration of assessing and offering analgesia within 30 minutes of the patient’s arrival on the ward. This service had improved compliance of this target from 15% to 50% since commencing the initiative.

The trust had a pain management policy that staff could access on the intranet. The policy included information on how to contact the specialist pain team. Staff we spoke to know how to contact them.

Staff had access to a trust wide pain management service and the trust had a dedicated pain management page on their website for patients with chronic pain. In addition, staff had access to significant pain management information and advice for end of life patients that was available via the palliative care trust intranet page.

We observed staff assessed patient’s pain levels at set intervals prior to each medication round and additionally when required, and administered painkillers as required. We saw there was a section specifically about pain management in the patient safety bundle.
Staff used a one to ten pain scale when asking patients about their level of pain, and used a facial expressions tool for patients with impaired cognition or those unable to verbally communicate.

We saw visual pain charts on the stroke rehabilitation wards. These were designed to help patients who could not verbalise indicate their level of pain or discomfort.

The patient records we reviewed showed staff had regularly checked patient’s pain levels and reassessed patients who were given painkillers to ensure their effectiveness.

All patients we spoke with reported they had pain relief medication promptly brought by staff when required.

**Patient outcomes**

**Relative risk of readmission**

From March 2017 to February 2018, patients at Royal Sussex County Hospital had a higher than expected risk of readmission for both elective and non-elective admissions when compared to the England averages.

**Elective Admissions - Royal Sussex County Hospital**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

- Patients in clinical haematology had a lower than expected risk of readmission for elective admissions
- Patients in cardiology had a higher than expected risk of readmission for elective admissions
- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions

**Non-Elective Admissions - Royal Sussex County Hospital**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

- Patients in general medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a similar risk of readmission for non-elective admissions
- Patients in cardiology had a higher than expected risk of readmission for non-elective admissions
Sentinel Stroke National Audit Programme (SSNAP)

Royal Sussex County Hospital

The Royal Sussex County Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade A in latest audit, August 2017 to November 2017. This had improved since the 2017 inspection where the trust achieved a grade B in the audit from August 2016 to November 2016.

In the most recent audit the hospital was awarded either a grade A or B for nine out of the 10 patient centred performance metrics. The lowest scoring domain for the hospital was the stroke unit which was awarded a C grade (down from a grade B in the period April 2017 to July 2017).

The hospital also scored the lowest for its stroke unit for team centred performance where a grade C was awarded (down from a grade B in the period April 2017 to July 2017).

### Patient centred performance

<table>
<thead>
<tr>
<th>Domain</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
<th>Aug 17 - Nov 17</th>
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<td>B</td>
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<tr>
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<td>C</td>
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<td>A↑</td>
</tr>
<tr>
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<td>C↑</td>
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### Team centred performance

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<tr>
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<td>C↑</td>
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Lung Cancer Audit

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 64.6%, which did not meet the audit minimum standard of 90%. The 2016 figure was 60.0%. The service told us that they had streamlined rapid access pathway for new referrals compliant with National Optimal Lung Pathway which NHS Improvement had approved for rollout in late 2018/early 2019.

The proportion of patients with Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 18.1%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 53.1%. This is within the expected range. The 2016 figure was significantly better than the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 62.7%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The one-year relative survival rate for the trust in 2017 was 38.7%. This is within the expected range. The 2016 figure was not significantly different to the national level.

National Audit of Inpatient Falls 2017

The crude proportion of patients who had a vision assessment (if applicable) was 26%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 30%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 42%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 83%. This did not meet the national aspirational standard of 100%.
However, the trust had implemented several actions to reduce falls across the service. For example, the blanket project on Jowers ward showed a falls rate of 0.79 falls per 1000 bed days as at September 2018. This is eight times lower than the national average. Another example, Emerald ward (dementia unit) showed a reduction in falls from 60 to 26 in the last financial year due to raised awareness, use of falls mats, placing patients within the ward and impact of staffing.

**Competent staff**

The trust offered staff planned in-house learning and development and staff could attend face to face group learning sessions, or complete training online.

At the 2017 inspection, we found the practice educator that supported nurses' education had been vacant for one year. At this inspection, we found this service had appointed several practice educators. Two of the practice educators we spoke with told us how their appointments had improved uptake of mandatory and statutory training, and had facilitated more targeted continuous professional development. Staff we spoke on the wards reported the positive impact they practice educators had on access to training, and monitoring of learning and development.

The trust had developed a series of one-day study days to enhance the acquisition of clinical skills. In addition, staff could complete courses for specific competency development through the local university. Staff we spoke with expressed how pleased they were with the continual professional development training on offer, for example one nurse had been enrolled on a three-day dementia training.

We observed established processes for induction of permanent and temporary (bank and agency) staff. We saw examples of these staff had applied in all the wards and units we visited. Staff showed us completed induction records and told us the induction processes supported them in their roles.

Medical staff told us they had been provided with good education opportunities and were almost always able to attend in-house training sessions.

We found staff involved in the decontamination of endoscopes demonstrated training and competencies. We saw examples of the use of competency frameworks for health care support assistants trained in decontamination processes.

**Appraisal rates**

Trust data as at September 2018 showed staff within medicine had their appraisals completed at 93.1%. This met the trust target of 90% which was raised in March 2018. The service had shown a marked improvement compared with the previous rates of 73.8% from May 2017 to May 2018 and 75% from April 2016 to January 2017.

All staff we spoke with reported they had received a comprehensive appraisal within the last 12 months.

**Multidisciplinary working**

Staff of different professions worked together as a multidisciplinary team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
We observed examples of strong and positive effective multidisciplinary working. Staff consistently praised the “family feel” of the organisation and we observed effective working relations between speciality doctors, nurses, therapists, specialist nurses and social workers.

At safety huddles, we saw proactive engagement between all members of the multidisciplinary team. We found the ward rounds were well organised and well attended by representatives from the ward clinical team, therapists and operational managers.

Medical, nursing and therapy staff of all grades also described good working relationships with staff in other directorates.

The wards used integrated patient records, which were shared by clinical staff and therapists. This improved communication and provision of care was better co-ordinated between healthcare professionals.

Staff told us a dietitian sometimes attended the multidisciplinary team ward rounds to assess and manage the nutritional needs of patients. We saw dietitians contributed to the patient’s care plan and recorded instructions for other members of the multidisciplinary team.

This service had a system to ensure that inpatients know who their allocated consultant and nurse is responsible for their care during their stay based on the guidance ‘The Academy of Royal Colleges Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients’. For example, medical wards and units used name boards placed above patients’ beds.

However, we saw name boards on Emerald unit, Vavance and Chichester wards were not completed or were only partially completed. For example, some were completely blank and some had the nurses’ names only. While this was not in line with trust standards, we found patients and relatives we spoke with at this inspection described they knew who to speak and raise questions with when required. They provided examples of opportunities to speak with the nurse-in-charge and consultant during their daily rounds. We raised the name boards issue with the leadership team and we were told the trust had plans to implement an electronic version across the trust.

Seven-day services

Medical out of hours cover was provided by on-call, agency or locum staff supplementing the permanent members of staff. Consultant cover was available every day including weekends, with on-call arrangements for bank holidays. We saw consultants working multiple day blocks which helped maximise the continuity of care for patients. We also found that medical ward patients moved from an acute area of the hospital were reviewed by a consultant, seven days a week.

Diagnostic services were available throughout the week and staff did not report any issues with obtaining diagnostic results out of normal hours.

Physiotherapy for inpatients was available every day including weekends.

Since the 2017 inspection, the service had extended and established a routine weekend clinical pharmacy service to the acute medical unit. This had resulted in 7.5 hours coverage each for Saturday and Sunday. The trust had further plans to balance provision through the weekend working review (newly established) and the pharmacy workforce plan.

Access to dieticians or speech and language therapists was provided Monday to Friday, 9am to 5pm with an out of hours telephone advice line to support staff. Nurses were trained to carry out assessments for patients on the stroke ward where dietary advice and support with eating affected recovery were required out of hours.
The trust was working toward seven-day services in line with National Health Service Improvements (NHSI), Seven-day services in the NHS. We saw in the trust operational plan 2018-2019, that they plan to fulfil the seven-day service standards for all admitting specialities by 2020. The seven-day service programme is designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter the hospital.

**Health promotion**

We observed there was a wide range of information and support available for patients, their families and carers. The information was good quality literature with informative content and was available from the patient literature stands on the wards and units we visited. There were also leaflets on managing different health conditions. For example, within the oncology ward there was informative and practical information to support the dietary needs of patients living with cancer and within endoscopy unit there was patient information leaflets on the full range of procedures.

We saw the trust website had a full range of patient information leaflets and they were available in different languages.

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

The trust had a current and comprehensive policy based on the guidance issued by the Department of Health that staff followed for consent to examination and treatment. The trust also had a pictorial guide supporting people with learning disabilities about what giving consent meant. Staff understood their roles and responsibilities under the Mental Capacity Act 2005 and the Mental Health Act 1983. They knew how to support patients who lacked the capacity to make decisions about their care and patients experiencing mental ill health.

Across the medical services, staff demonstrated a good understanding of the legislation and best practice regarding consent, the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with described their responsibilities and were clear about roles related to gaining consent from people, including patients who lacked capacity to consent to their care and treatment. We saw examples in the patient records we reviewed where, clear documentation that staff had discussions related to consent before an examination or procedure was undertaken and where the consultant responsible for the patient’s care undertook mental capacity assessments for those unable to consent.

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

The trust target rate for Mental Capacity Act and Deprivation of Liberty training completion is 90%.

Trust data as at September 2018 showed 84% staff within medicine at the Royal County Sussex Hospital site had completed training. Of all the staff groups, nursing staff achieved the highest compliance rate at 92% and the administrative and clerical staff achieved the lowest at 50%. Although the service had not met the trust target, we saw future training dates arranged for staff to complete the training.

**Is the service caring?**

**Compassionate care**
NICE QS15 Statement 1 states, “Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.” We found staff of all grades in all the medical wards and units we visited adhered to these principles during their interactions with patients, families and their carers, and visitors.

Staff showed awareness of the ‘6C’s’ of ‘Compassion in Practice - Nursing, Midwifery and Care Staff - Our Vision and Strategy 2012: compassion, care, commitment, courage, competence, communication’.

We saw staff going above and beyond in looking after people and we were provided with examples during this inspection.

On Jowers ward, staff told us one patient was worried about staying in hospital as he had to leave his dog behind. They advised us they rallied as a team and volunteered to look after the patient’s dog while he was in hospital.

We observed staff understood and respected the personal, cultural, social and religious needs of patients. We saw staff took account the totality of people’s needs when they discussed each patient during handovers and multidisciplinary meetings.

Staff interacted with people who used the service and those close to them in a respectful and considerate way. We saw kind interactions from all medical staff across all wards. As an example, on Vallance ward, healthcare assistants helped patients eat and adapted their support to the patients’ different levels of ability to hold cutlery.

Staff were encouraging, sensitive and supportive towards patients and those close to them. All patients we spoke with were overwhelmingly positive in their praise of staff. We saw some of many examples of patient feedback written to staff expressing their gratitude; on Solomon ward a patient wrote, “Nothing but grateful to the staff and I was very well looked after”, on Jowers ward wrote, “Thank you for taking such good care of our mother in her final days”, “Thank you for everything you did for mum and the support you gave me. You are truly wonderful people” and on Chichester ward, “At all times she was treated with the greatest respect, dignity, and kindness. You represent the NHS at its very best”.

People’s privacy and dignity needs were consistently understood and respected. We observed in all wards and units staff drew curtains before examinations and spoke quietly enough so patients in adjacent beds could not hear conversations.

We observed staff introduced themselves to patients and their carers in line with National Institute for Health and Care Excellence, QS15 Statement 3: Patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.

Friends and Family test performance

The Friends and Family Test response rate for medicine at the trust was 14% which was worse than the England average of 25% from June 2017 to May 2018. A breakdown by site and ward can be found below.

Royal Sussex County Hospital
### Emotional support

Staff provided emotional support to patients to minimise their distress. Staff we spoke with highly valued people’s emotional and social needs. Staff supported and encouraged links to external resources to help patients, families and carers cope with their emotional needs.

Staff showed they understood the impact that a person’s care, treatment or condition would have on their wellbeing and on those close to them. Staff were knowledgeable and sensitive to space, time and people’s needs when providing diagnosis and potential emotionally charged information. We saw staff encouraged patients and their families to establish links with support services and condition specific special interest groups.

(Source: NHS England Friends and Family Test)
Staff provided appropriate and timely support and information to cope emotionally with their care, treatment and condition. This is in line with National Institute for Health and Care Excellence, QS15 Statement 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety.

We heard staff and patients’ accounts of how staff go ‘the extra mile’ in looking after people’s needs. A remarkable example is how this service had implemented the ‘Small Acts of Friendship’ scheme in February 2018, a creative idea initiated by a consultant. It is a unique programme to help elderly patients retain dignity, social activity, mobility and well-being whilst in hospital. This scheme is run by volunteers and included staff who told us they came in on their non-working days to help with the scheme. Staff had also in their own time participated in the making of a short video to promote and raise funds for this scheme.

The scheme offered free-of-charge hair dressing, hand massages, nail therapy and a mobile library service to patients on the care of the elderly wards. It had an area where patients could gather to relax and watch a movie or listen to music. They also organised group activities for patients to engage in poetry reading and art. The scheme also had a digital reminiscent therapy system called RITA which helped patients living with dementia get access to archives of historic photos, music, games and even allowed patients to take their own photos.

Patients and their relatives we spoke with told us how positive they were about the ‘Small Acts of Friendship’ scheme. Examples of some comments we heard were, “I am so thankful, I feel alive again”, “It is so lovely to have my hair done, made me feel all brand new” and “The hand massage was great and soothing, and took my worries away”.

Staff we spoke with thought the scheme was excellent and provided patients some normality away from home and community. One doctor said they had seen patients more engaged with the medical team. An occupational therapist reported the activities had actively encouraged patient’s engagement, mobility and social activity to aid rehabilitation. One member of staff advised us that families of patients who were previous inpatients on the ward had approached them in the street to thank them for their care, and said “this made my job worthwhile”.

Staff demonstrated the ability to identify and provide carers, family and dependents with emotional support and information. An example of this is a telephone helpline, aimed at providing information and emotional reassurance for patients undergoing chemotherapy as well as their carers, dependents and relatives.

We witnessed a distressed patient on Jowers ward. Staff handled the situation well, communicated with the patient in a calm manner, and offered to take the patient to visit their spouse who was also an inpatient in the adjacent ward.

Patients also had access to physiotherapists and occupational therapists that provided practical support and encouragement for patients with both acute and long-term conditions. Patients spoke highly of the therapy staff and told us of the help and support they received from them.

There was a non-denominational hospital chaplaincy service, which provided pastoral support for patients and their relatives, carers and staff. We saw the chapel located in an area that was easily accessible to patients, staff and visitors. We saw contact details of the chaplaincy service for patient and staff referrals 24 hours a day. Staff we spoke with knew how to contact the service and we also saw patient leaflets on display in ward areas. Staff told us patients were encouraged and supported to attend chapel services held twice a week if they wish. In addition, a bedside communion service was offered by arrangement.
Staff we spoke with told us they had access to a 24-hour telephone hotline if they required support themselves.

We saw all wards and units we visited had a side room that could be used for private or difficult conversations with patients and families. All side rooms were not located in open areas therefore noise within the rooms was kept to a minimum.

Understanding and involvement of patients and those close to them

The care culture in this service demonstrated that patients and their families were active partners in their care. Staff were fully committed to working in partnership with patients and always involved patients and those close to them during decision making and discussing next steps in care. Staff always took into consideration people’s preferences.

Patients and relatives we spoke with said staff communicated with them in plain English and they could understand their care and treatment plans. This made patients and their relatives feel valued and engaged in episodes of care. This is in line with National Institute for Health and Care Excellence, QS15 Statement 2: Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills.

We saw staff established effective ways to communicate with people when their protected equality and other characteristics made this necessary. We heard examples of speech and language therapists engaging with patient-centred multidisciplinary teams to conduct assessments and education sessions. Therapists used communication charts and assistive technology aimed at facilitating rehabilitation as well as supporting future communication needs in a community and social setting. On Solomon ward, a clinical psychologist described how they used a communication chart to assess how patients are feeling.

Inpatients staying at the hospital could access a welcome booklet from the Trust website. It included information regarding life on the ward, what patients could expect from their medical team including the discharge process. We saw examples of how people could find further information, including community and advocacy services, or ask questions about their care and treatment. This included readily available leaflets and posters.

Patients told us staff involved them in their care and considered their views such as discharge planning. A patient described making a decision on a suitable place to live. Another patient explained staff arranged the relevant equipment ready for them when they arrived home. Family members said to us they felt positive about the involvement they had in their relatives’ treatment and discharge processes. Patients and their relatives told us they were given time to ask questions about their preferences. This was in line with National Institute for Health and Care Excellence, QS15 Statement 4: Patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care.

In all wards and units we visited, we saw the nurse in charge wore red shoulder straps on their uniform and were therefore easily identifiable. All patients and relatives we spoke with knew who the nurse in charge of their ward was, as well as the nurse and consultant who were looking after them. Patients advised us that all nurses introduced themselves at the start of their shift.

Is the service responsive?

Service delivery to meet the needs of local people
The trust planned and provided services in a way that met the needs of local people. Patients were admitted to the medical wards via direct referral from their general practitioner, transfer from a critical care unit at the hospital or through the emergency department.

We saw facilities and premises appropriate for the services that were delivered and divisional staff, at all levels, were candid about where improvements were needed and how this was being achieved. For example, bed signage was being reviewed, in line with national guidance, to achieve more consistency and clarity across the whole site. Free Wi-Fi had also been recently introduced for the convenience of patients and visitors.

The medical division actively sought feedback from patients and relatives about the service and incorporated this into their improvement plans. As part of the ‘Patient First’ initiative, we saw display boards showing friends and family test results and examples of feedback drawn from letters of appreciation and patient surveys.

Staff at all levels clearly and passionately described how they met patients’ needs and demonstrated a good awareness of protected characteristics including race, sexuality and disability. We saw a variety of resources made available to staff to help them support these population groups. For example, the Public Health England and Royal College of Nursing toolkit to support gay, lesbian and bisexual young people, a resource guide designed to help staff respond to the needs of patients and clients who identify as ‘transgender’ and a communication guide for patients who had a learning disability.

The trust dementia service acted to meet the needs of the local people. As part of a ‘Dementia is my business’ campaign, the trust had adopted a range of initiatives such as the ‘This is me’ Alzheimer support assessment, Abbey pain scale and ‘Forget-me-Not’ scheme to help staff recognise and care for those patients living with cognitive impairment.

Staff we spoke with knew how to access these guides and where to get assistance when required. Systems for contacting the safeguarding team and social services were well established and understood by all staff we spoke with.

Although the hospital site presented a challenging physical environment for people living with limited mobility, the trust had building services which allowed access to all. We saw staff and volunteers helping to advise and direct visitors to the best access and routes were signposted.

On the wards and units we visited, we saw clear advice and guidance on how to make a complaint about the service. This was mirrored on the trust website.

The trust had an integrated discharge team and we saw that discharge information was monitored through daily operational meetings such as board rounds and multi-disciplinary case conferences.

In the previous 2017 inspection, we saw several mixed sex breaches where male and female patients had to cross an area used by the opposite sex in order to access bathroom facilities. On this inspection, this had reduced. While we saw a breach in the acute medical assessment unit and renal inpatient unit, managers acknowledged the challenges presented in these particular areas where unplanned admissions occurred with patients needing access to urgent specialist treatment. Staff we spoke with explained that patients were promptly transferred to the appropriate bay or single room accommodation whenever possible. In the meantime, the patient was screened to help preserve their dignity. Breaches were reported and monitored by the division.

Staff and managers expressed their expectation that this issue would be improved further when the new build was completed. We saw examples of the improved accommodation in the newly opened ambulatory unit and we noted that we did not see any breaches in the other wards and units we visited.
Average length of stay

*Trust Level*

From April 2017 to March 2018 the average length of stay for medical elective patients at Brighton and Sussex University Hospitals NHS Trust was 3.2 days, which is lower than the England average of 6.0 days. For medical non-elective patients, the average length of stay was 6.8 days, which is similar to the England average of 6.4 days.

**Elective Average Length of Stay – Trust Level**

![Bar chart showing average length of stay for electives specialties]

*Note: Top three specialties for specific trust based on count of activity.*

Average length of stay for elective specialties:

- Average length of stay for elective patients in respiratory physiology is similar to the England average.
- Average length of stay for elective patients in cardiology is similar to the England average.
- Average length of stay for elective patients in gynaecological oncology is lower than the England average.

**Non-Elective Average Length of Stay – Trust Level**

![Bar chart showing average length of stay for non-electives specialties]

*Note: Top three specialties for specific trust based on count of activity* 

Average length of stay for non-elective specialties:

- Average length of stay for elective patients in geriatric medicine is lower than the England average.
- Average length of stay for elective patients in general medicine is similar to the England average.
- Average length of stay for elective patients in respiratory medicine is lower than the England average.

**Royal Sussex County Hospital**

From April 2017 to March 2018 the average length of stay for medical elective patients at Royal
Sussex County Hospital was 3.5 days, which is lower than England average of 6.0 days. For medical non-elective patients, the average length of stay was 7.1 days, which is higher than England average of 6.4 days.

**Elective Average Length of Stay - Royal Sussex County Hospital**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This Site</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>3.5</td>
<td>6.0</td>
</tr>
<tr>
<td>Cardiology</td>
<td>2.9</td>
<td>2.6</td>
</tr>
<tr>
<td>Gynaecological Oncology</td>
<td>3.5</td>
<td>4.3</td>
</tr>
<tr>
<td>Nephrology</td>
<td>4.2</td>
<td>11.4</td>
</tr>
</tbody>
</table>

Note: Top three specialties for specific site based on count of activity.

Average length of stay for elective specialties:

- Average length of stay for elective patients in cardiology is similar to the England average.
- Average length of stay for elective patients in gynaecological oncology is lower than the England average.
- Average length of stay for elective patients in nephrology is lower than the England average.

**Non-Elective Average Length of Stay - Royal Sussex County Hospital**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This Site</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>7.1</td>
<td>6.4</td>
</tr>
<tr>
<td>General Medicine</td>
<td>5.4</td>
<td>5.9</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>10.1</td>
<td>9.5</td>
</tr>
<tr>
<td>Cardiology</td>
<td>5.5</td>
<td>5.3</td>
</tr>
</tbody>
</table>

Note: Top three specialties for specific site based on count of activity.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is lower than the England average.
- Average length of stay for non-elective patients in geriatric medicine is higher than the England average.
- Average length of stay for non-elective patients in cardiology is similar to the England average.

**Meeting people’s individual needs**

The service took account of patients’ individual needs. The trust employed specialist nurses to support ward staff. This included a dementia service and link or champion nurses who provided support, training and resource to help promote best practice.

We saw dementia friendly environments in the units and wards, where the signage and decor used bold colours and fittings such as large font day/date clocks to aid orientation. The service used ‘forget-me-not’ flower pictograms to help visiting staff identify patients living with dementia, or
those with short term memory loss or confusion. The flower symbols were placed next to the patient’s name on their bed and also used on the patient status board in the ward office. On Emerald Unit, we saw the use of distraction techniques, such as the provision of ‘twiddle muffs’ and on Jowers ward we saw the use of patterned blankets to help patient identify their own beds.

We saw pictorial aids available for use for people with communication difficulties.

Each bed had a call bell in place and within reach of the patient. We saw these being answered promptly by staff.

Throughout the hospital we saw leaflets and useful information on display to help patients and their relatives understand their conditions and the treatment options available. The printed information was in several languages.

Staff told us that an interpreter service was available for those patients who needed assistance.

The general environment had been designed to provide assistance for those with limited mobility. This included assisted bathrooms and lavatories, mobility aids and manual handling equipment.

Staff told us that specialist equipment such as bariatric equipment or specialist pressure relieving mattresses were available on request. This meant that the hospital was able to care for patients with mobility difficulties.

We saw staff offered snack boxes to patients who had missed mealtimes on their return from a therapy session. We saw a variety of menus in use to support the nutritional needs of patients.

The trust website used a computer programme to support users with visual impairment. The programme enabled users to highlight information within the website, which the system then read back to them. This programme was also available in numerous other languages.

**Access and flow**

People could access the service when they needed it. We saw good examples of bespoke computer systems to help ensure people had timely access to initial assessment, test results, diagnosis and treatment.

The trust provided portering and internal mail systems to facilitate the delivery of stores, medication and patient files. We also saw a pneumatic tube transport system in use. Staff told us this recently introduced system was popular.

Since our last inspection, we noted a range of initiatives designed to improve referral to treatment times and the impact this had on patients. We saw the newly opened medical assessment complex where GPs could directly refer patients to the hospital. This was used to reduce referral to treatment times.

The service monitored and managed medical outliers using operational meetings, which were scheduled three times a day. We saw an average low number of medical outliers in the last 12 months.

Staff in all wards described initiatives used to expedite discharge and support patient flow through the hospital. For example, discharge planning was discussed with night staff who assisted in getting patients ready the morning of discharge. Patient transport services were arranged in advance and private services contracted in to help ensure transport teams had the capacity to include the patient.

We visited the discharge lounge in the Barry Building and spoke with patients, staff and managers about the rapid discharge arrangements. Where possible discharges took place at 10am to allow
beds to become available sooner in the day. Data from June 2017 to August 2018 showed the percentage of discharges before midday in the medicine division had steadily improved.

Staff and managers expressed pride in the improvements the service had achieved in managing performance and patient flow despite the recognised limitations in bed capacity. For example, staff expressed pride in the way the hospital provided medical support to large public events such as the gay pride festival.

All of the staff we spoke with looked forward to the capacity improvements the new build would help to achieve. Most staff commented on the “positive feel” about the future now they could all see the new building taking shape.

Referral to treatment (percentage within 18 weeks) - admitted performance

From June 2017 to June 2018 the trust’s referral to treatment performance was consistently worse than the England average.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Six medical specialties at the trust were above the England average for admitted RTT pathways (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>100.0%</td>
<td>97.0%</td>
</tr>
<tr>
<td>Neurology</td>
<td>96.5%</td>
<td>91.3%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>100.0%</td>
<td>94.4%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>97.8%</td>
<td>92.8%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>90.8%</td>
<td>82.2%</td>
</tr>
<tr>
<td>General medicine</td>
<td>100.0%</td>
<td>96.4%</td>
</tr>
</tbody>
</table>

There were also two medical specialties at the trust that were below the England average for admitted RTT pathways (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>51.5%</td>
<td>82.1%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>90.5%</td>
<td>93.7%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Patient moving wards per admission
The trust has reported the number of ward moves for non-clinical reasons for the period May 2017 to April 2018. They have provided details of ward moves for the five wards with the highest number of non-clinical ward moves. However, none of these were medical care wards.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night

From May 2017 to April 2018, there were 2,364 patient moving wards at night within medicine. At site level, there were 1,747 ward moves at night within medicine at Royal Sussex County Hospital and 617 at Princess Royal Hospital.

(Source: Routine Provider Information Request (RPIR) – Moves at night)

Learning from complaints and concerns

The Division treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. We saw examples of incident and complaint investigations that had been communicated to staff through ward and divisional meetings.

We saw advice leaflets readily available on the wards and departments we inspected. Patients had access to the Patient Liaison and Advice service, who supported patients with concerns and complaints and provided information about NHS services.

Staff confirmed that complaints were discussed at clinical governance meetings and information disseminated to staff through team meetings and briefings. We reviewed a sample of team meeting minutes and saw that complaints were discussed and monitored.

Staff could access the complaints policy on the trust’s intranet and knew how to direct patients to make a complaint. Medical and nursing staff told us that they received feedback from any complaint they had been involved in.

Patients we spoke with said they would raise any issues or concerns with the ward staff in the first instance and were aware that a complaints process existed. The trust website provided clear information on how to make a complaint and also had links on how to join the trust patient experience panel.

The most recent national complaints guidance, and the approach supported by the Parliamentary and Health Service Ombudsman (PHSO) is to remove a requirement on NHS providers to adhere to specific response times. The focus is on the individual, making sure there is a quick acknowledgement, early engagement with the patient and to seek to resolve the complaint to their satisfaction. We reviewed five complaints and found the trust had consistently investigated and responded to the complaints in this way. In all five responses, we saw the trust had completed thorough investigations, supported people and explained outcomes to the person. Duty of Candour had been applied correctly.

The trust did however work to a 25 working day response target. This target was not published or shared with the complainant it was an internal driver to make sure complaints were investigated in a timely way.

Summary of complaints

From April 2017 to March 2018 there were 44 complaints relating to medical care. The trust took an average of 49 days to investigate and close complaints.
Of the 44 complaints received for medical care, 43.2% were concerning access to treatment or drugs, 20.5% related to admission and discharges and 11.4% of the complaints related to patient care.

- Royal Sussex County Hospital: There were 32 complaints relating to medical care. Of these, 16 complaints related to access to treatment or drugs (50.0%), five related to admission and discharges (15.6%), and four related to patient care (12.5%).

- Princess Royal Hospital: There were 12 complaints relating to medical care. Of these, four complaints related to admission and discharges (33.3%) and three complaints related to access to treatment or drugs (25.0%).

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

**Number of compliments made to the trust**

From April 2017 to March 2018 there were 80 compliments within medicine.

The breakdown by site is shown below;

- Royal Sussex County Hospital: 46 compliments
- Princess Royal Hospital: 32 compliments
- ‘Other’ sites at the trust: two compliments

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

**Is the service well-led?**

**Leadership**

Since our last inspection, the trust had rationalised the number of divisions from 10 to five and refocused on triumvirate divisional leadership.

The triumvirate consisted of an operational manager, a clinical director and a lead nurse who worked together to support and manage all aspects of their directorate. Each member had a clear role and responsibilities.

The medical division was divided into three functional groups: the ‘acute floor’ directorate, speciality medicine directorate and a ‘specialised division’ comprising cardiology, renal medicine and neurology.

Overall, we saw good examples of strong local ward and department leadership. The service had clinical and operational managers with the right skills and abilities to run a service providing high-quality sustainable care.

Compared to our last visit, staff at all levels now said they felt well-supported, valued and that their opinions counted. All ward managers we spoke with knew what their wards were doing well and could clearly articulate the challenges and risks their team faced in delivering good care.

Staff spoke in very positive terms about the visibility of the executive management team in addition to their divisional leadership. Many commented that “things had really improved” over the last year. In addition, staff we spoke with gave positive reviews of their ward managers.

There was also overwhelmingly positive praise for the chief executive and chief nurse. In addition, staff appreciated the ‘stability’ in the board compared to past interim appointments and high turnover.
Our findings were consistent with the last NHS staff survey, where improvements were noted in the responses to 10 of the 11 questions about management and communications.

**Vision and strategy**

The trust had adopted and developed a strategy called ‘Patient First.’ Introduced into the hospital last year, the model is similar to a strategy used by the executive team in their previous trust.

The strategy is presented visually as a triangle, with the patient shown at the apex with layers underneath showing the supporting trust values, strategic themes and foundations that help to enable the desired improvements.

The strategic themes are then translated into objectives for the trust. Senior managers explained that the three to five-year goals were broken into “True North” objectives. These acted as drivers for the divisional objectives and plans.

Overall, we found that the ‘Patient First’ trust strategy was embedded and understood by staff at all levels. Compared to our last inspection, medical services had a clearer vision for what it wanted to achieve and workable plans to turn it into action, developed with involvement from staff, patients, and key groups representing the local community.

As we toured the wards and departments, we saw poster displays and other publications about the vision and values. These were readily available for staff, patients and the public to view. In addition, the trust published information about its mission, values and vision on its public website.

**Culture**

We found significant improvements in the way managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff we spoke to confirmed this and described in positive terms how they felt more appreciated, supported and enjoyed their work.

Examples included the way the division had already benefitted from new facilities, with more environmental changes in prospect. For example, senior divisional managers benefitted from the new trust headquarters, which had moved closer to the emergency department and contained the operational centre. This provided a better venue for an operational hub that had new video conferencing facilities for dual site briefings and ‘bed state’ meetings.

We saw that safety and improvement ‘huddles’ had been embedded within the division and these included housekeeping and estates teams.

We observed a series of these meetings as well as ward handovers and medical case conferences, which included representatives from nursing and therapy groups as well as liaison representatives from external agencies. These were conducted effectively and supported by standing agendas and note-takers to record agreed actions. Staff spoke in very positive terms about multidisciplinary team working in order to provide high quality care.

Staff said they understood the trust whistleblowing policy and would feel comfortable using it if necessary. We also saw information displayed on the wards advising staff of the whistleblowing procedure. This suggested the trust had an ‘open culture’ in which staff could raise concerns without fear.

Staff we spoke with could describe the trust’s ‘speak up guardian’ and without exception described positive changes in the culture of the trust.
Governance

The trust operated a divisional governance model and ‘triumvirate working’. This was a structure which ensured that both clinicians and managers were involved in the management and planning of hospital activities at every level.

There were clear lines of accountability from ‘ward to board’ through the directorate governance structure. Staff we spoke with were clear about their roles and responsibilities and who or what they were accountable to or for. Each of the triumvirate leadership teams had responsibility for designated wards and departments.

The trust had recently approved a new governance model, which was being implemented at the time of our inspection. We were shown the organisational diagram that detailed lines of responsibility as well as a standing timetable that harmonised sub-committee and committee meeting schedules.

There were 35 sub-groups with oversight on topics ranging from medical devices to safeguarding reported via five main committees to the quality governance steering group, which reported to the board.

We reviewed the minutes of divisional meetings, which demonstrated that regular team and management meetings took place. The minutes documented how information on incidents and complaints were investigated and any learning shared and good practice promoted.

There were managerial updates as well as a focal topic related to the ‘issue of the week’ which during our inspection was Sepsis. All actions within the meeting were allocated an accountable person with a date for review and completion.

However, we found that fire risk assessments on one ward had actions outstanding. We were told the outstanding actions were discussed at divisional level, but we saw no evidence of these actions being addressed.

Management of risk, issues and performance

We viewed ‘up to date’ divisional risk registers, which helped to demonstrate that the trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

We found that quality improvement methodology was well embedded into the wards and units we visited.

As part of the ‘patient first’ initiative, we saw good examples of ‘lean’ tools in use and the improvement plans we read included systematic approaches to identifying and monitoring performance targets.

The department had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

There was a risk register in place to record risks within the division. Each risk was given an initial risk score and a current risk score after risk reductions strategies had been put in place. There were 19 risks recorded on the risk register for the division, was categorised into a minor,
moderate, major or extreme risk. Out of these, one was classed as a minor risk, 10 as moderate, 8 as major. The risk register had an explanation of the risks, and who had overall responsibility for the risk, ensuing existing risk controls and actions were completed for each identified risk. The highest risks related to capacity, patient flow and staffing.

The senior staff we spoke with were clear about the challenges the department faced and they were all committed to improving the patients’ journey and experience. Where national audits had demonstrated a weakness in clinical practice the senior clinical team ensured that action plans were developed and re-audit programmes undertaken to ensure improvements to patient outcomes.

The trust had access to trust infection prevention and control policies and procedures, and took part in the auditing of clinical practice.

**Information management**

Training records had improved since our last inspection and the trust were able to capture accurate compliance to mandatory training information.

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. The trust’s website provided safety and quality performance reports and links to other web sites such as NHS Choices. This gave patients and members of the public a range of information about the safety and governance of the hospital.

National and local audits were shared electronically to support continued improvement of practice. Staff had access to up-to-date accurate information on patients’ care and treatment.

Staff were aware of how to use and store confidential information. Information governance training was part of the trust’s statutory and mandatory training requirement for all staff. We saw data that demonstrated divisional staff information governance training met or exceeded trust targets.

**Engagement**

The trust engaged well with patients, staff, the public and local organisations to plan and manage services, and collaborated with partner organisations effectively.

The trust involved patients and the public in developing services by involving them in the planning, designing, delivering and improvement of services. The various means of engagement included a range of patient participation groups including the Stakeholder Forum, League of Friends and Healthwatch, feedback from the Friends and Family Test and inpatient surveys.

For instance, public events have been held to discuss the current building works and how this would affect patient services with a chance to ask questions of the project team. There were also regular newsletters published with updates on progress.

We saw positive examples of local engagement during our visit. We spoke with hospital volunteers who were talking and reading with patients, helping out with meals and drinks. We learned of a student volunteer programme for young adults who provided company to patients in the evening or at mealtimes. Emerald unit managers told us about carers groups, where family and friends could meet and support each other.
The management team told us that any good ideas put forward by staff were discussed at weekly ward meetings and monthly team meetings. We saw examples of these posted on ward ‘patient first’ display boards.

The trust had implemented Pulse surveys to engage with staff. These provided the service a monthly snapshot of their staff engagement levels, in addition to the national staff survey. The survey comprised of 13 questions; nine were key engagement questions, one focused on equality and diversity and the remainder focused on communications and ‘patient first’.

The trust’s 2018 Pulse survey results showed that all nine engagement questions had an increased level of engagement with respondents answering positively, including the trust’s “People breakthrough” objective. The trust’s overall engagement score indicated an increase from 3.63 to 3.78, based on 1462 staff. In the trust’s quarter four Staff Friends and Family Test, the results demonstrated 66.7% of staff would recommend the trust as a place to work and 47.0% would recommend the trust as a place to be treated.

Staff at all levels were happy to tell us they felt informed and involved with the day-to-day running of the service and its strategic direction.

All staff we spoke with during inspection advised us there were regular staff meetings and that management arranged these for different times and days to ensure all staff could regularly attend.

We saw posters around the hospital promoting employees who had won peer recognition. These were called ‘Patient First Star Awards’.

**Learning, continuous improvement and innovation**

Staff at all levels demonstrated a willingness to develop and improve the service provided. The ‘Patient First’ strategy promoted multidisciplinary working and engagement.

Staff consistently told us they could make suggestions to improve patient care and keen to give examples of improvements made to patient care. Examples include the use of anti-slip socks; distraction gloves and patterned bed covers. The trust recognised and rewarded its staff for the work they did to improve quality.

We saw the “Small Acts of Friendship” service on care of the elderly ward had staff involved with the design and implementation of this scheme. All patients we spoke with were full of praise for the scheme.

We found the “picture blanket project” initiative had reduced falls and promoted the dignity of elderly patients.

Other initiatives we saw in the division included the work on reducing violence and aggression to staff. For example, staff used the Brosset Tool checklist and attended Swartz rounds (evidence-based forum for staff to come together to talk about the emotional and social challenges of caring for patients). We saw staff contributed to the multidisciplinary improvement huddles which are short and succinct ‘standing only’ meetings conducted at the ‘Patient First’ visual display for all staff to discuss suggestions and the rationale for those ideas.

The service had also taken various actions to improve patient flow and discharges such as:

- Weekly inpatient discharge planning meeting to improve discharges before midday
- Daily board rounds and huddles
• Good use of discharge lounge
• Working with system partners to improve delayed transfer of care position
• Early reviews of medical outliers prioritised by specialty teams and zoning of clinical areas to ensure consistent care, which had resulted in low numbers of medical outliers throughout the year.
• The review of the trust Escalation and Surge policy
• Trialling of a new medical flow manager
• Roll out of “Patient First” programme on medical wards

### Surgery

### Facts and data about this service

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

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

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

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

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

There are 151 surgical beds across four wards. On Level 9a there are 58 beds for Upper/Lower Gastrointestinal and emergency surgery and digestive diseases. Level 8a East has 24 beds for Trauma and Orthopaedics. Level 8a West has 32 beds for neurovascular, spinal and ear, nose and throat surgery. Level 8 Tower has 37 beds for vascular assessment and surgery. We visited Sussex Eye hospital which undertakes all ophthalmic surgery and has its own theatres and pre-assessment area.

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

(Source: Hospital Episode Statistics)

During the inspection we spoke to 14 patients, two relatives, 41 hospital staff and looked at 13 sets of patient records.

### 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 set a target of 90% for completion of mandatory training.

### Mandatory Training Completion by module – Nursing and Midwifery Staff

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible staff</th>
<th>Compliance rate</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Safety Training</td>
<td>242</td>
<td>253</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety Training</td>
<td>239</td>
<td>253</td>
<td>94%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention – Clinical</td>
<td>231</td>
<td>252</td>
<td>92%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>231</td>
<td>253</td>
<td>91%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - patients</td>
<td>199</td>
<td>252</td>
<td>79%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults at Risk</td>
<td>237</td>
<td>252</td>
<td>94%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children and Young People - level 2</td>
<td>214</td>
<td>243</td>
<td>88%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Additional Data Request (ADR) – 74)

### Mandatory Training Completion by module – Medical and Dental Staff

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible staff</th>
<th>Compliance rate</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Safety Training</td>
<td>118</td>
<td>139</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety Training</td>
<td>113</td>
<td>139</td>
<td>81%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention – Clinical</td>
<td>109</td>
<td>139</td>
<td>78%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>110</td>
<td>138</td>
<td>79%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - loads</td>
<td>126</td>
<td>138</td>
<td>91%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults at Risk</td>
<td>120</td>
<td>139</td>
<td>86%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children and Young People – level 2</td>
<td>109</td>
<td>129</td>
<td>84%</td>
<td>No</td>
</tr>
</tbody>
</table>

Statutory and mandatory training compliance whilst not achieving the trust target of 90% for all staff groups, did show an overall improvement since the last inspection.

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Weekly meetings tracked progress and time was given to complete training in work time.

Compliance was monitored by human resources, all wards and departments had access to the electronic system to show what percentage of staff had attended training. On several wards managers had printed this out and there was evidence of forward planning to ensure staff planned to attend training and at a glance staff could see training they still had to attend.

Clinical leads had responsibility for ensuring all staff completed training and demonstrated how this was monitored. At Sussex Eye hospital we viewed the electronic system and saw that compliance for all their staff for training was on average between 88% to 100% with the current average at 90% achieving trust target.

Theatres at that site had evidence of tracking training and had a plan to be fully compliant. In main theatre staff tracked their compliance to training and generally found they could complete what they needed to do in work time. Ward 8a West demonstrated 93% compliance.

Staff received mandatory training on patients with complex needs such as mental health needs and dementia. The training strategy for the whole trust had been reviewed and was being
implemented. Across the trust there was 88% compliance for dementia training.

Staff had access to a Statutory and mandatory training policy which set out which training staff had to complete and how often training should be repeated. The policy contained a training matrix showing what training each level of staff had to complete. Staff told us that they knew what they had to achieve.

Staff were committed to achieving compliance and described the electronic system for eLearning as easy to use. Staff told us that generally they could complete the required training in work hours but they were also able to access the system at home if necessary.

Staff received training in recognising and managing deteriorating patients including those with confirmed or suspected sepsis. This was monitored and where compliance was low, or additional training needs identified, the sepsis team provided focused training.

**Safeguarding**

Nursing staff had achieved the trust target for adult safeguarding training and were close to target on safeguarding children training. Medical staff had an improved compliance on last year but had not yet achieved target. This was an improvement since the last inspection.

All staff had access to Safeguarding Adults policy which included reference to Prevent, one part of the government counter terrorism strategy.

The Chief Nurse was the executive lead for safeguarding. On all wards and departments there was a laminated poster showing the service leads for safeguarding, how to escalate concerns and the contact numbers. The poster was also a reference point for visitors if they had any concerns and available contacts were clearly shown.

Staff demonstrated an understanding of their safeguarding responsibilities and the procedures to follow if they had a concern. Staff gave an example of making a referral when a patient was to be discharged but had no family support. They referred to the safeguarding lead and following care and support this influenced the eventual discharge of the patient.

**Cleanliness, infection control and hygiene**

The theatre department displayed the National Specification of Cleanliness (NSC) checklists and there was a process in place to ensure deep cleaning of the theatre was carried out on a six-monthly basis, last done in August 2018. This was an improvement on the last inspection.

The theatre department was complying with The Health and Safety (Sharp instruments in Healthcare) Regulations 2013, which states that healthcare providers must use safer sharps. On this inspection we saw a change of product had been made and safe cannula were put into use.

The use of safety needles had been assessed and with no risk demonstrated this has not been adopted. Sharps disposal was managed safely and seven containers checked were dated and signed. This was an improvement on the last inspection.

Staff audited the cleanliness of the theatre, daily and weekly cleaning lists were fully completed. Recovery cleaning was carried out prior to patients being admitted. On the day of inspection, the unit appeared clean and dust free.

Staff used control measures to prevent the spread of infection. All staff we saw in the clinical area were bare below the elbows to prevent the spread of infections in accordance with national guidance.

There was alcohol-based hand gel at the entrance to ward areas and through the department. Notices reminded staff and visitors about the importance of hand hygiene. We saw that staff
washed their hands and used gel before and after treating patients in accordance with the World Health Organisation ‘Five moments for hand hygiene’. There was access to hand wash sinks in bays and side rooms.

Staff could take precautions to prevent the risk of cross infection. Staff explained that single rooms on all the ward areas could be used if a patient had an infection. One ward had a patient being barrier nursed and the cleaning staff had received training on how to manage that patient.

Throughout surgical wards and theatres there was access to personal protective equipment such as gloves and aprons and these were available in sufficient quantities.

In theatres staff wore appropriate theatre attire, such as theatre scrubs, hats and masks and staff were bare below the elbow. We observed good scrub technique and aseptic non-touch technique (ANTT) in main theatres and in the theatres at the Sussex Eye hospital.

Theatre staff followed National Institute for Health and Care Excellence (NICE) guideline (CG)74, Surgical Site Infection’ this included skin preparation and management of post-operative wound. Information about the infection prevention team with photos and contact details were on all wards and departments. Infection Prevention and Control (IPC) link persons were in each ward and theatre. We met the links in theatre and ward Level 9 and they could discuss their responsibilities including hand hygiene and what actions they were taking with staff who were not complaint.

Hand hygiene results were available on the ward. On ward 8 Tower we saw the results that showed all nurses, healthcare assistants and housekeeping staff were fully compliant. Medical staff were 86% complaint and we saw staff were addressing this by reminding those staff of the importance of correct procedures.

Housekeeping staff on ward 8 Tower demonstrated colour coding of mops and buckets in line with policy, understood the care of the mops and when they were laundered. The Cleaners’ cupboard was secured with housekeepers only having access.

All wards and theatres displayed up to date cleaning schedules and their environmental risk assessments. For example, wards 8a East and 8a West had their cleaning audit score displayed within the area and all scores met the standards in accordance with the risk category they were in with regards to the National Specification of Cleanliness (NSC) in the NHS.

We asked for evidence that the theatres were safe to operate from a ventilation / air change perspective. We were shown the theatre verification programme which currently runs from May 2018 to February 2019. All theatres appeared on the verification programme. The theatres are shut down for 8 days with a further 2 or 3 days built in to the plan as contingency. We were told, following the work, if the theatre is not to the standard required it would not be handed over to the clinicians and further work would be undertaken.

The test criteria used when verifying the theatre ventilation was the one recommended in HTM 03-01 and this gave the recommended supply and extract supplied to and from theatre suites. We saw evidence of theatre verification reports that were undertaken by a specialist company and each theatre was verified annually which was in line with HTM 03-01.

Wards and theatres had effective processes for in place for the separation and disposal of waste.

An annual infection control report presented to the board in September 2018 showed actions taken against previous years objectives.

Between September 2017 and August 2018 there were no Methicillin-resistant Staphylococcus aureus (MRSA) blood stream infection, assigned to the trust, against an NHS objective of no avoidable blood stream infections.
The trust could not be confident it identified all patients with Methicillin-resistant *Staphylococcus* aureus to make sure appropriate infection prevention precautions were in place. Screening of patients pre-operatively for carriage of Methicillin-resistant *Staphylococcus* aureus (MRSA) has been a Department of Health recommendation since 2007.

Patients would be screened for Methicillin-resistant *Staphylococcus* aureus (MRSA), either prior to admission as an elective patient, or on admission as an emergency patient. Patients could also be screened regularly during their admission. We asked the trust for their compliance rates for screening of patients for Methicillin-resistant *Staphylococcus* aureus (MRSA). The trust informed us they do not monitor screening rates.

The trust took part in the Public Health England (PHE) surgical site infection surveillance service (SSISS). This allowed the trust to benchmark its infection rates against other trusts and identify areas for improvement. The trust supplied surgical site infection (SSI) knee replacements.

There were procedures in place to reduce the risk and monitor for signs of surgical site infections (SSI) in line with the National Institute for Health and Care Excellence (NICE) clinical guidance (CG) 74 Surgical site infections: prevention and treatment. Staff described their awareness and the importance of following procedures for the reduction of surgical site infection.

As part of the surgical site infection surveillance service, the trust sent out post-operative questionnaires to patients. This helped them identify more patients who developed a SSI after discharge but did not receive further treatment at the trust.

The trust’s total knee replacement surgical site infection report for January to March 2018 showed 0.9% of patients developed a surgical site infection following knee replacements during this period. This was worse than the average infection rate of 0.4% for other hospitals that sent patient questionnaires during the same period.

Between September 2017 and August 2018, there were seven cases of *Clostridium* difficile (C.diff) in the surgical directorate, four of which were at the Royal Sussex County Hospital site. *Clostridium* difficile is a type of bacteria, which can infect the bowel and cause diarrhoea.

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. We saw from the three cases, all three had an identified ‘lapse of care’. One was due to a delay in isolation, the second was antibiotics not prescribed in line with policy, the third was due to a delay in sending a specimen.

We saw each case of *Clostridium* difficile had been investigated through a process of root cause analysis (RCA), with outcomes and lessons learned shared with staff. We looked at one of the root cause analysis investigation reports, which had been completed, with recommendations and action plans, which confirmed the process.

Data supplied to us showed between September 2018 and August 2018, there were seven cases of Meticillin-sensitive *Staphylococcus* aureus (MSSA) blood streams infection (BSI) in the surgical directorate. Four of these were at the Royal Sussex County Site. There is currently no NHS Improvement objective for MSSA BSI.

Data supplied to us showed that between September 2017 and August 2018, there had been 17 *Escherichia coli* (E.coli) blood streams infection (BSI). Fifteen of these were at the Royal Sussex County Hospital Site. NHS Improvement requires all trusts to reduce gram-negative bacteria (such as *Escherichia coli*), by 50% by 2021.
Environment and equipment

The theatre department and recovery were seen to be tidy and organised. We noted that the Association of Anaesthetic of Great Britain and Ireland safety guidelines ‘Safe Management of Anaesthetic Related equipment (2009) was consistently adhered to as signatures to confirm a daily check of the anaesthetic machines were complete. This was an improvement on the last inspection when we saw that checks were not consistently made.

On this inspection we checked four anaesthetic machine log books and all signatures were complete with no gaps. The log books were located by each anaesthetic machine but the serial number of the equipment was not documented. This was mentioned to staff and we noted the next day serial numbers were added to the log books.

Three anaesthetic machines at Sussex Eye hospital were checked, serial number of machine was recorded and all checks were complete with no gaps.

In all wards checked, theatres and recovery unit we found Control of Substances hazardous to health (COSHH) to be managed safely. On wards Level 8a East and 8a West we found the control of substances hazardous to health folders had risk assessments and safety data sheets pertaining to all the cleaning chemicals found in the cleaning cupboards. All risk assessments and safety data sheets were in date and all had a review date.

All folders were as would be expected and in compliance with COSHH regulations 2002. These regulations provide a framework to help protect people in the workplace against health risks from hazardous substances used directly in the workplace e.g. cleaning chemicals. Staff had signed the folders as evidence of reading. Temporary or agency staff were not required to sign but the ward manager was starting this immediately.

The cleaning cupboards inspected on the wards 8a East and West had swipe card access and were locked at the time of inspection and all had the pictorial signs showing the chemicals in use. We also saw the cleaning trolleys with lockable compartments and of the ones inspected all were locked at the time of inspection.

On ward Level 8a East we looked at nine pieces of medical equipment checked, two were out of date with their service schedule, one had no record of service and one was out of date with September 2016 as their next expected service date. We fed this back to staff and these pieces of equipment were removed immediately from use and the central equipment library was contacted to remove them from the ward and make necessary checks.

Equipment in theatre was generally seen to be clean and in a good state of repair. However, of nine pieces of equipment checked four appeared to be out of date with service schedule. All were due in 2018, one in February, one April, one May and one June. In Sussex eye hospital there was one piece of equipment out of 10 checked across wards and theatres that had no service date sticker.

Theatre ventilation group minutes demonstrated that risks and issues are discussed every month and action plans produced. Clear governance around the verification testing which included ventilation and having sufficient air changes was in place. There were clear routes of escalation should this be required. The verification of theatres was ahead of schedule and taking place and compliant with HTM 03-01.

All wards had safety checks they completed. On ward Level 9 the ward manager was responsible for checking controlled drug levels, fire exits, fridge and ambient room temperatures and general stock levels. We saw that checks were complete for the past month.
Other ward areas there was a stock technician employed who made similar safety checks including resuscitation trolleys on all areas and all checks were seen to be complete for the past two months. Staff felt the role of the technician positively affected the safety of the wards as the regularity of the checks was checked and audited.

Five resuscitation trolleys were checked in wards, theatres and the eye hospital. All were tamper evident and daily external checks were complete, weekly content checks were also complete. On ward 8a East the trolley was opened to do a full content check and this was correct with all equipment in date. In the theatre admission unit, the resuscitation check list had two missing signatures but this was checked and corresponded to the unit being closed and staff were reminded to add this information to the log book.

There was a difficult airway trolley in main theatre and in the eye hospital which were checked, and noted to be correct with all equipment in date.

Lead aprons in main theatre were stored correctly on hangars to minimise any damage, they had serial numbers and were radiographically checked in line with regulation.

On ward Level nine we saw evidence that a fire risk assessment had been carried out in August 2018. The Fire risk assessments (FRA) are either carried out annually or every two years dependent on amount of staff, patients and visitors that can potentially be within the ward or department. On ward Level 8a East, of the 18 actions identified within the fire risk assessment, nine were completed and nine remained outstanding.

On ward Level 8A West of the 19 actions identified, 13 were complete and six remained outstanding. We were told the outstanding actions were discussed at divisional level, but we saw no evidence of actions following the meetings as actions remained outstanding.

There was evidence that major incident training and a desk top exercise was carried out on wards and theatres within the last year.

**Assessing and responding to patient risk**

Patient pre-assessment for most of the surgical cases was carried out at the Princess Royal Hospital. The Sussex Eye hospital undertook its own pre-assessment which was nurse led. Co located to the ward, the clinic followed an up to date policy for assessing patients for eye surgery. Following set criteria, complex patients were referred for anaesthetic assessment. Weekly debriefs between the nurse and anaesthetist allowed a review of those patients seen and the efficacy of the service.

In the main theatre department, we observed theatre staff carrying out the World Health organisation (WHO) ‘Five Steps to Safer Surgery’ we saw that all steps of the process were fully completed. This was an improvement on the last inspection when we observed that the final step of debriefing was not completed which indicated the process was not consistently completed.

We observed a theatre department briefing that was carried out every morning at 08.00am where any safety messages, learnings and staffing issues were communicated to staff. Before the start of each operating list there was a team briefing in line with the WHO checklist. This briefing discussed any risks, allergies or equipment requirements to minimise any potential risk to the patient.

During the inspection we observed on three separate occasion the sign in, time out and sign out of the process. One of these observations was at the Sussex eye hospital where the surgery safety checklist for cataract surgery was in place. We saw two debriefings in main theatre and saw all
staff fully engaged and participating. We noted that there was ongoing audit and research into the debriefing process to ensure the process was robust and develop further.

Data supplied to us showed the completion of the checklist compliance for the surgical division at Royal Sussex County Hospital for the weeks commencing, 6, 13, 20 and 27 August 2018, was 100%. For the Sussex Eye Hospital, we saw for weeks commencing 6 and 13 August 2018, the check list compliance was 90%, this improved to 100% for 20 and 27 August 2018.

Consultant surgeons and anaesthetists attended a weekly meeting to discuss complex patients who were for surgery. This enabled appropriate risk assessment and treatment plans to be made which were discussed with the patient and relatives.

To ensure the safe management of patients in theatre, one staff member was allocated to coordinate the flow of emergency patients and one staff member coordinated the trauma list.

Recovery had patient discharge criteria incorporated into the perioperative care pathway to make sure patients were safely recovered from anaesthetic before returning to the ward. Copies of this were also available at the bedsides in recovery.

The department had developed a number of local safety standards for invasive procedures for example the requirement to ‘stop before you block’ (injection of local anaesthetic to an area to provide pain relief). These standards were discussed at the perioperative standards forum and theatre safety bulletins were circulated to all staff.

Sussex Eye hospital managed an occasional paediatric list. We noted the use of a paediatric anaesthetist, and completed competencies for nursing staff. There was anaesthetist support during the recovery of the child.

The staff at Sussex eye hospital had access to a current emergency transfer policy for a deteriorating patient.

Staff on the surgical wards managed patients who were at risk of deteriorating safely. The National Early Warning Scores (NEWS) tool was in place across the service, to monitor the patient and to identify patients at risk of unexpected deterioration, in line with National Institute for Health and Care Excellence (NICE) Guidance.

We checked six NEWS scores and they were fully completed. These recordings and scores were regularly audited and compliance across the ward areas was tabulated so results could be compared. It was recorded that the compliance with calculating NEWS for the previous twenty four hours varied between 62% and 90% but overall compliance to scoring was good. Results were shared with staff and an action plan aimed to improve compliance with ongoing audit.

Staff told us that that in the case of a deteriorating patient there was never any difficulty in accessing medical staff. The service used a communication tool called Situation Background Assessment Recommendations (SBAR) for both medical staff and nursing staff to use when escalating concerns about a patient’s condition.

Staff had access to and were supported by the outreach team from critical care during the hours 7.30 am to 7.30pm. Ward staff described this support as prompt and efficient and if necessary patients would be transferred to the critical care unit. From 7.30pm to 07.30am the ward staff could call the doctor on call or the night sister who would assess the patient and make a referral to the critical care team for admission if necessary. Staff felt well supported by critical care for the whole twenty-four-hour period.

The trust had a paper based screening tool and all surgical wards had information about screening and managing sepsis. The trust had reviewed its data and identified the wards that had a greater risk. Ward Level 9 was one ward identified and there was a centrally located sepsis trolley. This
enabled staff to locate all required equipment and protocol for the screening and treatment of sepsis. All checks of the trolley were fully complete.

The trust supplied a strategy document setting out its current state on managing sepsis and the vision to 100% adherence to the pathway. Sepsis champions were appointed and weekly meetings were proposed to discuss any patient that did not receive treatment appropriately.

We saw in patient records, that patients had regular falls risk assessment carried out in line with NICE guidelines (CG)161 Falls in Older People, Assuring Risk and Prevention.

There was evidence that individual wards audited and focused on any areas of concern, for example on ward 8a East we saw sign for patients saying, ‘call before you fall’ and at the safety huddle any patients at risk of falling were identified and staff checked there was a fall alarm in place. Staff also provided one to one care if a patient was thought to be at significant risk of falling.

Staff could contact the mental health team to give support to distressed patients, when necessary one to one care was available for these patients.

On ward Level 9 there was an initiative for staff to ‘take pride in their bay’ where they were working to ensure all safety and environment checks were made. This was recorded in each of the patient bay areas.

**Nurse staffing**

The trust has reported their staffing numbers below for two different times; March 2017 and April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>As at 31 March 2017</th>
<th>As at 30 April 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>All sites</td>
<td>829.6</td>
<td>947.3</td>
</tr>
</tbody>
</table>

In March 2017 the trust reported they had filled 87.6% of their planned staffing. This decreased to 86.0% in April 2018.

No site breakdown is available as the trust did not report the data at site level.

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

At the time of the inspection and looking at staff rotas the staffing within the theatre department staffing was in line with Association for Perioperative practice guidelines.

Surgical wards we visited were staffed to their agreed establishment during the inspection. Planned versus actual staffing levels and skill mix were displayed on the wards for patients and members of the public to see.

**Vacancy rates**

From May 2017 to April 2018, the trust reported a vacancy rate of 15.0% in surgery. This was higher than the trust target of 10.5% in March 2018, reducing incrementally to 9.0% by March 2019.

The breakdown by site was as follows:

- Princess Royal Hospital: 24.1%
Vacancy rates varied across the wards. On Ward Level 9 we were told there were 16 band five vacancies, and three band four. To lessen this there had been a review of skill mix and active recruitment of healthcare assistants.

All ward managers were aware of their vacancy factor and the initiatives underway such as local advertising and open days.

**Turnover rates**

From May 2017 to April 2018, the trust reported a turnover rate of 13.4% in surgery. This was better than the trust’s overall target turnover rate of 14% in March 2018 reducing incrementally to 11% by March 2019.

- Princess Royal Hospital: 6.3%
- Royal Sussex County Hospital: 24.7%

There are a number of nursing staff working in surgery which are unable to be assigned to a specific site. These staff have a turnover rate of 16.4%.

**Sickness rates**

From May 2017 to April 2018, the trust reported a sickness rate of 3.0% in surgery. This was better than the trust overall target sickness rate of 4.20% in March 2018 reducing incrementally to 3.50% by March 2019.

A site level breakdown is shown below:

- Princess Royal Hospital: 3.1%
- Royal Sussex County Hospital: 3.2%

**Bank and agency staff usage**

Please note that the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff in all cases. Therefore, we have been unable to analyse bank and agency usage as a proportion of the total shifts needing to be filled.

The table below shows the numbers of shifts in this core service from April 2017 to March 2018 that were covered by qualified nursing and nursing assistant bank and agency staff or left unfilled.

For qualified nurses, 5,282 shifts were filled by bank staff and 2,858 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses. In addition, 2,803 shifts were not filled by either bank or agency staff.

For nursing assistants, 5,221 shifts were filled by bank staff and 3 shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants. In the same period, 1,815 shifts were not filled by either bank or agency staff.
<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Qualified nurses</th>
<th>Healthcare assistants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>5,282</td>
<td>5,221</td>
<td>10,503</td>
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<tr>
<td>Agency</td>
<td>2,858</td>
<td>3</td>
<td>2,861</td>
</tr>
<tr>
<td>Not filled</td>
<td>2,803</td>
<td>1,815</td>
<td>4,618</td>
</tr>
</tbody>
</table>

Unfortunately, we are unable to provide a site-specific breakdown of nursing bank and agency usage in this core service, due to the format of the data provided by the trust.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

**Medical staffing**

The trust has reported their staffing numbers below for two different times: March 2017 and April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>As at 31 March 2017</th>
<th>As at 30 April 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>All sites</td>
<td>461.9</td>
<td>492.8</td>
</tr>
</tbody>
</table>

In March 2017 the trust reported they had filled 93.7% of their planned staffing. This decreased to 89.0% in April 2018.

No site breakdown is available as the trust did not report the data at site level.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

The medical staffing on ward 9 had been reviewed and in line with the change in structure.

Previous gaps in the middle grade rota had now been resolved through recruitment and there was a full complement of these doctors.

On call shifts for theatre were fully covered across the two sites.

**Vacancy rates**

From May 2017 to April 2018, the trust reported a vacancy rate of 15% in surgery. This was higher than the trust target of 10.5% in March 2018, reducing incrementally to 9.0% by March 2019.

The breakdown by site was as follows:

- Princess Royal Hospital: 24.1%
- Royal Sussex County Hospital: 11%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From May 2017 to April 2018, the trust reported a turnover rate of 4.2% in surgery. This was better than the trust’s overall target turnover rate of 14% in March 2018 reducing incrementally to 11% by March 2019.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)
Sickness rates
From May 2017 to April 2018, the trust reported a sickness rate of 0.8% in surgery. This was better than the trust overall target sickness rate of 4.20% in March 2018 reducing incrementally to 3.50% by March 2019;

A site level breakdown is shown below:
- Princess Royal Hospital: 0.0%
- Royal Sussex County Hospital: 0.4%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage
From April 2017 to March 2018, the trust reported that 4,119 shifts within this core service trust-wide were filled by bank staff and 1,025 shifts were filled by locum staff. There were 675 shifts which were not filled by either bank or locum staff. A breakdown of bank and locum usage by staff type at the trust is shown below.

Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
<th>Unfilled shifts</th>
<th>Total shifts (bank + locum + unfilled)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>658</td>
<td>525</td>
<td>42</td>
<td>1,225</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>2,842</td>
<td>492</td>
<td>559</td>
<td>3,893</td>
</tr>
<tr>
<td>Junior</td>
<td>619</td>
<td>8</td>
<td>74</td>
<td>701</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,119</strong></td>
<td><strong>1,025</strong></td>
<td><strong>675</strong></td>
<td><strong>5,819</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix
In March 2018, the proportion of consultant staff reported to be working at the trust was the same as the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the whole time equivalent staff working at Brighton and Sussex University Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>49%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>5%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>39%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>7%</td>
<td>11%</td>
</tr>
</tbody>
</table>
Records

We looked at 13 sets of records across the surgical wards and they were comprehensive and well documented. The patient journey was easy to follow and included a diagnosis and treatment plan. Patients were reviewed daily and entries into the record were signed and legible.

There was evidence of multi-disciplinary input and documentation in line with National Institute of Clinical Excellence (NICE) quality standard 15 statement 12: Patients experience coordinated care with clear and accurate information exchange between relevant health and social care professionals. In both nursing and medical records there was record of discussion with patient, families or carers.

Wards told us there were medical record audits undertaken but on asking no results were available for us to view at the time of inspection.

Patient records were stored in trolleys on ward areas. When not in use these trolleys were seen to be locked and secure.

The theatre department checked the accuracy of its documentation on its integrated care pathway by selecting 20 patient records at random each week to check accuracy. This data was seen to be put into a monthly matrix and this was presented at the peri operative standards forum. From this forum actions were seen to be shared with the staff.

Operating registers in two theatres were checked and were fully completed and legible with information about the patient, procedure carried out and time in and out of theatre.

The theatre list was seen to be checked for correctness and changed manually if necessary. A new electronic system was to be introduced in the next month, and staff were positive about this change which was seen to be more efficient than the current process.

Medicines

At the last inspection we found that controlled drug registers in main theatres were not always completed in line with regulations. There was evidence of block signing for supply, administration and when discarded. There was poor recording of amount administered and destroyed. On this
inspection we found this had improved and in both main theatres and at Sussex eye hospital we checked four registers and they were all correct with drug amounts recorded in detail and each entry was signed. The was a process of daily checks to ensure stock levels were correct.

During the inspection we noted that thermometers were being connected to all drug fridges in theatre to allow remote monitoring of temperature. We saw that all checks on fridge and ambient room temperatures had been carried out daily.

The hospital had an in-house pharmacy service which provided a supply function and a clinical pharmacy service. Audits were carried out on all aspects of the management of medicines. The patient's own medicines followed them around the hospital and were kept securely whilst patients were on the wards.

On ward Level 8a West the clinic rooms were clean and medicines were stored safely. Only authorised staff could access medicines. All medicines that were checked were in date. Medicine fridge temperatures and clinic room temperatures were monitored daily and action taken if they were outside the required temperature range. Controlled drugs (medicines liable to be misused and requiring special management) were stored securely and access was restricted in line with trust policy.

All wards had secure key cupboards that were clear at the front so you could see that all ward keys were present. The cupboard could only be opened by the nurse entering a unique identifying number. To access the controlled drug keys, two nurses needed to enter their identifying number. On ward nine we noted that in the area outside the clinical room where medicines were stored and the keys were secured there were closed circuit television (CCTV) cameras to maintain medicine safety.

We looked at controlled drugs in wards. We checked registers and found entries to be correct and fully completed. Ward staff checked the balance daily and we found these to be fully completed. We randomly checked a sample of stock in each department, all were in date and stock balance correct.

Checks made on ward level 8a East, ward Level 9 and at the Sussex eye hospital showed medicines to be stored securely in clean utility room with key pad access. All cupboards containing drugs were locked. Checks on controlled drugs showed correct recording in the register and regular daily checks on stock with no admissions. Random checks stock drugs showed no out of date stock.

On ward 8a East there was a weekly micro meeting ensuring that all antibiotic prescribing was in line with local antibiotic microbial guidelines.

During the inspection we checked eight prescription charts and most sections were well completed. In four of the charts there was some inconsistency in the documentation of reasons for not administering drugs with codes not being used, which meant a lack of information when reviewing treatment.

Sussex eye hospital staff administered and gave to patients take home supply of eye drops and ointments. This process was authorised using patient group directions (PGD). Staff had access to a current PGD policy. Patient group directives are written directions that allow the supply and / or administration of a specific medicine by a named authorised health professional to a well-defined group of patients for a specific condition. The PGDs in place were seen adhered to policy, were in date and were authorised according to policy. Only staff who had undergone training and assessment could administer to patients using the directives.
Prescriptions for patients to take for dispensing outside the hospital were secured in a locked cupboard. Prescriptions used for patients were signed out of stock by the consultant and nurse. Records were checked and all checks were correct.

Some eye drops, eye ointments and pain relief drugs were prepacked for giving out to patients. A check of these showed all packs to contain pre-printed information and details such as the patient name and date were completed by the nurse on discharge with a second nurse present to check. For patients who had poor vision there were data sheets with larger print. If the nurses were concerned about a patient’s compliance with medication given they demonstrated how a community nurse referral would be made.

Incidents

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 July 2017 to June 2018, the trust reported one incident classified as a never event for surgery. This was a surgical/invasive procedure incident meeting SI criterion that occurred at the Princess Royal Hospital. There were no never events at the Royal Sussex County Hospital. Learnings for this incident were discussed at the peri operative standards forum and shared with all nursing and medical staff.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 13 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from July 2017 to June 2018.

Of these, the most common types of incident reported were

- Slips/trips/falls meeting SI criteria with eight (62% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with 2 (15% of total incidents).
- Treatment delay meeting SI criteria with one (8% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (8% of total incidents).
- HCAI/Infection control incident meeting SI criteria with one (8% of total incidents).
- All other categories with zero (0% of total incidents).
Between September 2017 and August 2018, there were 1,784 incidents reported by the surgical division at Brighton and Sussex University Hospital NHS Trust. Of these, 978 were reported at the Royal Sussex County Hospital. The biggest category was No harm, impact not prevented 778 incidents, low harm accounted for 190 incidents and moderate 16. The top three themes were Implementation of care and ongoing monitoring/review (145), Medication (133), treatment and procedure (113).

The Sussex eye hospital had a total of 72 incidents, of these, 57 were no harm, 13 low impact and two moderate. Main themes were staffing facilities and environment (16), documentation (8), and Implementation of care (8).

In theatres learning from incidents were seen to be shared at the morning briefing, weekly safety meeting and at the perioperative practice forum. This forum discussed learning and local safety standards for invasive procedures. These were displayed in theatre, and this ensured staff were informed of the correct procedure to follow.

An electronic system for reporting incidents was in place. Staff understood the mechanism of reporting incidents and received training during their induction.

On the wards staff were briefed of incidents at their safety huddles which were undertaken in the morning. Staff told us that if there was an incident or safety concern during the day an additional safety huddle would be arranged to discuss this. As there were no emergency concerns during our inspection on the wards we did not observe this.

On ward 8a East there was an example of four incidents with improvement actions with implementation dates. There was evidence these were all discussed and were displayed in the ward office for staff to access.

The chief nurse bulletin which we saw on several wards also contained learnings from trust wide incidents.

There was an open culture for reporting medicines incidents, these were investigated and were reported to the medicines safety committee. Learning from incidents was identified and the information disseminated across the organisation. Staff understood the principles of Duty of Candour regulations, and were confident in applying the practical elements of the legislation when necessary.

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. For example, the urology and trauma and orthopaedic directorates discussed their mortality and morbidity issues in their monthly clinical governance meetings.
The perioperative directorate used its perioperative quality, safety and patient experience meetings to discuss their cases. The trust sent us copies of the last three minutes of each meeting. We saw there was evidence of individual cases discussed along with outcomes and any learning.

**Safety thermometer**

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 ten days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported eight new pressure ulcers, ten falls with harm and 15 new catheter urinary tract infections from July 2017 to July 2018 for surgery.

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

1. **Total Pressure ulcers (8)**

2. **Total Falls (10)**

3. **Total CUTIs (15)**

(Source: NHS Digital)
Safety thermometer information was displayed on each ward area for patients and visitors to the ward to see. The information was up to date and presented in such a way that it could be easily understood. The data could be compared with other wards and departments as a measurement of harm free care, this was then collated across the trust which allowed comparison and areas of risk.

For example, on ward 8a East the information on the ward notice board showed for the month of August, no falls, no pressure ulcers, no infections and this was displayed alongside hand hygiene and cleanliness compliance. All other wards displayed similar information.

Risk assessments were part of the nursing records and all patients on admission received an assessment for pressure ulcers, falls and venous thromboembolism. Generally, these were well completed and actions were in place to mitigate any risk.

Pressure relieving aids including mattresses were used on the wards to prevent a pressure ulcer developing and staff could access these resources as required.

Venous thromboembolism assessment was completed on the medication chart and on all charts checked this was fully completed and treatment prescribed as necessary.

Ward Level 9 had identified in screening patients for VTE they did not always give patients the information on how to prevent a deep vein thrombosis. This was now being addressed with information leaflets, and this was to be audited again.

Is the service effective?

Evidence-based care and treatment

The trust policies and guidelines were developed in line with current legislation and nationally recognised evidence based guidance, and these were available on the intranet for staff to review at the point of care.

Staff assessed patients for the risk of venous thromboembolism (VTE) and took steps to minimise the risk where appropriate, in line with the venous thromboembolism in adults: reducing the risk for patient in hospital National Institute for Health and Care Excellence (NICE), quality standard (QS) three, statement five.

National Institute for Health and Care Excellence (NICE), clinical guidance (CG) 65, for hypothermia: prevention and management in adults having surgery was followed, and the patient’s temperature was monitored within an hour of going to theatre, in the anaesthetic room and then every 30 minutes if the operation took longer than 30 minutes. This was important as keeping patient’s warm lowers the risk of complications following surgery.

We saw patients’ observations, including patients’ temperatures and pulse rates, were recorded appropriately in patient’s records. This was in accordance with National Institute for Health and Care Excellence (NICE), clinical guidance (CG) 50, ‘Acutely ill patients in unit- recognising and responding to deterioration’.

The surgical directorate carried out sepsis screening which was managed in line with national guidance. The sepsis screening was part of the care bundles and had been updated to reference ‘sepsis six’. Sepsis six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. Sepsis six consists of three diagnostic and three therapeutic steps, all to be delivered within one hour of the initial diagnosis of sepsis.
Sepsis management was in line with the National Institute for Health and Care Excellence (NICE) guidelines (NG51). A policy was available on the trust's intranet, and staff we spoke to were of it and knew how to find the policy. Staff we spoke with had received annual training on sepsis, including the use of sepsis screening tools and use of the care bundle.

The surgical division contributed to national audits and used the information to identify and act on areas for improvement.

Staff in pre-assessment at Sussex Eye hospital reviewed patients’ physical, mental health and social needs holistically, this started at the pre-assessment stage. For example, staff obtained information about a patient’s social care needs and abilities with activities of daily living (ADL) to facilitate discharge planning.

**Nutrition and hydration**

Staff had access to a current Nutrition and Hydration policy which contained assessment tools, food record chart and guidance on diets and supporting patients with dietary choices. Across the trust food and drink were available twenty-four hours a day.

During the patient assessment process, the Malnutrition Universal Screening Tool was used to assess the patient’s risk of malnutrition and if a patient was at risk, or had a specific dietary need, they were referred to a dietician. Speech and language therapists were available if the patient had a problem swallowing.

The trust standard was that the patient should have a MUST assessment made within twenty-four hours of admission. The completion and accuracy of the assessment was audited. On ward Level 9 MUST audit scores showed only 33% completion, and this was posted with actions for staff to take to improve completion.

Dietitians attended the wards daily and staff on the ward could make an online referral. Patients receiving parental nutrition (giving nutrition into the body through a vein) were seen daily by the dietician. On ward 9 where digestive diseases were managed, the nutritional support team did a ward round twice a week.

There was a choice of diets including soft, vegetarian, balanced choice and gluten free in line with British Dietetic Association guidance. Patients could choose specific diets such as kosher, halal and vegan. This was in line with National Institute of Clinical Excellence quality standard 15 statement 10: Patients have their physical and psychological needs addressed including nutrition.

There was a policy across the trust of protected mealtimes when all activity was minimised to ensure the focus was on the patients having their meals without disruption. Food was delivered to the patient’s bedside. On ward Level 9, gastric diseases with 55 beds, there were two healthcare assistants allocated every day to act as nutritional support assistants. Their role was to ensure patients have their diet and fluids in reach and where necessary to assist patients with eating.

Patients gave varied responses when being asked about the hospital food. Overall patients appeared to be satisfied, one patient described the food as fine as there was always a choice of options. All patients agreed that they always had fluids available during the day with hot drinks offered on a regular basis and water always available.

There was a process in place to ensure patients were appropriately starved prior to undergoing a general anaesthetic. Information was available electronically for staff to see when the patient was expected to go to theatres. This traffic light system allowed ward staff to view the progress of the operating list and when to stop patients drinking prior to theatre. Theatre staff regularly
communicated with ward staff any delays to theatre so that a patient could not have prolonged periods without food or drink.

Staff assessed a patient’s vomiting and nausea after their surgery and medication could be given to relieve symptoms if necessary. Patients were given anti sickness medicine intravenously in the recovery area if they complained of feeling nauseous post operatively.

**Pain relief**

Patients were monitored regularly to assess whether they were in pain. Staff used the National Early Warning score (NEWS) scale. On checking patient records, we noted that the scoring for pain was completed at regular intervals.

We observed that staff asked patients if they were in pain and patients told us that both day and night staff checked to ensure they were comfortable. If they were in pain patients said they were offered pain relief medication. One patient told us how the changes were made to their pain medication when it had been found not to be working well for them.

Staff had access to an acute pain team if they found difficulties in managing a patient’s pain. In recovery the staff also had access to support from the team but would also be supported by the anaesthetist. Staff received training in pain management.

Some surgical patients received intravenous patient-controlled pain relief post-operatively. This was in line with national best practice guidance from the British pain society.

The service undertook a Patient Controlled Analgesia (PCA) Pump Audit in May 2018. The audit showed improvements had been made in all areas from the previous audit, including the recording of observations, recording of the rate of breathing and reasons for when observations had not been recorded. Actions have been put in place for any areas that fell below the required level, and a re-audit planned for 2019.

The service undertook an epidural (an injection into the back, which produces a loss of sensation below the waist) re-audit in December 2017, which demonstrated poor compliance with the trust’s epidural policy. For example, half-hourly observation for the first five hours were completed for 16% of the time, hourly observation for the first five hours were completed for 50% of the time and vital signs observations following a rate change was completed in 48% of the cases. Actions had been put in place for any area that fell below the required level, and a re-audit planned.

Staffing of the pain team was noted to be on the surgical risk register but at ward level staff told us that they had good access to the team.

**Patient outcomes**

The service took part in national audits, such as the elective surgery Patient Reported Outcome Measures (PROMs) programme and the National Emergency Laparotomy Audit. PROMs were reviewed by the clinical lead for the relevant speciality. The hospital benchmarked patient outcomes with other trusts to improve patient care.

Staff we spoke with told us that significant work had been undertaken to address sepsis performance including additional training and internal auditing and there was participation in the Commissioning for Quality and Innovation (CQUIN) framework. The Commissioning for Quality and Innovation (CQUIN) encourages care providers to share and continually improve care,
including how it is delivered, achieving transparency and overall improvement in healthcare. This ensures a better experience and outcomes to patients.

We saw the service participated in the reducing the impact of serious infection Commissioning for Quality and Innovation (CQUIN) and that the trust had an action plan in place to ensure patient care was delivered in line with evidence-based guidance, standards and best practice.

We saw the trust had an incrementally rising target, over the four quarters to achieve 100% compliance with the CQUIN. The latest data indicated that they achieved senior review of antibiotics prescribed (element one) 97% of the time. A review of the antibiotics between 24-72 hours of prescribing (element two) in 78% of the cases. For element three, a reason for continuing intravenous administration was documented in 87% of the cases. This meant the trust had a CQUIN compliance of 75% this was against a trust target of 25%, for quarter one.

There were nursing audits undertaken by the department that fed into monitoring patient outcomes such as recording of pain, pressure ulcers, hand hygiene, and falls. Staff had access to a current clinical audit plan which detailed all audits undertaken and who was responsible for completion.

**Trust level**

From April 2017 to March 2018,

- All patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
- Colorectal surgery patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
- Urology patients at the trust had a similar expected risk of readmission for elective admissions when compared to the England average.
- Trauma and orthopaedics patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

**Elective Admissions – Trust Level**

![Graph showing trust level for elective admissions](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity*

- All patients at the trust had a similar expected risk of readmission for non-elective admissions when compared to the England average.
- Colorectal surgery patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at the trust had a similar expected risk of readmission for non-elective admissions when compared to the England average.
- Neurosurgery patients at the trust had a higher expected risk of readmission for non-elective admissions when compared to the England average.
Non-Elective Admissions – Trust Level

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

(Source: Hospital Episode Statistics - HES - Readmissions (01/04/2017 - 31/03/2018))

Royal Sussex County Hospital

From April 2017 to March 2018,

- All patients at Royal Sussex County Hospital had a similar expected risk of readmission for elective admissions when compared to the England average.
- Colorectal surgery patients at Royal Sussex County Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.
- Cardiac surgery patients at Royal Sussex County Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.
- Neurosurgery patients at Royal Sussex County Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.

Elective Admissions - Royal Sussex County Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity

- All patients at Royal Sussex County Hospital had a similar expected risk of readmission for non-elective admissions when compared to the England average.
- Colorectal surgery patients at Royal Sussex County Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at Royal Sussex County Hospital had a similar expected risk of readmission for non-elective admissions when compared to the England average.
- Neurosurgery patients at Royal Sussex County Hospital had a higher expected risk of readmission for non-elective admissions when compared to the England average.
Non-Elective Admissions - Royal Sussex County Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity

Sussex Eye Hospital

From April 2017 to March 2018,

- All patients at Sussex Eye Hospital had a similar expected risk of readmission for elective admissions when compared to the England average.
- Ophthalmology patients at Sussex Eye Hospital had a similar expected risk of readmission for elective admissions when compared to the England average.

Elective Admissions - Sussex Eye Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity

- All patients at Sussex Eye Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Ophthalmology patients at Sussex Eye Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
Enhanced recovery

Non-Elective Admissions - Sussex Eye Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity.

National Hip Fracture Database

In the 2017 National Hip Fracture Database, the risk-adjusted 30-day mortality rate was 4.2% which was better than expected. The 2016 figure was 4.4%.

The proportion of patients having surgery on the day of or day after admission was 83.1%, which failed to meet the national standard of 85%. This was within the top 25% of trusts. The 2016 figure was 81.7%.

The perioperative medical assessment rate was 95.9%, which failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 95%.

The proportion of patients not developing pressure ulcers was 99.1%, which failed to meet the national standard of 100%. This was within the top 25% of trusts. The 2016 figure was 98.7%.

The length of stay was 16.4 days, which falls within the top 25% of trusts. The 2016 figure was 19.5 days.

(Source: National Hip Fracture Database 2017)

Bowel Cancer Audit

In the 2017 Bowel Cancer Audit, 63.9% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than expected. The 2016 figure was 66.7%.

The risk-adjusted 90-day post-operative mortality rate was 9.9% which was a negative outlier. The 2016 figure was 5.0%.

The risk-adjusted 2-year post-operative mortality rate was 33.7% which was worse than expected. The 2016 figure was 28.0%.

The risk-adjusted 30-day unplanned readmission rate was 12.0% which was within the expected range. The 2016 figure was 9.0%.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 66.7% which was worse than expected. The 2016 figure was 66.9%.

(Source: National Bowel Cancer Audit)

National Vascular Registry

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 1.1% for Abdominal Aortic Aneurysms. The 2016 figure was
1.0%.
Within Carotid Endarterectomy, the median time from symptom to surgery was 12 days, better than the audit aspirational standard of 14 days.
The 30-day risk-adjusted mortality and stroke rate was 0%, this was within the expected range.

(Source: National Vascular Registry)

National Oesophago-Gastric Cancer Audit

In the 2016 National Oesophago-Gastric Cancer Audit, the age and sex adjusted proportion of patients diagnosed after an emergency admission was 3.7%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2015 figure was 2.2%.
The 90-day post-operative mortality rate was 4.6%. The 2015 rate was 4.8%.
The proportion of patients treated with curative intent in the **Strategic Clinical Network** was 40%. This was similar to the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres; the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit

The national Emergency Laparotomy audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80% and red ratings indicate performance under 50%.

In the 2016 National Emergency Laparotomy Audit (NELA), Royal Sussex County Hospital achieved a green rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 219 cases.
The site achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 172 cases.
The site achieved an amber rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 120 cases.
The site achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 87 cases.
The risk-adjusted 30-day mortality for the site was within the expected range based on 219 cases.

(Source: National Emergency Laparotomy Audit)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements
Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17 performance on groin hernias was worse than the England average.
For varicose veins, performance was about the same as the England average.
For hip replacements, performance was worse than the England average.
For knee replacements performance was worse than the England average.

(Source: NHS Digital)

**Competent staff**

**Appraisal rates**

From May 2017 to May 2018, 82% of staff within this core service at the trust received an appraisal compared to a trust target of 78%. The trust target is correct at March 2018 as they have commented that the target will increase incrementally to 90% by June 2018. Below is a split of appraisal completion rate by staff group.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals complete</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>15</td>
<td>13</td>
<td>87%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>260</td>
<td>222</td>
<td>85%</td>
</tr>
<tr>
<td>Medical &amp; dental</td>
<td>361</td>
<td>305</td>
<td>84%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>607</td>
<td>492</td>
<td>81%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>60</td>
<td>45</td>
<td>75%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>19</td>
<td>11</td>
<td>58%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>6</td>
<td>3</td>
<td>50%</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>11</td>
<td>5</td>
<td>45%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>1339</strong></td>
<td><strong>1096</strong></td>
<td><strong>82%</strong></td>
</tr>
</tbody>
</table>
At the last inspection we saw some improvement on the overall appraisal rate for all staff. On this inspection we saw the trust had continued to have a focus on the completion of appraisals. Managers focused on getting appraisals completed and staff found the appraisal process of value and involved setting objectives for personal development.

Staff told us that they could access training for their own professional development with the trust supporting either time to complete training or the cost.

On all wards and departments, we could view the electronic system recording appraisal rate and found it to be around 90 to 95%. At Sussex eye hospital we saw 100% completion.

Each ward had a practice educator allocated who monitored staff training, delivered training and worked with new members of staff supporting a preceptorship programme enabling new staff to develop their skills. Practice educators met monthly at the practice development forum.

Ward Level 9 had been allocated two practice educators and this ward had a focus on end of life care. There was a step by step guide for junior doctors and nurses on how to manage the patient and family at the end of life and immediately after death. The resources included documentation and current guidance supported by ward based training. There was evidence of other training being delivered during the patient’s rest time on the ward.

Healthcare assistants were completing the care certificate qualification and relevant competencies were being developed.

Sussex Eye hospital staff had developed specialty related competencies in pre-assessment and ward area. All staff working in those areas were expected to complete them.

We saw information on wards about revalidation which showed staff were being supported to complete this.

In theatre there were four practice educators involved with supporting staff in their training. Advanced Nurse Practitioners were being trained to support staff. The anaesthetic course run in the department was a positive initiative by all staff and generally staff felt well supported in their continuing professional development.

Infection prevention leads for ward areas confirmed they had received relevant training enabling them to carry out their role.

All theatre recovery staff attended a Post Anaesthetic Care Unit training programme relevant for their department which included competencies. Regular scenario training was undertaken, the most recent being airway management and the management of patients with low blood pressure.

Junior doctors felt well supported and did not report any problems with contacting senior colleagues. To support the training and development of junior doctors on the digestive diseases ward a registrar was based permanently on that ward which supported junior doctor’s development.

Multidisciplinary working

On all wards and departments visited during the inspection we saw good team working and staff being a collaborative and supportive team.
Ward rounds took place on all wards and were attended by medical and nursing staff together with a physiotherapist and/or occupational therapist, and a dietitian would also attend. We observed good interaction between all staff.

Daily multi-disciplinary team meetings took place on all the wards, usually in the morning. On ward Level 9 this took place at 09.30am. Nursing and medical staff were joined by an occupational therapist, physiotherapist and relevant specialist nurses. All patients were discussed including discharge plans and the support services required to facilitate this.

We attended a safety huddle on one ward and this was attended by all levels of nursing and support staff. All safety issues, staffing, equipment and environment concerns were discussed and all staff were encouraged to contribute.

In pre-assessment at the eye hospital staff gave examples of how nursing and medical staff worked well together. On the ward staff spoke of good working relations with all members of the team working there.

In theatres the initial team briefing of the day was attended by all staff in the department including medical, nursing and support staff. All staff were seen to be attentive and were encouraged to contribute.

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.

Pharmacy staff did not routinely attend multidisciplinary meetings or consultant ward rounds but did attend speciality clinical and governance meetings.

**Seven-day services**

The service was working toward seven-day services in line with National Health Service Improvements (NHSI), Seven-day services in the NHS. We saw in the trust operational plan 2018-2019, that they planned to deliver the Seven Day Service standards for all admitting specialities by 2020. The seven-day services programme is designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital.

There was a consultant presence seven day a week within surgery at the Royal Sussex County Hospital. Doctors provided consistency in care for their patients and reviewed patient conditions regularly. Consultants covered patient intakes for a week at a time in some surgical care division services. Patients in acute areas were reviewed by consultant led ward rounds daily seven days a week and this was documented in patient records.

Theatres were staffed so they could provide emergency surgery twenty-four hour a day. There was also a poly trauma team available seven day a week. Consultants had no elective commitments when on call.

Diagnostic services were available 24 hours a day, seven days a week. This allowed surgical 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).

Physiotherapy for ward patients was provided seven days a week.

Patients requiring elective surgery received a pre-operative assessment and appointment before their surgery. The pre-assessment service was available Monday to Friday at the Princess Royal site between 8.15am to 12pm and 1.30 pm to 3pm Monday to Friday. Monday to Friday between
8.15 am to 12.45pm and 1.15 to 3.45pm at the Sussex Orthopaedic Trauma Centre. For patients requiring pre-assessment for vascular surgery, this was provided at the Royal Sussex County Hospital Tuesday afternoons between 1.30 pm to 4.30 pm and Thursday mornings between 9.30am to 12.30pm.

Pharmacy services were available five days a week, Monday to Friday, between the hours of 8.30am to 5.30pm and 8.30 to 16.00 at weekends. An on call pharmacist was available out of hours and an emergency cupboard of stock was available.

**Health promotion**

The service supported patients to live healthier lives. The enhanced recovery programme (ERP) provided patients with information on how they could ensure they were as fit for their procedure as possible. It reminded patients of the importance of eating a balanced diet, quitting smoking and reducing alcohol intake. On wards we saw a range of patient and visitor information which promoted healthier lives.

There was evidence that patients who needed extra support with emotional needs would be referred to mental health liaison team. There were procedures in place to support patients who required specific support with the withdrawal of drugs and alcohol and some staff had received training to understand these patient’s needs.

Staff at pre-assessment at Sussex Eye hospital explained that they would discuss with patients their operation, health and risks. This included information about diet, smoking and alcohol intake, which allowed staff to identify additional support or intervention for patients who may require it, and signpost patients as appropriate.

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

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

Mental Capacity Act (MCA) training was completed by 86% of staff in surgical services compared to the trust target of 90%.

A breakdown of completion rates for medical, dental, and nursing staff is shown below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate (%)</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical staff</td>
<td>106</td>
<td>137</td>
<td>77%</td>
<td>90%</td>
<td>NO</td>
</tr>
<tr>
<td>Nursing staff</td>
<td>163</td>
<td>172</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Additional data request (ADR) – 109)

The completion of training by medical and nursing staff had improved since the last inspection.

All staff were required to follow the current trust policy and procedure for consent. The policy was based on guidance issued by the Department of Health. This included information for staff on obtaining valid consent, and links to consent forms.

Staff understood the process of consent, mental capacity and knew the process for making an application for deprivation of liberty safeguards. We reviewed eight consent forms for surgery and
they were all completed and signed and dated. All forms outlined the possible complications and had no abbreviations. In theatre we saw that the consent form was checked as part of the safe surgery checklist.

Each of the surgical wards had access to specialist nurses. For example, if a patient lacked capacity staff could refer to the dementia lead or learning disability nurse. Wards and theatres worked with an independent mental capacity advocate if that was appropriate for patients.

Is the service caring?

Compassionate care

Friends and Family test performance

The Friends and Family Test response rate for surgery at Brighton and Sussex University Hospitals NHS Trust was 24% which was worse than the England average of 26% in June 2018. A breakdown of response rate by site can be viewed below.

Friends and family test response rate at Brighton and Sussex University Hospitals NHS Trust, by site.
A breakdown by ward for wards with over 100 responses can be found below:

<table>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Newick Ward</td>
<td>1,127</td>
<td>38%</td>
<td>99%</td>
<td>98%</td>
<td>98%</td>
<td>97%</td>
<td>97%</td>
<td>98%</td>
<td>98%</td>
<td>96%</td>
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<td>98%</td>
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<td>100%</td>
</tr>
<tr>
<td>Pickford Ward (First Floor)</td>
<td>1,010</td>
<td>21%</td>
<td>89%</td>
<td>100%</td>
<td>100%</td>
<td>86%</td>
<td>97%</td>
<td>93%</td>
<td>93%</td>
<td>100%</td>
<td>99%</td>
<td>95%</td>
<td>93%</td>
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<td>95%</td>
</tr>
<tr>
<td>Ansty Ward</td>
<td>903</td>
<td>19%</td>
<td>97%</td>
<td>100%</td>
<td>98%</td>
<td>100%</td>
<td>97%</td>
<td>88%</td>
<td>100%</td>
<td>88%</td>
<td>98%</td>
<td>95%</td>
<td>93%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>L9A Level 9 Millennium Wing</td>
<td>680</td>
<td>25%</td>
<td>87%</td>
<td>86%</td>
<td>100%</td>
<td>84%</td>
<td>76%</td>
<td>95%</td>
<td>100%</td>
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<td>84%</td>
<td>86%</td>
<td>96%</td>
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<td>90%</td>
</tr>
<tr>
<td>Day Surgery Unit</td>
<td>584</td>
<td>38%</td>
<td>98%</td>
<td>98%</td>
<td>88%</td>
<td>100%</td>
<td>97%</td>
<td>95%</td>
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<td>99%</td>
<td>96%</td>
<td>97%</td>
<td>97%</td>
</tr>
<tr>
<td>Albourne Ward</td>
<td>583</td>
<td>48%</td>
<td>100%</td>
<td>96%</td>
<td>95%</td>
<td>92%</td>
<td>93%</td>
<td>97%</td>
<td>100%</td>
<td>98%</td>
<td>81%</td>
<td>93%</td>
<td>90%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>L8A West Ward - Level 8 Millennium Wing</td>
<td>491</td>
<td>24%</td>
<td>91%</td>
<td>82%</td>
<td>98%</td>
<td>87%</td>
<td>100%</td>
<td>96%</td>
<td>100%</td>
<td>100%</td>
<td>92%</td>
<td>87%</td>
<td>92%</td>
<td>75%</td>
<td>91%</td>
</tr>
<tr>
<td>Cardiac Surgery - Level 7 Millennium Wing</td>
<td>277</td>
<td>1%</td>
<td>30%</td>
<td>14%</td>
<td>8%</td>
<td>0%</td>
<td>33%</td>
<td>36%</td>
<td>33%</td>
<td>33%</td>
<td>1%</td>
<td>30%</td>
<td>14%</td>
<td>8%</td>
<td>0%</td>
</tr>
<tr>
<td>Surgical Ward - Level 8 Thomas Kemp Tower</td>
<td>265</td>
<td>8%</td>
<td>0%</td>
<td>38%</td>
<td>55%</td>
<td>33%</td>
<td>33%</td>
<td>33%</td>
<td>2%</td>
<td>10%</td>
<td>11%</td>
<td>79%</td>
<td>44%</td>
<td>91%</td>
<td>11%</td>
</tr>
<tr>
<td>East Ward - Level 8 Millennium Wing</td>
<td>314</td>
<td>7%</td>
<td>30%</td>
<td>78%</td>
<td>9%</td>
<td>0%</td>
<td>36%</td>
<td>0%</td>
<td>0%</td>
<td>5%</td>
<td>6%</td>
<td>0%</td>
<td>34%</td>
<td>0%</td>
<td>6%</td>
</tr>
<tr>
<td>Twineham Ward (1st Floor)</td>
<td>209</td>
<td>0%</td>
<td>88%</td>
<td>12%</td>
<td>2%</td>
<td>0%</td>
<td>33%</td>
<td>30%</td>
<td>0%</td>
<td>0%</td>
<td>33%</td>
<td>12%</td>
<td>94%</td>
<td>11%</td>
<td>94%</td>
</tr>
<tr>
<td>General Unit - Day Case Ward</td>
<td>219</td>
<td>0%</td>
<td>90%</td>
<td>1%</td>
<td>0%</td>
<td>37%</td>
<td>4%</td>
<td>4%</td>
<td>12%</td>
<td>95%</td>
<td>90%</td>
<td>11%</td>
<td>94%</td>
<td>11%</td>
<td>94%</td>
</tr>
<tr>
<td>RAH Medical and Surgical Day Care Ward - Level 7</td>
<td>112</td>
<td>5%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>RSCH Theatre Admissions</td>
<td>129</td>
<td>3%</td>
<td>92%</td>
<td>5%</td>
<td>9%</td>
<td>0%</td>
<td>98%</td>
<td>1%</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>Endoscopy Suite - Cuckfield Ward</td>
<td>125</td>
<td>5%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>POLY Day Case Unit - Main Reception</td>
<td>123</td>
<td>8%</td>
<td>92%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Sussex Orthopaedic Post-anaesthesia Care Unit</td>
<td>103</td>
<td>9%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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<td>0%</td>
</tr>
</tbody>
</table>

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

Note: sorted by total response

(Source: NHS England Friends and Family Test)
All wards displayed their friends and family feedback showing a response rate between 23 and 34 per cent. Staff gave patients a card on discharge asking them to feedback about their experience by emailing or calling the patient experience team. Staff said this was a less efficient way of collecting feedback, the previous system used questionnaires and these could be collected on discharge. All wards had an annual positive performance above 90%.

All wards displayed compliments received from patients describing wonderful care and dedicated and caring staff. On ward 8A West 33 cards were displayed and ward 9 had 14 cards which described staff as kind, caring and professional. Patients described ‘patient centred care’ with good support from the multi-disciplinary team. Staff were described as caring and compassionate. Call bells were seen to be within in reach and staff were responsive if called.

We observed patients being treated with dignity and respect. Curtains were pulled round patients when intimate care was taking place and patients were addressed by their name and permission was asked before care commenced.

Staff were observed to be non-judgemental and caring in the way they managed a patient with mental health needs. Staff had access to the mental health team when necessary and described the support from security staff with distressed patients as prompt, supportive and safe. All staff undertook conflict management training.

On the digestive diseases ward on Level 9 the patients had a designated rest time between 2pm and 3pm with blinds closed and minimal interventions. There was time to rest which patients appreciated.

Theatre staff maintained patient dignity in the anaesthetic room by ensuring the patient was appropriately covered during preparation for surgery. In recovery staff exchanged patient information in a respectful way and privacy was maintained.

All surgical wards had a welcome board which contained information for patients and visitors which included how to access appropriate spiritual care. All patient records contained information about individual patient spiritual needs. The chaplaincy team provided religious support twenty-four hours a day and there was access to literature about different religions.

**Emotional support**

Staff provided emotional support to patients to minimise their distress. On ward Level 9 staff received training in managing patients with digestive diseases to support the delivery of sensitive and compassionate care and positive patient feedback was seen.

At the Sussex eye hospital there was a rota of trained volunteers who supported and held the hands of patients undergoing eye surgery under local anaesthetic. Patients who were nervous found this reassuring. All day case patients received a phone call the following day to check on their wellbeing and to answer any questions. The main complaint from those contacted was the waiting for surgery, and this concern was under review.

There were many specialist nurses who supported patients with complex or specific needs. For example, the Macmillan team were available to support patients at the end of life. Staff told us that this supported the staff as well to ensure the care was individualised for the patient.
Understanding and involvement of patients and those close to them

We spoke to 14 patients during the inspection and many of those patients commented they felt involved in their plan of care. One patient described feeling like a “participant not a passenger” in care. Another patient described how the doctor communicated what surgery needed to be done by drawing a picture, he felt well informed and was seen by doctors and nurses regularly.

Discharge planning was evident within the patient records and one patient told us how particular family needs were taken into consideration when planning the support which would be needed at home. Consideration had also been given to allowing a family member to visit outside of visiting times and for longer to ensure reassurance to the family.

Staff introduced themselves to patients and were seen to discuss their plan of care, checking that they understood. Patients were addressed by name and were treated with respect.

All wards had information displayed on who was in charge of the ward, who was on duty and how to leave feedback. There was a range of patient and visitor information both disease specific and covering general information such as hand hygiene. All wards had information on display about translation services.

Is the service responsive?

Service delivery to meet the needs of local people

The surgery directorate provided both elective (planned) and non-elective (emergency) surgical treatment and procedures for patients. A range of elective surgical procedures were available to patients, some of which could be done as day cases.

The service understood the different needs of the people it served and acted on those to plan, design and deliver its services.

The hospital had a significant redevelopment programme underway, as part of their 3T’s development. The 3T’s were teaching, trauma tertiary, and directions to the surgical wards and departments were clear and easy to follow. Information about the building work and services was clearly available to visitors at the main entrances of the hospital.

The hospital was well sign-posted from the main road, and was on a bus route. Patients and staff told us there were issues with parking, and sometimes it was difficult to find a space. Signposting around the hospital was satisfactory.

Average length of stay

Trust Level – elective patients

From May 2017 to April 2018, the average length of stay for all elective patients at the trust was 4.6 days, which is higher compared to the England average of 3.9 days.

- For trauma and orthopaedics elective patients at the trust was 4.9 days, which is higher compared to the England average of 3.8 days.
- For colorectal surgery elective patients at the trust was 5.5 days, which is lower compared to the England average of 7.1 days.
- For urology elective patients at the trust was 2.4 days, which is as expected compared to
the England average of 2.5 days.

Elective Average Length of Stay – Trust Level

![Graph](image)

Note: Top three specialties for specific trust based on count of activity.

Trust Level – non-elective patients

The average length of stay for all non-elective patients at the trust was 7.5 days, which is higher expected compared to the England average of 4.9 days.

- The average length of stay for colorectal surgery non-elective patients at the trust was 6.2 days, which is higher compared to the England average of 4.4 days.
- The average length of stay for trauma and orthopaedics non-elective patients at the trust was 10.7 days, which is higher compared to the England average of 8.8 days.
- The average length of stay for neurosurgery non-elective patients at the trust was 8.5 days, which is lower compared to the England average of 13.1 days.

Non-Elective Average Length of Stay – Trust Level

![Graph](image)

Note: Top three specialties for specific trust based on count of activity.

Royal Sussex County Hospital - elective patients

From May 2017 to April 2018 the average length of stay for all elective patients at Royal Sussex County Hospital was 7.4 days, which is higher compared to the England average of 3.9 days.

- The average length of stay for colorectal surgery elective patients at Royal Sussex County Hospital was 8.8 days, which is higher compared to the England average of 7.1 days.
- The average length of stay for cardiac surgery elective patients at Royal Sussex County Hospital was 9.2 days, which is as expected compared to the England average of 9.0 days.
- The average length of stay for Neurosurgery elective patients at Royal Sussex County Hospital was 5.6 days, which is higher compared to the England average of 5.0 days.

Elective Average Length of Stay - Royal Sussex County Hospital
Royal Sussex County Hospital - non-elective patients

The average length of stay for all non-elective patients at Royal Sussex County Hospital was 7.3 days, which is higher compared to the England average of 4.9 days.

- The average length of stay for colorectal surgery non-elective patients at Royal Sussex County Hospital was 6.2 days, which is higher compared to the England average of 4.4 days.
- The average length of stay for trauma and orthopaedics non-elective patients at Royal Sussex County Hospital was 8.6 days, which is as expected compared to the England average of 8.8 days.
- The average length of stay for neurosurgery non-elective patients at Royal Sussex County Hospital was 8.5 days, which is lower compared to the England average of 13.1 days.

Sussex Eye Hospital – Average Length of Stay

From May 2017 to April 2018 the average length of stay for ophthalmology elective patients at Sussex Eye Hospital was 1.6 days, which is as expected compared to the England average of 1.9 days.

The average length of stay for ophthalmology non-elective patients at Sussex Eye Hospital was 1.6 days, which is as expected compared to the England average of 1.8 days.

Staff monitored theatre utilisation and achieved 71% against a target of 90%. There were few cancellations during the six months prior to inspection.

Meeting people’s individual needs
At our last inspection we noted good progress had been made in the use of recovery with no emergency department or medical patients being admitted and no high dependency patients transferred in. On this inspection we saw this standard had been maintained.

However delayed discharges from recovery remained a challenge for the staff. In the months of July and August 20 patients out of 26 stayed in recovery longer than three hours. Eight out of 12 intensive therapy unit (ITU) patients stayed in recovery longer than three hours until a bed became available. Data supplied from the critical care team showed that the number of patients ventilated for longer than four hours in recovery for the five months varied between 11 in April to five in August.

Staff had received training in the management of complex patients and were supported by the outreach team but thought this situation would not improve until the expansion of critical care as part of the building work was complete. We requested further information from the trust about length of stays in recovery following the inspection but did not receive this.

The service took account of patients’ individual needs through the provision of specialist staff, link persons and champions at ward and department level.

The trust had a named dementia lead and strategy. All wards and departments had boards with information about the butterfly scheme. The scheme supports with dementia and memory impairment. It aims to improve patient care and wellbeing by teaching staff to offer a positive and appropriate response to memory impairment. Butterfly symbols were put by the patient’s bed to remind staff to follow a special response plan. The trust was 88% compliant for dementia training.

All patients living with a learning disability were referred to the disability liaison team. Information was captured on an electronic system which meant that any adjustments that had to be made on admission or when treated could be put in place in a timely way.

In theatres patients with complex needs were assessed at a weekly meeting by the anaesthetist and there was evidence of research being done into managing patients with safeguarding issues, anxiety and fear of operations. The standard of practice had been developed and there was already a waiting list of patients.

On all wards staff were aware how to contact the mental health team of specialist nurses to support distressed patients. The Macmillan nurses were available on referral for all relevant patients requiring end of life care.

The homeless team was available to support patients for discharge and worked closely with social services and the occupational therapist. Patient records showed comprehensive discharge planning involving all members of disciplinary team.

Depending on specialty the wards had access to appropriate specialist nursing care. On the orthopaedic and trauma ward 8a East, the staff had access to trauma practitioners. In addition to supporting patients on the ward, these practitioners also supported any outlying patients based in other surgical beds waiting for transfer to the ward. This ensured continuity of care.

On ward 8a West the head injury nurse practitioner supported ward staff in addition to the trauma practitioner. Staff found this support valuable in planning care and was a learning resource.

Staff on the surgical ward had access to and were supported by the outreach team from critical care during the hours 7.30am to 7.30pm. Ward staff described this support as prompt and efficient.
Patients and staff had access to translation services that could be contacted online or by phone twenty-four hours seven days a week. Staff described the service as efficient and gave relevant examples of how the service had been used.

There were contact numbers for support with patients who were visually impaired. The hospital had a book showing how to communicate with patients with needs such as autism and learning difficulties.

**Access and flow**

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From July 2017 to June 2018 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was about the same as the England average.

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**

Two specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and orthopaedics</td>
<td>80.5%</td>
<td>60.4%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>69.4%</td>
<td>69.0%</td>
</tr>
</tbody>
</table>

Seven specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>74.9%</td>
<td>76.8%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>65.1%</td>
<td>70.3%</td>
</tr>
<tr>
<td>ENT</td>
<td>63.0%</td>
<td>63.2%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>58.8%</td>
<td>60.5%</td>
</tr>
<tr>
<td>General surgery</td>
<td>58.6%</td>
<td>72.7%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>56.9%</td>
<td>79.8%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>0.0%</td>
<td>81.4%</td>
</tr>
</tbody>
</table>

Waiting times for referral to treatment within 18-weeks were below the England average in three out of the eight surgical specialities provided at the trust. Out of the remaining five, three were
similar to the England average, and two were better. This was an improvement on the previous inspection when all specialties were below the England average.

The trust had stated in its objectives that measures would be put in place to eliminate 52-week waiters. The surgical services achieved this in July 2018. New consultant appointments were made in colorectal surgery and a further appointment planned. Consultants undertook weekend and ad hoc operating lists and had reviewed all patients on the waiting lists. This involved reviewing notes, telephone conversations with patients, virtual clinics and working closely with the booking office.

To improve the management of patients on the digestive diseases ward on level 9 there were two separate Consultant lead teams for upper and lower gastrointestinal surgery. These consultants reviewed all patients coming in while a Consultant for emergency surgery remained based in theatre to support patient flow through that department. Consultants had no elective commitments while on call.

**Cancelled operations**

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Over the two years, the percentage of cancelled operations at the trust showed no correlation against England average but an improvement from Q1 2017/18.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Brighton and Sussex University Hospitals NHS Trust**

![Graph showing percentage of cancelled operations over time](image-url)
Over the two years, the percentage of cancelled operations at the trust showed better performance than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

In theatres all cancellations were recorded daily but not put on the incident reporting system, they were reviewed internally.

Learning from complaints and concerns

Summary of complaints

From April 2017 to March 2018 there were 120 complaints about Surgical Care. The trust took an average of 51 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be closed within 25 days.

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of complaints</th>
<th>Average days to close</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Sussex County Hospital</td>
<td>95</td>
<td>54</td>
</tr>
<tr>
<td>Princess Royal Hospital</td>
<td>18</td>
<td>45</td>
</tr>
<tr>
<td>All other sites</td>
<td>7</td>
<td>26</td>
</tr>
</tbody>
</table>

Most complaints (48%) were related to access to treatment or drugs.

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

Number of compliments made to the trust

From April 2017 to March 2018 there were 260 compliments within surgery.

A breakdown by site is shown below.

- Princess Royal Hospital: 52 compliments
- Royal Sussex County Hospital: 164 compliments
- Other sites: 44 compliments

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Senior staff were aware that response time for complaints was currently outside the complaints guidelines and were meeting weekly to improve this.

The trust had a policy and procedure for the management of formal and informal complaints for patients and their representatives. The policy set out the need for close collaboration between the Patient Advice and Liaison service (PALS) and the trust complaint services to ensure a means of resolving patients concerns.

All ward areas had information on how to make a compliment, complaint or raise concerns with the staff. Staff were aware of the process and received feedback at their team meetings and daily safety huddles and minutes reflected this. 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.

The Chief of surgery was responsible for managing the complaints process across the service. The complaint was investigated by the clinical lead for the department, who drafted a response, which was reviewed and signed off for sending by the Chief of Surgery or Chief Executive.

At the time of inspection, we reviewed four complaints. The investigation of complaints was managed efficiently. PALS and Complaints communicated to make sure any concerns were acknowledged promptly. Upon acknowledging the complaint or shortly after, the trust’s Complaints Manager arranged telephone calls with complainants to discuss their complaint further.

Complainants were provided with regular updates on progress. To personalise the response, the trust considered who would be the most suitable individual to write to a complainant with the resolution of their complaint. In response to one recent complaint, a clinician with a long standing professional relationship with the complainant requested to draft the response.

Letters in response to complaints were sympathetic to the patient’s experience and often included an offer to meet with those who had been responsible for providing the care referred to in the complaint. There was evidence of effective internal communication to coordinate the investigation in to the complaint and to draft a response to the complainant. When providing a response and the outcome of a complaint, the complainant was signposted to the Ombudsman.

Each written complaint response signposted the complainants to the Parliamentary and Health Service Ombudsmen (PHSO), so patients, relatives or carers knew who to contact if they were not satisfied with the trusts response to their complaint.

Ward staff described how they would deal with a complaint and would try to resolve immediately during the hospital stay. If issues could not be resolved, the patient or relative was directed to the complaints process.

Staff were aware of complaints made about their department and described a recent patient complaint concerning a patient’s hygiene needs not being met was shared with all wards across the service at team meetings. We observed that learnings from complaints were discussed at safety huddle on ward areas.

On ward 8A east the ward displayed a recent complaint about communication and staff, the weekly newsletter shared learnings from patient concerns and was distributed to the multi-disciplinary team. On ward Level 9 some patients complained about noise at night and there were plans to give patients eye shields and ear plugs.
Is the service well-led?

Leadership

The surgery division was led by a chief of service, director of operations and head of nursing. This leadership style was referred to as a triumvirate. Members of the triumvirate had clear roles and responsibilities. Some of the surgery undertaken at the trust fell into the specialist services division, this division had the same triumvirate leadership style. On the wards and in theatres staff told us that the division leads were visible and approachable.

Within the surgical division there were four directorates, abdominal surgery and medicine, head and neck, musculoskeletal and perioperative. Each directorate had a mirroring triumvirate style and was led by a clinical director, directorate manager and lead nurse. Medical and nursing staff in theatre described good engagement with the triumvirate.

Each speciality and the theatre department had a matron who was supported by the ward and theatre manager. Service leaders felt they had the necessary skills and knowledge required to lead the service effectively. They understood the challenges to quality and sustainability such as financial pressures and bed capacity.

Ward managers told us they felt very well supported and that matrons were visible and frequently on the ward areas. They were also able to contact their head of nursing, would be listened to and would be supported. The Chief of Nursing was seen in the ward areas and was also found to be approachable.

Staff described matrons, ward and theatre managers as visible, approachable and supportive and were clear about the management structure. They knew who their line manager was and their own responsibilities within the structure.

During the inspection we observed ward and department teams to be organised, demonstrated good leadership and were positive about the team work across the service. Any issues raised were dealt with promptly.

Staff told us they felt well supported by their immediate line manager. They felt there was a clear management structure within the service 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.

Vision and strategy

The trust vision was clearly visible across the service. The vision was to be locally and nationally renowned for delivering safe, high quality and compassionate care and being the regional centre of clinical and academic excellence. The vision was underpinned by a set of values; communication, kindness and understanding, fairness and transparency; working together, and excellence.

The trust strategy was called patient first. This was a process of continuous measurable improvement through existing pathways, to put patients first by empowering staff to deliver those changes and make them sustainable.

The patient first symbol with the patient at the top of a triangular plan was visible on every ward and department. Ward and department leaders spoke of both interest and enthusiasm for this programme and in many cases, were in the process of completing the modular training before this
was introduced to their departments. Staff were aware of the programme and were positive about its introduction into their departments and wards.

At the Sussex eye hospital, we saw the values for the department were those for the trust and were displayed for staff, patients and visitors to see. Staff spoke about the patient first project and were keen to be involved.

**Culture**

Managers across the trust promoted a positive culture that supported and valued the staff. Staff told us they felt valued and were proud to work at the trust. Most staff indicated a positive improvement in culture and this change had occurred over the last eighteen months. Some staff identified a few staff groups where this change was still being accepted but all staff we spoke to described good progress.

In theatres staff told us that managers were working for the retention of staff and there were good opportunities for professional development and change was seen to be positive.

We asked some staff about equality of opportunity and whether the trust was inclusive of all staff, in all instances we received a positive response. Staff told us that they did not experience bullying or harassment.

We asked a few staff about the freedom to speak up guardian and they were not aware who that was or how they would make contact.

Staff described feeling more supported than ever before. Staff were energised and described feeling involved and committed to the service. Staff frequently told us they were proud to work at the trust and felt a lot of positive changes had been made.

**Governance**

There were clear lines of accountability from the department to the board through the directorate governance structure. Managers, matrons, and leaders of the service described the systems and processes of accountability within surgery. Staff we spoke with were clear about their roles and responsibilities and who or what they were accountable to or for.

The Surgery Division Clinical Governance Meetings took place monthly. We saw copies of the minutes for June and July 2018, which showed key areas for patient safety were covered. These included, incidents, risk register, updates on national guidance, safeguarding, infection prevention and control, clinical outcomes and patient experience. We saw that where an action was required a person would be named responsible, this made sure that actions that arose during the meeting were completed, and the assigned person held accountable if not.

As part of our additional data requests we requested one of the directorate’s clinical governance meeting minutes. The perioperative directorate held bi-monthly Safety and Quality Meeting. We looked at the minutes for April, June and August 2018. The minutes showed items discussed included, incidents, never events, risk register and areas of concern. The minutes were brief, but contained an adequate level of detail of the items discussed. Where actions were required, a named person was held accountable.

There were similar meetings held in all the surgical directorates. Sussex Eye hospital had a quarterly governance meeting and a regular team meeting and amongst other topics there was
discussion of risk, patient safety, lessons learnt, infection prevention and control, audit and patient feedback. At ward level we saw these minutes were available.

Ward managers had regular meetings and met frequently with their matrons to discuss any incidents and complaints. Learnings from incidents and complaints were discussed at department briefings, safety huddles and ward meetings. The Chief nurse bulletin also shared new initiatives and points of learning. Information was also shared by email and on the notice board.

In theatres medical staff spoke about well led governance meetings every Friday afternoon when all complex, emergency and difficult cases were discussed. Theatres had an audit and governance half day and in August this covered major incident training and manual handling.

An Annual Safeguarding Adults, Mental Capacity Act, Learning Disabilities and domestic violence report was presented to the Board of Directors in May 2018.

Management of risk, issues and performance

The department had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

There was a risk register in place to record risks within the division. Each risk was given an initial risk score and a current risk score after risk reductions strategies had been put in place. There were 66 risks recorded on the risk register for the division, which were categorised into a minor, moderate, major or extreme risk.

Out of the 66 risks three were classed as minor risks, 36 as moderate, 26 as major and one extreme. The risk register had an explanation of the risks, and who had overall responsibility for the risk, ensuring existing risk controls and actions were completed for each identified risk. The risk register in theatre showed the main risks to be theatre ventilation, inappropriate use of recovery and storage of equipment in the corridors presenting a fire hazard. Some of the risks on the register were historic, the oldest being 2007.

At department and ward level staff could identify risk within their own area and what had been done to lessen that risk, for example in theatre staff were aware of concerns about the ventilation system and the importance of keeping corridors clear of equipment and stores as far as possible to prevent a fire safety risk.

The senior staff we spoke with were clear about the challenges the department faced and they were all committed to improving the patients’ journey and experience. Where national audits had demonstrated a weakness in clinical practice the senior clinical team ensured that action plans were developed and re-audit programmes undertaken to ensure improvements to patient outcomes.

The trust had access to trust infection prevention and control policies and procedures, and took part in the auditing of clinical practice. This was 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, which 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 fed back to the department. This was in line with National Institute for Health and Social Care Excellent, quality standard 121, statement five.

**Information management**

The trust had collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. The electronic clinical incident system was widely used by all staff and enabled sharing of information and identification of severity of events and trends across the specialties, services and trust wide. This enabled shared learning and development of safe working practices.

National and local audits were shared electronically to support continued improvement of practice. At local level for example results of the national early warning score audit enabled staff to compare their results across the whole trust and see areas of best practice.

Surgical services had performance measures which were used to feed into the metrics dashboard, we saw these included but not limited to, falls and pressure damage, nutrition, pain, fluid balance and discharge planning. The metrics were presented in a way that the ward could see how they were performing in each area, and where they were in comparison to the trust average for the month, monitor trends and improve and make changes to practice.

Staff had access to up-to-date accurate information on patients’ care and treatment. Staff were aware of how to use and store confidential information.

Information governance training was part of the trust’s statutory and mandatory training requirement for all staff. Data supplied to us showed that 98% of nursing staff and 100% of medical staff were up to date with this training, which was better than the trust target of 90%.

**Engagement**

A trust wide staff engagement survey demonstrated that staff working in surgery across all sites scored an improvement in overall staff engagement. The most significant improvement was in how likely staff would be to recommend the trust to friends and family as a place to work with a positive response of 46.71% in 2017 rising to 75% in August 2018. This was an improvement on last year when the staff survey showed the trust performed worse than other trusts in a number of categories.

The trust identified the patient first strategy approach and process as a means of engaging all staff in service improvement and staff spoke positively about undergoing the training that had just started across the surgery division.

There was an annual patient first star award with nominations made by patients, staff and volunteers and 54 staff were nominated across the surgery division with three winners. Staff also spoke positively about the star of the month award when they could nominate a member of staff for the award. On ward 8a West staff awarded a ‘best of west’ award for a colleague who had gone ‘above and beyond’ in their practice.

At Royal Sussex County hospital public events had been held to discuss the current building works and how this would affect patient services with a chance to ask questions of the project team. There was a regular newsletter giving up to date information about the building works.
The hospital website was easy to navigate and contained information about services, visiting times and parking. Information was there about how to feedback about services, volunteer and local public events.

The surgical division gathered patient feedback through the friends and family test. The Friends and Family Test gives patients the opportunity to submit feedback to providers of NHS funded care or treatment, using a simple question which asks how likely, on a scale ranging from extremely unlikely to extremely likely they are to recommend the service to their friends and family if they needed similar care or treatment. We saw this could be done in different ways, either on the ward via a hand held mobile electronic device or via the trust’s main website.

The Friends and Family Test response rate for surgery at Brighton and Sussex University Hospitals NHS Trust was 24% which was worse than the England average of 26% in June 2018. During the inspection staff told us they were looking at ways to improve the response rate.

We found there was little evidence of patient forum groups and an opportunity for patients to feedback about specific specialties or to influence the design of services.

Learning, continuous improvement and innovation

The department made regular data submissions to the Royal Colleges and national audits, which allowed patient outcomes to be benchmarked nationally. We saw evidence of actions plans being implemented because of noncompliance’s found.

On ward Level 9 the staff had analysed their own response to medical emergency calls and had devised a system to be more effective as a team. On each shift a member of the nursing team wore a badge which allocated a role to be undertaken in the event of an emergency call being made for a collapsed patient. This was being assessed for effectiveness in practice.

Theatre staff were aware and enthusiastic about business cases to advance surgical practice and staff spoke enthusiastically about possible developments.

At Sussex Eye hospital a research nurse worked as part of the team and participated alongside medical colleagues in the review of current practice and the development of the service.

In theatres a member of staff had devised a way of ensuring effective use of equipment and was being supported to present his achievement at the Difficult Airway Conference later in the year.
Critical care

Facts and data about this service

The trust has 80 critical care beds. A breakdown of these beds by type is below.

**Breakdown of critical care beds by type, Brighton and Sussex University Hospitals NHS Trust and England.**

<table>
<thead>
<tr>
<th>This trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal, 25.0%</td>
<td>Adult, 68.3%</td>
</tr>
<tr>
<td>Adult, 63.7%</td>
<td>Neonatal, 23.8%</td>
</tr>
<tr>
<td>Paediatric, 11.2%</td>
<td>Paediatric, 7.8%</td>
</tr>
</tbody>
</table>

*(Source: NHS England)*

The data provided above details all aspects of critical care. However, the inspection did not include paediatric critical care or neo natal critical care. This report only provides detail about critical care for adults at the Royal Sussex County Hospital.

Is the service safe?

**Mandatory training**

Mandatory training modules included child and adult safeguarding, infection prevention and control and information governance.

At the time of the inspection the overall mandatory training rate for critical care at the Royal Sussex County Hospital was 89.4%. This was just below the trust target of 90%. The trust told us that by the end of the inspection week the overall figure would go above the 90% target. This was because only a small number of modules needed to be completed and staff had set time aside to complete those that were outstanding. The trust provided us with evidence, following the inspection, that the mandatory training completion rate met the trust target of 90%.

All individual categories of mandatory training had met or exceeded the 90% target except for the manual handling of patients’ module.

The directorate manager for critical care oversaw the directorate’s compliance with statutory and mandatory training. They told us that specific days for statutory and mandatory training were well attended. The directorate manager was also able to be reactive to demand and put on a training day if there was the demand. The directorate manager received a weekly email from human resource about compliance rates which they could then use to encourage staff to complete the training and facilitate training days.
Safeguarding

We reviewed seven sets of patient notes and saw that there were safeguarding reviews in each of them. All staff we spoke with were aware what issues and triggers would constitute a safeguarding concern. They were all confident they knew how to make a referral and how and where to seek advice if it was required. One member of staff told us exactly what they had to do in the event of a safeguarding concern and could show us how they would report it. All staff were trained to level two in both adult and child safeguarding.

All staff were trained in adult and child safeguarding level one. Nursing staff were trained in child safeguarding up to level two and there was a safeguarding lead for the service that was trained to level three.

At the time of the inspection six out of seven staff (86%) that were required to complete child safeguarding at level one had completed it. 153 of 169 (91%) of nursing staff had completed child safeguarding to level two and the one member of staff required to complete level three child safeguarding had completed it. All 16 (100%) of the medical staff had completed level two child safeguarding. Only 20 of the 28 (71%) allied health professional had completed their child safeguarding training.

160 of the 170 (94%) nursing staff had completed adult safeguarding training. 20 of the 28 (71%) allied health professionals had completed adult safeguarding training and all 15 (100%) medical staff had completed adult safeguarding training.

Cleanliness, infection control and hygiene

All the critical care units were visibly clean. Housekeeping staff were present throughout the inspection ensuring that the whole environment was kept clean.

We observed that staff on each of the critical care units were bare below the elbows and the uniform policy was upheld by both clinical and non-clinical staff. All staff were seen to clean their hands when entering and exiting the critical care units. We also observed that all staff cleaned their hands prior to patient contact and where necessary wore gloves or other personal protective equipment. There were sufficient sinks available for staff to wash their hands. Above each sink were guides regarding the five moments of hand hygiene. There was hand cleansing gel at each bed space and sufficient soap dispensers outside and across the units for staff and visitors to use. The dispensers always had sufficient soap in them and none were empty.

A small team from another part of the hospital visited the unit. They all cleaned their hands before they entered the critical care unit and when they left.

Signs at the entrances to the units reminded visitors of the importance of hand hygiene and the need for staff to be bare below the elbow.

All equipment in the storage areas that we viewed was clean and had plastic covers to indicate they had been cleaned. Resuscitation trolleys were clean and free from dust.

In cardiac critical care we found two boxes stored under a table that could hinder the housekeepers’ activity when cleaning the area. However, when the boxes were moved we could see that the area was visibly clean.

The Royal Sussex County Hospital carried out audits on the cleanliness of both level five critical care unit and level seven critical care unit. They had aimed to achieve 98% compliance with the cleanliness standards. On level seven they did not meet the target in August 2018, achieving 97%. However, they had achieved and exceeded the target in each of the four preceding months. On level five they had exceeded the target in each of the five months from April 2018.

The critical care service at the Royal Sussex County Hospital audited hand hygiene across the critical care units. They set a target of 95% compliance. This was achieved in April, May and June
2018 with scores of 100% in April, 99% in May and 99% in June. However, in July and August, compliance dropped to 92.5% and 92% respectively.

**Environment and equipment**

All resuscitation trolleys we saw across level five and level seven, as well as the cardiac critical care were secure, regularly checked and all items were in date.

Checks on all defibrillators had been completed and correctly recorded for the month prior to the inspection.

The medicines storage rooms were clean, uncluttered and fitted with air conditioning units which kept the environment cool. The critical care technician team carried out frequent temperature checks on the fridges and ambient temperatures in the room. We saw records of the temperatures were recorded consistently.

The dirty and clean utility rooms were clean, tidy and free from clutter. We saw that all substances hazardous to health were stored correctly. The folder containing guidance around this subject had to be signed by all members of the critical care team. Most staff had signed to say that they had read it. Those that hadn’t were encouraged to do it at the improvement huddle and the folder was made available after each huddle so staff could take the time to read it.

All staff we spoke with told us that they had sufficient equipment to undertake their roles safely and effectively. There was sufficient physiotherapy equipment available to assist with rehabilitation including a bicycle and a rehabilitation chair on both floors.

Nine out of 17 pieces of equipment we checked had either passed their service due date or did not have a ‘next service due’ date. This was raised with senior staff who told us that they would raise it with estates management. The equipment was not in use at the time of the inspection.

Staff we spoke with were aware of what to do in the event of a major incident. There was a major incident file in the main part of the unit on level seven and level five. Staff were aware of the levels of command in any event that required evacuation.

**Assessing and responding to patient risk**

The inspection team attended the tissue viability ward round. This was led by a band seven nurse but was also attended by the clinical risk lead nurse, the matron and the dietitian. All patients were given an initial review and any risk prone patients were identified and a full review was carried out. Diagnosis and risks were assessed using the skin structure format tool. We observed the team caring for a patient by changing tape to avoid any skin damage as well as providing additional support to their heels to prevent any damage to the skin. The service had also introduced Q-Roller equipment to assist with the turning of patients.

The tissue viability ward round was effective and allowed the team to identify additional risks to patients early and be proactive in their management.

Staff in the critical care units could access mental health support for patients if they were concerned about risks associated with a patient’s mental health. During the inspection we saw mental health input being requested and within one hour a mental health nurse attended the unit to offer advice. Staff reported there was generally good support available for those patients that required mental health support.

The critical care units had seven-day coverage from the critical care outreach team. However, this was not provided 24 hours a day. Coverage was from 7:30am to 7pm. The outreach team would visit deteriorating patients in the emergency department or on the wards. At the end of a shift they would compile a list of patients where there were concerns. The list would be left with the critical care doctors. The outreach team would then go back in the morning for handover from the night team. We observed the morning board round and saw that the outreach team had thorough
knowledge of patients across the hospital that may need to be admitted to critical care. The outreach team would follow up patients that had been discharged to the wards.

In August 2018, 54% of patients received a follow up visit from the critical care outreach team. Priority was given to those patients that had a National Early Warning Score (NEWS) of 5 or more. NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. A score of five or more is statistically linked to increased likelihood of death or admission to an intensive care unit. The outreach team would also prioritise patients with acute kidney injuries.

Staff on the surgical wards managed patients who were at risk of deteriorating safely. They had access to and were supported by the outreach team from critical care during the hours of 7.30 am to 7pm. Ward staff described this support as prompt and efficient and if necessary patients would be transferred to the critical care unit. From 7pm to 7.30am the ward staff could call the critical care doctor on call or the night sister who would assess the patient. If necessary, they would make a referral to the critical care team for admission. Staff on the wards felt well supported by critical care for the whole 24-hour period.

The hospital's lead sepsis nurse was a critical care nurse. Staff in critical care and the critical care outreach team were aware of the 'sepsis six' and how they would need to escalate their concerns if a patient was displaying any signs of suspected sepsis. All patients were screened for sepsis on arrival in the critical care units and monitored throughout their stay.

In the three sets of records we reviewed specifically to look at venous thromboembolisms, we saw that the assessments had been completed and recorded correctly.

We were told that on occasions, patients that had undergone surgery were ventilated in the recovery area. This was because there were no beds available on the critical care units. If a patient was ventilated in recovery, a critical care nurse would provide that patient with 1:1 care in the recovery area. We were provided with data that showed that between April 2018 and August 2018 this happened a total of 44 times with a ranging between five patients in August 2018 and 13 in July 2018. These instances were not reported as incidents because the critical care team were caring for the patient.

Nurse staffing

The trust has reported their staffing numbers below for two different times; March 2017 and April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>As at 31/03/2017</th>
<th>As at 30/04/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>All sites</td>
<td>186.5</td>
<td>203.8</td>
</tr>
</tbody>
</table>

In March 2017 the trust reported they had filled 91.5% of their planned staffing. This decreased to 86.4% in April 2018.

No site breakdown was available as the trust did not report the data at site level.

Vacancy rates

From May 2017 to April 2018, the trust reported a vacancy rate of 12.3% in critical care. This was higher than the trust target of 10.5% in March 2018. This target will reduce incrementally to 9.0% by March 2019. However, during the inspection we received information that showed that since April 2018, the service had reduced their vacancy rate to 8.8%. This was better than the service target of 10%.
**Turnover rates**

From May 2017 to April 2018, the trust reported no staff turnover in critical care. This was better than the trust’s overall target turnover rate of 14% in March 2018. This target will reduce incrementally to 11% by March 2019.

Information received during the inspection showed that from April 2018 to August 2018, staff turnover in critical care at the Royal Sussex County Hospital had risen from 10.2% to 14.2%. This was worse than the critical care target of 10%.

**Sickness rates**

From May 2017 to April 2018, the trust reported a sickness rate of 5.6% in critical care. This was worse than the trust overall target sickness rate of 4.20% in March 2018. This target will reduce incrementally to 3.50% by March 2019.

During the inspection we received site specific data from the critical care team at the Royal Sussex County Hospital. This showed that the sickness rates for the site had fluctuated between 4.3% and 5.5%. All months from April 2018 had been above the trust target of 4%.

**Bank and agency staff usage**

The table below shows the numbers of shifts in this core service from June 2017 to May 2018 that were covered by qualified nursing and nursing assistant bank and agency staff or left unfilled.

For qualified nurses, 2,523 shifts were filled by bank staff and 2,014 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses. In addition, 1,080 shifts were not filled by either bank or agency staff.

For nursing assistants, 291 shifts were filled by bank staff and 1 shift was covered by agency staff to cover sickness, absence or vacancy for nursing assistants. In the same period, 65 shifts were not filled by either bank or agency staff.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Qualified nurses</th>
<th>Healthcare assistants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>2,523</td>
<td>291</td>
<td>2,814</td>
</tr>
<tr>
<td>Agency</td>
<td>2,014</td>
<td>1</td>
<td>2,015</td>
</tr>
<tr>
<td>Not filled</td>
<td>1,080</td>
<td>65</td>
<td>1,145</td>
</tr>
</tbody>
</table>

Unfortunately, we are unable to provide a site-specific breakdown of nursing bank and agency usage in this core service, due to the format of the data provided by the trust.

The service was meeting the Guideline for the Provision of Intensive Care Services, 2015. Level three patients were nursed at a ratio of 1:1, level two patients were nursed at a ratio of 1:2.

The critical care units did not have their own full-time pharmacist. The units had pharmacy provision three days per week.

The unit was using significantly less bank and agency staff than the maximum recommended in the Guidelines for the Provision of Intensive Care Services, 2015. The guideline says that units should not utilise greater than 20% of registered nurses from the bank or agencies when they are
not their own staff. During the inspection we saw that around 10% of staff per shift were from the bank or agency. A significant number of these were the trusts’ own staff working bank shifts.

The trust had recently employed a Nursing Rota Administrator who was responsible for co-ordinating and managing all aspects of the roster. This roster covered both level five and level seven critical care units and was normally drawn up two months in advance. The Nursing Rota Administrator assessed who had the requisite neuro competencies for each shift and allocated accordingly. A running record of all staff that didn’t have full neuro competencies was also kept. This showed how many hours each member of staff had completed towards their neuro competence. The role of the administrator and the general oversight they had of the rota had meant the units had started to see a drop in the use of agency staff and an increase in the use of their own bank staff.

During the inspection we were told that there was an ongoing recruitment process for the role of directorate lead nurse for critical care and that an appointment was expected that week.

We observed the morning handover meeting that covered the two main critical care units. This meeting was held each day at 7:30am. The senior nurse from the night shift handed over every patient, identifying any significant issues, length of stay for each patient, new admissions, any events or incidents that had occurred over night and any planned admissions and discharges planned for the day. Following the handover, the team discussed any education requirements that needed to be met as well as considering requests from the staff to care for certain patients to support patient continuity.

After the handover staff left to have bedside handover and the two shift leaders had a more detailed handover covering more detailed aspects of clinical care. They also discussed family and next of kin issues. Following this meeting all staff attended the board ward round. This was led by the matron and was seen to be well organised and disciplined. This covered all the information that the team would need to know for the shift. The discussions were aligned to five areas which were; patient, quality, people, systems and performance and sustainability.

Medical staffing

The trust has reported their staffing numbers below for two different times; March 2017 and April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>As at 31/03/2017</th>
<th>As at 30/04/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>All sites</td>
<td>31.3</td>
<td>44.5</td>
</tr>
</tbody>
</table>

In March 2017 the trust reported they had filled 70.4% of their planned staffing. This increased to 85.5% in April 2018.

No site breakdown was available as the trust did not report the data at site level.

Vacancy rates

From May 2017 to April 2018, the trust reported a vacancy rate of 18.9% in critical care. This was higher than the trust target of 10.5% in March 2018. This target will reduce incrementally to 9.0% by March 2019.

No site level detail was provided to allow for a site level breakdown of this data.

Turnover rates
From May 2017 to April 2018, the trust reported no staff turnover in critical care. This was better than the trust’s overall target turnover rate of 14% in March 2018. This target will reduce incrementally to 11% by March 2019.

**Sickness rates**

From May 2017 to April 2018, the trust reported a sickness rate of 2.2% in critical care. This was better than the trust overall target sickness rate of 4.20% in March 2018. This target will reduce incrementally to 3.50% by March 2019.

**Bank and locum staff usage**

From April 2017 to March 2018, the trust reported that 287 shifts within this core service trust-wide were filled by bank staff and 2 shifts were filled by locum staff. There were 20 shifts which were not filled by either bank or locum staff. A breakdown of bank and locum usage by staff type at the trust is shown below.

Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
<th>Unfilled shifts</th>
<th>Total shifts (bank + locum + unfilled)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>287</td>
<td>2</td>
<td>20</td>
<td>309</td>
</tr>
<tr>
<td>Junior</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>287</strong></td>
<td><strong>2</strong></td>
<td><strong>20</strong></td>
<td><strong>309</strong></td>
</tr>
</tbody>
</table>

The three critical care units across the Royal Sussex County Hospital had a consultant ratio of 1:6. 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.

**Records**

Record keeping was clear, consistent and comprehensive. During the inspection we reviewed five sets of records across the level five and level seven critical care units and two in the cardiac intensive care unit. Patient safety and care bundles for each patient were kept on the electronic record keeping system and were of a good standard.

Post-surgery cardiac patients, cared for on the cardiac Intensive Care Unit, used a care framework which was quality checked by the band seven nursing staff and the matron completed a weekly quality check. We reviewed drug charts which were consistently completed and there were full details of any medicines prescribed, as well as any allergies. There were no gaps in any of the records.

We reviewed the discharge summary of a patient that was leaving critical care to be admitted to a general ward. We saw that there was good information about the patient including information about their risk of a fall, their NEWS score and any manual handling challenges. There were also details of the critical care outreach team should the patient deteriorate. We saw reports from the medical team with details of post intensive care syndrome and any risks that were present. There was also a comprehensive rehabilitation assessment. There was a nursing report about the patient’s physiological condition as well as details of the most recent contact with the next of kin.
**Medicines**

Medicines storage rooms were accessed using a swipe card. We were told that access to the room was restricted to staff that had a clinical need to access the room. We saw that a member of the housekeeping team could access the medicines storage area. This was raised with the matron who immediately contacted the security systems manager who cancelled the housekeeper’s access. This was done as there were unlocked fridges in the storage room that contained various medicines that had the potential to be abused.

The critical care team had devised a system to do a monthly check to see that all drugs were in date, or if they weren’t, to have them removed. This involved rota team one checking one cupboard and rota team two checking the other. Although the system was mostly working well, we did see some gaps in the recording of the checks in May and July 2018. This was a relatively new system and by their own admission, had not been fully embedded. There was no mandatory requirement to do this.

Both the level five and level seven medicines storage rooms had CCTV fitted to monitor what happened when people were in them.

To minimise the number of medication errors the service used a system where they would give some background to what was happening, a problem statement that detailed what the problem was, what the current situation was and the visions and goals. Using this method, they identified that between December 2017 and March 2018 there had been 35 medication errors, this represented 0.08% of all medicines given. Having reviewed the errors they were able to identify that ten had the potential to cause harm or cause harm to patients. Five of these were incorrect doses. They had set a goal to reduce medication errors by 50% over the course of the next six months. To help achieve this they had introduced the ‘five rights’ of medicine administration where staff checked for the right patient, right drug, right dose, right route and the right time. These elements would be looked at three times to ensure that medication errors were reduced. This piece of work formed part of one of the critical care unit’s drivers for change.

Between April 2018 and August 2018 there had been 14 medication errors. Ranging from one in June 2018 to four in May 2018.

We reviewed the controlled drugs book and saw that all checks were consistently completed in line with trust policy. Controlled drugs were stored securely and all cupboards clearly labelled. The service had introduced a weekly matron audit of the controlled drugs.

**Incidents**

**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 2017 to May 2018, the trust reported no incidents classified as never events for critical care.

At the time of the inspection the trust had 42 open incidents that were being investigated. This had been reduced significantly since the previous inspection when there were approximately 250 outstanding incidents.

During this inspection we saw that there was only one incident that remained open that was from 2017. This was due to factors beyond the services control which meant they were unable to
complete their investigation. The service submitted around 40-60 incident reports per week and kept the number outstanding at a constant level and had not allowed a backlog to build up. The appointment of a clinical risk nurse in April 2017 had allowed for someone to have an oversight of all the incidents being reported. There was also oversight from the unit matron. The matron and the clinical risk manager met weekly to review all incidents that had been reported. There were also daily reviews of any incidents reported to ensure that any immediate learning could be taken. An example was given of how changes were made to a clinical process following a cluster of incidents about moisture damage related to the use of a tracheostomy.

Any themes that were identified were shared with all staff through the management structure. The matron would disseminate through the ward sisters who in turn would pass the information to their teams. There was also a system in place for the matron to provide written feedback, thanking staff for reporting incidents. The system could also be used to highlight any areas where individuals had made an error, and what the impact of that error was. We were shown an example where a member of staff had been given feedback. It was considered by the inspection team to be supportive in tone.

We reviewed two full incident investigations. We considered that both were comprehensive investigations that had been thoroughly carried-out. All information had been considered and conclusions had been reached. Although the incidents were not preventable, the service still recognised that lessons could be learned. Changes had been made to process in response to one incident investigation to mitigate any future risk.

The clinical risk lead nurse told us that there had been an improvement in the reporting culture and that staff were more confident in reporting any incidents. This was reflected when speaking with a range of staff on the units.

The inspection team were told about another example of how the service had learnt from a particular incident and what they had done to mitigate any future risk. It was noted that there had been an increase in the reporting of grade two pressure ulcers. The information was collected and the clinical risk nurse contacted another hospital that had a specific tissue viability team for critical care to see what learning could be taken from them. As a result, they replaced the mattresses across the critical care department.

The service also produced a newsletter called ‘Risky Business' where learning from incidents could be passed on. Learning from incidents was also shared at the daily safety huddle where necessary. The learning was described as improvement opportunities. The huddles used a structured format and were conducted using language that all staff could understand. We observed a huddle during the inspection and considered that these were an excellent initiative and were attended by a full range of clinical and non-clinical staff.

We discussed the management of Central Alerting System (CAS) alerts with the matron. CAS is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. We were shown that there was a clear process to follow to disseminate any messages to the team. This would ordinarily be done in the safety huddle although a message could be sent using the electronic patient records system if the message was urgent.

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 2017 to May 2018.

Safety thermometer
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 ten days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported six new pressure ulcers, one fall with harm and no new catheter urinary tract infections from July 2017 to July 2018.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls with harm and new urinary tract infections at Brighton and Sussex University Hospitals NHS Trust**

1. **Total Pressure ulcers (6)**
   - **Total Falls (1)**
   - **Total CUTIs (0)**

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

**Is the service effective?**

**Evidence-based care and treatment**

The critical care units had policies, protocols and care bundles that were based on guidance from the National Institute for Health and Care Excellence (NICE), the Intensive Care Society (ICS) and the Faculty of Intensive Care Medicine (FICM). This was evident from observing the nursing care and reviewing the records. Adults receiving intravenous fluid therapy received treatment from fully competent staff. Patients at risk of venous thromboembolism were assessed and treated in accordance with NICE guidance.
Handovers we observed included details about the patients psychological and emotional needs. They also considered the psychological needs of relatives or carers.

Every patient, on admission to the critical care units was screened for sepsis in accordance with NICE guideline 51 (Sepsis: recognition, diagnosis and early management).

Although the critical care teams could access support from the dementia lead nurse, they did not carry out their own assessments for dementia. Therefore, if a patient was admitted with delirium, they were not routinely assessed for dementia following the period of delirium.

Staff had received conflict management training which would assist if a patient became violent and aggressive. However, there was no formal training of staff to assist with dealing with patients that had a mental health problem in accordance with NICE guideline NG10 (Violence and aggression: short term management in mental health, health and community settings).

**Nutrition and hydration**

The critical care units had appointed a dietitian to the service on a full-time basis. There was also one whole time equivalent dietitian provision in addition to this from other areas of the hospital. The dietitian would see patients on a referral basis for those that required their intervention most. There was an out of hours protocol in place for dietitian cover when the full-time dietitian was not working.

When reviewing patient records, we saw that there were dietitian referrals and evidence of dietetic reviews. This was in line with guidelines for the provision of intensive care services, 2015. We also saw that fluid balance charts had been completed.

Nursing staff assessed patients' nutrition and hydration needs using the malnutrition universal screening tool (MUST). We saw that this had been used when reviewing patient records.

We also saw a comprehensive document entitled Nutrition Support in ITU and HDU. This provided guidance to nursing staff around:

- Dietitian referrals
- Adult critical care nutrition pathway
- Refeeding Syndrome
- Starting enteral feeds: checking the pH of gastric aspirates
- How much to feed: enteral feeds
- Types of enteral feeds
- How much to feed: parenteral feeds
- Useful nutritional policies on the Intranet

**Pain relief**

During the inspection we saw good evidence, in the records we reviewed, that demonstrated that pain was managed. Patients we spoke with told us that they were not in pain and that if they were, they could obtain pain relief.

The trust had a target to complete 100% of individualised pain assessment carried out regularly. Performance against this had varied from as low of 45% in June and July 2018 to 62% in August 2018.
We were shown a chart with pictures that people could use to describe their pain if they could not communicate verbally. There were a series of pictures that showed an ascending scale of pain with a score next to it.

**Patient outcomes**

At the time of the inspection the service was working towards a target of completing 95% of rehabilitation assessments on admission and discharge. In August 2018 the service achieved the 95% target in relation to rehabilitation assessments on admission. The service had not met the target for rehabilitation assessments on discharge in August 2018 achieving 61%. However, there had been an improving trend throughout the previous months.

**ICNARC Participation**

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.

The cardiac intensive care unit did not contribute to ICNARC although at the time of the inspection consideration was being given to how this may be possible in the future.

**Hospital mortality (all patients)**

**Royal Sussex County Hospital**

For the Intensive Care Unit at Royal Sussex County Hospital, the risk adjusted hospital mortality ratio was 0.9 in 2016/17. This was within the expected range. The figure in the 2015/16 annual report was 1.0.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,736 admissions</td>
<td>Risk-adjusted hospital mortality ratio (all patients)</td>
<td>1.0</td>
<td>0.9</td>
<td>1.0</td>
<td>none</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

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

**Royal Sussex County Hospital**

For the Intensive Care Unit at Royal Sussex County Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.6. This was within the expected limits. The figure in the 2015/16 annual report was 0.8.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,238 admissions</td>
<td>Risk-adjusted hospital mortality ratio</td>
<td>0.8</td>
<td>0.6</td>
<td>1.0</td>
<td>none</td>
<td>Within expected limits</td>
</tr>
</tbody>
</table>
for patients with predicted risk of death <20% (lower risk)

At the time of the inspection, we were provided with up to date ICNARC data for the period April 2017 to March 2018. This showed that for the Intensive Care Unit at Royal Sussex County Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.8. This was within the expected limits. The figure in the 2016/17 annual report was 0.6

**Competent staff**

**Appraisal rates**

From May 2017 to May 2018, 80.6% of staff within this core service at the trust received an appraisal compared to a trust target of 78%. The trust target is correct at March 2018; however, they have commented that the target will increase incrementally to 90% by June 2018. Below is a split of appraisal completion rates by staff group.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals complete</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>78%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>150</td>
<td>182</td>
<td>82.4%</td>
<td>78%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>11</td>
<td>18</td>
<td>61.1%</td>
<td>78%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>162</strong></td>
<td><strong>201</strong></td>
<td><strong>80.6%</strong></td>
<td><strong>78%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

During the inspection we were shown evidence that the overall appraisal rate for all staff groups had reached 94.4%. This exceeded the trust target of 90%. This information had been validated through human resources and the electronic system for monitoring appraisals. There was a monthly meeting between the service leads and human resources to review progress. All staff that we asked about their appraisals told us that they had them and that they were useful and provided them clear direction.

The matron described how each of the band seven ward sisters had clear responsibilities for improvement projects. Each band seven would lead their teams on projects such as falls, staff support, mouth and eye care and pain management. The project work used the patient first methodology to identify the problem. There would be a problem statement to demonstrate what needs to improve, the current situation, the vision and goals. The preliminary analysis was linked to the ‘five whys’ technique. The primary goal of the technique is to determine the root cause of a defect or problem by repeating the question “Why?” Each answer forms the basis of the next question. They will then consider the opportunities, the countermeasures, benefits and impact. At the time of the inspection there were different improvement projects underway, all aligned to the trust’s ‘True North’ strategy, values and objectives.

We were shown a competency and training package for all new band five nurses. Further educational courses were available that were fully funded. New Band five nurses told us how they were given five weeks of supernumerary practice at the beginning of their employment and that their induction, training and education were good. During the inspection we were told that the
supernumerary period had increased to six weeks. We were also told that senior staff were supportive and helped with their development.

At the time of the inspection the critical care units had 56% of their staff trained with full neuro competencies. This was due to increase over time as more staff completed their required number of hours practice to be considered neuro competent.

Junior medical staff we spoke with told us how they had been well supported by the critical care lead consultant, that there was a good teaching programme supervised by the consultant team and good peer learning.

Other medical staff told us that nurse leadership was good, that the services were now more integrated and that real value was put on the skill of individuals. This in turn had meant that everyone’s skill sets had improved and that the units felt safer with more neuro competent staff around.

Staff we spoke with told us they did not receive any formal training on how to screen for dementia. Some patients that came to the critical care units had previously been assessed as living with dementia. However, staff would have to call the dementia lead nurse no make a formal assessment.

**Multidisciplinary working**

There was a weekly rehabilitation ward round across both level seven and level five critical care units that happened on a Tuesday morning. During the inspection we observed this ward round. The ward round was attended by the consultant, nursing staff, physiotherapist and student physiotherapist, speech and language therapist, dietitian and the rehabilitation assistant. The consultant approached the patient to explain who was at the bedside and asked if there was any objection to a CQC inspector being present. Following this each member of the team introduced themselves to the patient. The communication between each member of the team was clear and easily understood, plans for the care of the patient were discussed and agreed. All members of the team were respectful of what others were saying and there were no occasions where there were separate conversations going on.

All of the nursing staff we asked told us that therapy staff, including physiotherapists, speech and language therapists and the rehabilitation assistant were always accessible. The appointment of a full-time dietitian had also helped with patient care.

The inspection team were told about a situation where a heavily pregnant patient was admitted to the critical care unit. It was decided, in conjunction with the maternity team that the baby would need to be delivered by emergency caesarean section. The team called on their colleagues with the relevant expertise and the baby was successfully delivered.

We spoke with staff in the cardiac critical care department who told us they did not work very closely with the general and neuro critical care units. They gave an example of how they would send patients for haemo-filtration but there was little other cross over. However, we were told how the two different departments will move closer together and how the governance for critical care has improved since joining the same directorate.

**Seven-day services**

The outreach team provided a seven-day service although it wasn’t provided 24 hours a day. The critical care units had employed a full-time dietitian but they were not available seven days per week. There was a full five-day physiotherapy service with reduced service at the weekend.

A full-time physiotherapist who was on secondment from another area in the specialist services division was available to the critical care team. There were also other physiotherapy support staff working in critical care.
Health promotion

Patients that attended the critical care units at the Royal Sussex County Hospital were offered support when they left hospital. Patients could access a charitable organisation where information, support and help could be sought after. This included help with drug addiction, alcoholism and smoking cessation.

Patients were also signposted to other organisations that could assist with a range of other physical and mental health problems.

Information about patients’ stay on the critical care unit was also provided to other health professionals and carers involved in their day to day care. Patients and relatives had access to information that advised about healthier lifestyles.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

We saw good recording of mental capacity assessments in the three sets of notes we selected at random. We saw evidence of best interest decisions being made and documentation regarding conversations about a patient’s care with the patient’s family. Any decisions made were reviewed daily. We saw that where possible consent was sought in accordance with General Medical Council guidance: patients and doctors making decisions together.

During the inspection we saw a member of the nursing team complete a deprivation of liberty safeguard review on a long-term patient. We observed them complete the form and send it off to the relevant local authority.

We saw that during a rehabilitation ward round, a patient who was ready to be transferred to a general ward, needed to wear gloves for their own safety. Consideration was given to applying to the local authority for a deprivation of liberty safeguard.

During a review of the records we did not see that any formal assessments for dementia had been undertaken in critical care. We were told that if it is suspected that a patient has dementia the teams can call on a dementia nurse to visit the patient.

Mental Capacity Act and Deprivation of Liberty training completion

Trust data showed us that 94% of nursing staff and 100% of medical staff had completed Mental Capacity Act and Deprivation of Liberty safeguard training.

Is the service caring?

Compassionate care

During the inspection we were shown what the service described as plaudits. These had all been received within the last month. There were letters and cards and they all described in detail just how caring all the staff had been. There were letters from those that had lost loved ones as well as those where the team had undoubtedly saved their loved one’s life. During the inspection we saw the plaudits board on level seven which displayed all the cards and letters that critical care units had received. There were at least 15 separate cards and letters, all of which spoke incredibly positively about the care and support patients and their loved ones had received.

We were given a specific example of how the team had saved someone who came to the critical care unit extremely sick having been involved in an accident. The family of the patient had then travelled from overseas to meet the team and offered thanks in person for the work they had done and the compassion they had shown the patients immediate family at the time of the accident.

We also saw a plaudit from a family member who had lost their relative, who had in turn become an organ donor. They were extremely grateful for the understanding and compassion shown when
they were going through the organ donation process and thankful that their relative could provide life to another person.

We repeatedly heard that the care provided by the staff on the critical care units had been exceptional. It was variously described by both patients and visitors as "amazing, brilliant care", "everything has been great, couldn’t have asked for more" and "absolutely brilliant". Another patient described how the care was really good and nothing was too much trouble. Staff never made them feel that they were a hindrance and all staff treated them well including the doctors and physiotherapists who were described as "brilliant".

A patient specifically asked to speak to one of the inspection team about their experience on the critical care unit. They told us that they had had many hospital admissions at different hospitals. They singled out one doctor for praise, describing them as "beyond excellent". They explained how the whole team had been excellent and that it was the best unit they had ever been on. The patient had had cause to repeatedly ask a nurse for help with something and described how the nurse had never shown anything but kindness and that staff were as good as they could be and were very attentive.

The inspection team were told about a situation where a heavily pregnant patient required treatment on the critical care unit. The baby was subsequently delivered in critical care by caesarean section. Although this was an event that rarely happened in critical care, we saw letters and cards from the family which demonstrated that the team had dealt with a rare event with the same degree of kindness and compassion that they would any other patient.

Staff devoted time and effort to ensure that patient’s privacy and dignity was always maintained. Because the critical care environment is mixed sex, coupled with the delays experienced discharging patients out of critical care, mixed sex breaches did happen. However, we saw that staff did all they could to ensure that patients had their privacy and dignity maintained. No patients we spoke with raised any concerns in this regard and there had been no complaints about the issue.

**Emotional support**

We observed many interactions between staff and patients that demonstrated excellent care that went beyond just supporting patients with their physical wellbeing. Patients we spoke with talked of how supportive all the staff had been and how they couldn’t have done more for them. Relatives and loved ones of patients being cared for in critical care units also told us of the support that they had been given when dealing with very sensitive situations.

We saw a specific example during the inspection where a patient discussed a difficult decision with a member of nursing staff. During a busy period, the member of staff spent extra time with the patient to ensure they were clear about what they wanted to do and explained how they could help them. Another member of staff also joined the conversation to ensure that what had been discussed with the original member of staff was correct. The interactions we observed between the staff and the patient were exceptional and it was clear that the staff were considering their physical and mental wellbeing at a time of heightened emotion.

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

We observed an improvement huddle where the topic of patient diaries was discussed. An issue had been raised that on occasions diaries had gone missing when a patient was either transferred to a ward or moved hospital. All staff were aware of the importance of ensuring that the diary stayed with the patient so they had a record of what happened to them while in critical care.

During the inspection we were present when a relative returned to the unit to say thank you for the care that staff had provided for their relative. They wanted to visit in person to thank all the staff for the help and love they showed them, as well as their relative during the time they were on the unit.
Service delivery to meet the needs of local people

The inspection team were shown round the relatives’ room adjacent to the level seven ITU. In there we were shown the information that was provided to those visiting. There were a range of information leaflets available in English and three other languages. The service had carried out research with their provider of interpreting services to establish the three most commonly used languages. As such, they had translated information leaflets into Arabic, Russian and Polish. They had also established the nine most common languages used and now displayed a poster with text in all these languages about how they could access further information as well as providing the details of the interpreting service available.

Relatives could stay in this room overnight if necessary. The room was large enough to accommodate a small number of people and had a TV that could be used by anyone staying if they wanted to. The service had also obtained a vending machine that contained healthy snacks and drinks.

Also in the relatives’ room was a large picture that showed all the stages of the critical care pathway. The picture was approximately three feet tall by six feet wide. Although it was essentially a flow chart, the pictures it displayed could be understood by adults and children alike as well as those who did not speak English as a first language. Included in the picture were links to a wide variety of support groups and information sources. These could be directly accessed by using a smartphone to link to the QR code. A QR (quick response) code is a type of two dimensional bar code that is used to provide easy access to information through a smartphone. In this process, known as mobile tagging, the smartphone’s owner points the phone at a QR code and opens a barcode reader app which works in conjunction with the phone's camera. The inspection team tested this technology during the inspection. Each time we scanned a QR code, we were immediately taken to the information resource.

Meeting people’s individual needs

The service had introduced a standard operating procedure to be used when a person under the age of 18 was admitted to critical care. We reviewed the document and saw that it ensured that the paediatric critical care consultant would be involved in any decisions made about the care of the patient. During the inspection there was a patient under the age of 18. We saw staff follow the procedure and notify the nurse in charge and the consultant at the children’s hospital that was co-located at the Royal Sussex County Hospital.

The service ran a bi-monthly Steps group for patients that had been discharged from critical care. This was a support group that would be led by the clinical team which patients and relatives could attend. The meetings were held close to the hospital. Patients could also be taken back to the critical care department, if they wanted to, so they could see where they were cared for.

The critical care service had developed what they called ‘stress busting’ boxes. These were plastic boxes that were large enough to contain a number of items important to the patient but small enough to remain at their bed space. If they were able, patients could leave a message for loved ones to read if they were unable to communicate when they visited. Staff would provide paper and pencils so the patients could draw. Some patients would ask for a mirror so they could look at themselves, while patients that had spinal injuries could have a clock that they could view without having to be moved. Each box would be tailored to the individual and the contents were funded by charitable donations.

If a patient was approaching the end of their life, and they had children, the service would provide something like a teddy bear for the patient so they could have it with them when their children visited. This was something that the children could take home to remind them of their parent. The service had a range of items that they could use for this which would be suitable for a range of ages.

Is the service responsive?
We were told by the relative of a 17-year-old patient that the service had looked after them well and had provided them with a side-room when they initially came to the unit. They made particular mention of how flexible the service had been around visiting times and accommodating the patient’s friends when they visited.

**Access and flow**

The trust had a target to admit 100% of patients within four hours of the decision to admit being made. They had been unable to meet this target for any of the months between April 2018 and August 2018. This ranged from 42% in April 2018 to 78% in June 2018. The figure had since stabilised around 74%.

**Bed occupancy**

From July 2017 to June 2018, Brighton and Sussex University Hospitals NHS Trust has seen adult bed occupancy remain stable, this is about the same as the England average.

**Adult critical care Bed occupancy rates, Brighton and Sussex University Hospitals NHS 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)*
Delayed discharges

Royal Sussex County Hospital

For the Intensive Care Unit at Royal Sussex County Hospital, there were 11,315 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 10.6%. This compares to the national aggregate of 4.9%. The unit was not in the worst 5% of units. The figure in the 2015/16 annual report was 17.0%.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>11,315 available critical care bed days</td>
<td>Crude delayed discharge (% bed-days occupied by patients with discharge delayed &gt;8 hours)</td>
<td>17.0%</td>
<td>10.6%</td>
<td>4.9%</td>
<td>0%</td>
<td>Not in the worst 5% of units</td>
</tr>
</tbody>
</table>

Non-clinical transfers

Royal Sussex County Hospital

For the Intensive Care Unit at Royal Sussex County Hospital, there were 1,854 admissions, of which 0.4% had a non-clinical transfer out of the unit. This was within the expected range. The figure in the 2015/16 annual report was 0.4%.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,854 admissions</td>
<td>Crude non-clinical transfers</td>
<td>0.4%</td>
<td>0.4%</td>
<td>0.4%</td>
<td>0%</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

During the inspection we were given data that showed that the critical care units at the Royal Sussex County Hospital had recorded zero non-clinical transfers between April 2018 and August 2018.
Non-delayed out of hours discharges to the ward

Royal Sussex County Hospital

For the Intensive Care Unit at Royal Sussex County Hospital, 3.6% of admissions were non-delayed out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. This was within the expected range. The figure in the 2015/16 annual report was 3.8%.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,434 admissions</td>
<td>Crude, non-delayed, out-of-hours discharge to ward proportion</td>
<td>3.8%</td>
<td>3.6%</td>
<td>1.9%</td>
<td>0%</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

The trust had a target that there would be less than 6.3% of patients discharged to the ward. However, they had not been able to meet this target in any of the months from April 2018 to August 2018. The most recent data, provided during the inspection showed that there were 16 discharges in April 2018 equating to 14% of patients. In May there were 23, equating to 23% of patients. In June there were 30 patients, equating to 21% of patients. In July there were 24, equating to 19% of patients and in August there were 26, equating to 20% of patients.

All admissions to critical care had to go through the most senior consultant on duty. All admissions to critical care were reviewed by a consultant with 12 hours. This was in line with the Guidelines for the Provision of Intensive Care Services 2015.

We heard from members of the consultant team that the introduction of the patient first improvement system, coupled with workshops regarding patient flow had made conversations regarding patient flow a little easier, and consequently more patients were moving, more quickly.

The critical care service at the Royal Sussex County Hospital had a target to have less than 1.2% of patients readmitted to critical care within 48 hours of discharge. The service did not meet this target in April 2018, with 1.7% of patients being readmitted within 48 hours. However, there were zero readmissions within 48 hours for the following four months.

The Royal Sussex County Hospital set a target that no elective surgery would be cancelled due the lack of a critical care bed. However, there were four elective surgical procedures cancelled in April 2018, two in May 2018 and one in June 2018. There was no data available for July and August 2018.

Learning from complaints and concerns

Summary of complaints

From April 2017 to March 2018 there were six complaints about critical care. Three were related to access to treatment or drugs. The trust took an average of 68 days to investigate and close complaints. This was worse than the target of 25 days. These complaints all related to Royal Sussex County Hospital.

From the first of January 2018 to 1 July 2018 there had been one complaint about the critical care service. This had been investigated and passed to the corporate complaints team. During
the inspection we were told about the complaint and saw that there had been learning taken from it.

In the month prior to the inspection (August 2018) the service had received 15 compliments. At the time of the inspection there had been at least another 15 sent in September 2018. The service had managed to exceed its target of receiving ten compliments every month since April 2018.

**Is the service well-led?**

**Leadership**

Nursing staff we spoke with were overwhelmingly positive about the support they got from their managers and from the medical team. They felt they were part of the unit and were involved in improvement initiatives.

Staff we spoke with were confident in their leaders’ abilities and skills. Leaders were clearly aware of the challenges faced by the critical care directorate and were keen to tackle them where and when they could.

The critical care directorate did not have a specific lead for mental health within the service. However, one of the consultant team lead on investigating any incidents that related to patients with mental health needs. The service also worked closely with the mental health team from the emergency department (A&E). On occasions they did employ agency mental health nurses to care for patients with mental health needs. There was no specific general training for staff around mental health. There was face to face training provided in conflict management from one of the mental health nurses in the trust.

Senior staff we spoke with told us that the relationship with Human Resources (HR) had improved significantly since the last inspection. Leaders felt that they were supported by the HR team when they needed their input. Referrals to occupational health were dealt with more quickly and were reported to be helpful for staff.

**Vision and strategy**

Staff we spoke with around the vision and strategy for the service all described how it was linked to the objectives of the trust. We were told that for all short to medium term plans, everything had to align with the four aspects of true north. These were: sustainability, people, quality improvement and systems and partnerships.

The team had six drivers that would help them deliver against true north objective. The drivers for critical care at the Royal Sussex County Hospital were: to increase feedback from relatives, reducing medication errors and pressure ulcers, reducing the reliance on agency staff, improving infection prevention and control, improving staff support and wellbeing and a reduction in delayed discharges.

**Culture**

We spoke with a range of staff about the culture in the critical care directorate. All staff said that there had been a change and that the critical care units were more cohesive places to work than they were previously. We heard how senior members of nursing and medical staff had an open door and that they had the confidence to ask questions when necessary. Throughout the inspection we saw this was the case even when staff were not immediately aware that members of
the inspection team were close by. We were also told how 34 people had attended a ‘we are staying party’ that was organised by staff to celebrate where they worked.

Staff told us how the differences between the neuro and general nursing team had now been resolved. The programme to equip general nursing staff with neuro skills was proving successful and helped reduce any feelings that the teams were significantly different. We were told that the introduction of the neuro nurse practice educators had also helped in changing this aspect of culture.

The directorate managers also described how a culture had developed where they, and senior nursing and medical staff were able to constructively challenge each other and that the mindset was about making improvements to the service.

We were told by members of the medical team how the improvement huddles had shown that staff at all levels could contribute to the unit’s improvement and that a lot of the best ideas came from the nurses and HCAs. It was also recognised that it no longer felt like a ‘top down’ structure and that everyone had their chance to contribute. This was also echoed by housekeeping and other support staff we spoke with.

Medical and nursing staff were generally aware of their responsibilities relating to the duty of candour although not all staff knew exactly what it meant. They were aware of what may constitute an incident that required them to exercise the duty of candour and were clear about the process they needed to follow.

**Governance**

We were told by a variety of staff how the arrival of the new executive team and the move to a new structure, in which critical care was its own directorate in the specialist services division, had all combined to show real benefits to critical care. This had been largely achieved through the patient first programme but there was now a sense that critical care specific matters got dealt with and resolved more quickly.

There were effective structures, processes and systems of accountability to support the delivery of the strategy and to provide good, quality based sustainable services. These were regularly reviewed and improved. We also heard of the audit program development scheme which looked to review a range of data including ICNARC and other audits carried out trust wide and locally. The results would be used to improve the quality of service. We saw evidence that recent audits were displayed on notice boards across critical care. These were easily accessible through the audit nurse. Dissemination of results was made via team meetings, huddles and handovers or during appraisals if these were directly relevant to the individual.

We heard that all levels of governance and management functioned effectively and interacted with each other. One example of this was how the senior staff used the strategy deployment reviews on a weekly basis to support the monthly clinical governance leadership meeting which looked at incident trends and themes as well as topics such as staffing and recruitment. In addition to the monthly clinical governance meetings, the finance meeting would follow and assist with any decisions that needed to be made.

The governance structure also included the divisional clinical governance meeting which looked at never events, significant incidents and the application of the duty of candour. Exception reports were reviewed and these would be escalated to the board. The meetings were held on a bi-monthly basis. Messages from this meeting were fed back to leaders at unit level so all staff could review information and learning. Staff were encouraged to participate in conversations about any topics or themes.

**Management of risk, issues and performance**
During the inspection we were told by a range of staff about the introduction of the improvement huddle and how this led to changes being made that improved safety and mitigated risk. The huddles were held daily, although there were plans to run one per shift in the future. All staff in critical care were welcome to attend. Staff completed a ‘ticket’ with ideas about how anything could be improved. This ticket was then attached to the board. At the start of each session, the member of staff running the improvement huddle, which could be any member of staff regardless of their role, would look at the ticket. All those present would then use a pick chart to show if the idea could be implemented or dismissed and whether it was easy or challenging and what the impact of its implementation would be. Tickets would then be moved around the board depending whether they were a work in progress or whether they were part of a problem-solving exercise using the ‘plan, do, study, act methodology. There was an area where all tickets could be stored that showed all the ideas that had been implemented.

We reviewed the risk register and saw that the three biggest risks to the service at the Royal Sussex County Hospital related to patient flow, pharmacy cover and 24-hour, seven-day outreach provision. These were all long standing issues, were systematically reviewed and had dates for future review. The critical care leadership team met with the corporate risk team on a quarterly basis to assist with managing their directorate risks.

Information management

The service collected the information it needed for submission to ICNARC using the electronic patient record and monitoring system. Data was then extracted by the data quality administrator and provided to matron on a weekly basis. This included data on delayed discharges and out of hours discharges. They would also produce a bereavement report that would go to the organ donation team. There was a monthly report around the safety thermometer and a safer staffing report.

The critical care directorate kept a dashboard for each of their critical care units. The dashboard contained a wider range of information about the team’s performance, staffing, infection prevention and control as well as data about the access and flow to and from the critical care units. The dashboard also contained data about how the teams were performing in relation to the overarching drivers for improvement. We reviewed the data collected and saw that it would provide the leadership team with up to date information. It also analysed any trends which showed where improvements had been made or where performance had dropped.

Engagement

The critical care directorate had a service level agreement with another local NHS trust that had a specialist burns unit. If the critical care units had a patient with burns, they could get one of the burns specialists to visit the patient and be involved in the management of their burns until they were well enough.

The service also had in reach from another major hospital specialising in care for spinal injuries where staff would come and visit patients until they could be transferred.

The NHS staff survey showed that there had been a 24% increase in critical care staff response, rising from 27% to 51%. In that survey it was found that there had been a 14% increase in staff valuing their appraisal, from 82% to 96%, an 8% increase in staff feeling able to raise concerns, improving from 52% to 60% and a 5% increase in staff believing the organisation took action to prevent errors, up from 55% to 60%.

Learning, continuous improvement and innovation

During the inspection we were shown a new initiative that had been introduced for key roles across critical care. They had developed a template for key roles called leader standard work.
Here, the job role had been assessed to identify what they could improve, what they could delegate, things that they can stop doing and things that they want to do but can’t. This would also include a list of the persons’ daily tasks, weekly tasks and monthly tasks. While this provided a base guideline for individuals to have as a live document, it also meant that should someone be on leave or absent for an extended period, someone else could pick up the leader standard work document for that person and understand exactly what their role was and how tasks could be delegated.

The effect of this was that the ‘single point of failure’ had been mitigated and tasks would be covered during someone’s absence. During the inspection we saw a real example of this as the clinical risk nurse had taken an extended period off, but the management of incident investigations had been covered.

At the time of the inspection, one of these cards had been created for the lead consultant, the lead technician, the data lead, the directorate general manager and the clinical risk nurse. Others, including the matron’s, were also in development.

The critical care directorate had appointed a directorate manager in January 2018 to assist with some areas that had previously been dealt with by the clinical staff. They had been able to develop a positive working relationship with the medical and nursing staff in critical care. The directorate manager would attend meetings with the organ donation team, estates and maintenance teams and nursing team. This then allowed them to take forward any issues that had been raised.

We were told about an initiative that had been introduced by one of the practice nurse educators. It was called mindfulness Monday. There were sessions booked for the remainder of the year that staff could attend. This was an opportunity for staff to have some time where they could look after their own wellbeing in a relaxed and supportive environment.

A member of the medical team described how the changes that have happened across the critical care directorate had not been anything spectacular but instead small improvements that had led to bigger change. The approach to incident investigations, recognising themes and approaching any problems with an open mind had meant that patients were safer. The team now looked at what was within their control, what wasn’t and when it was not, who could help.

We were told that the critical care team had made improvements to their patient diary which were going to be placed on the ICU Steps (ICU Steps is the Intensive Care Patient Support charity) national data resource and that the outreach team were taking it to present to an international conference at a university hospital in the Unites States of America.

We saw information displayed on level seven, by the doctors’ station. This showed where the performance was in relation to the critical care drivers. We saw that there had been progress in improving feedback from relatives, reducing the reliance on agency staff and improving infection prevention and control. However, delayed discharges were still a cause for concern and action was being taken to improve patient flow. This was recognised as a system problem for the whole trust.

There had also been a target set to reduce pressure ulcers to no more than four per month at grade two. However, there had been 11 recorded at grade two in August 2018. This had dropped back to two in September 2018. There had been two recorded at grade three and above in September 2018 although only one had been recorded prior to this since April 2018. It was explained that there had been a recent change to the way that pressure damage was reported in some instances which had caused the spike in numbers. Pressure ulcers were reported using the National and European Pressure Ulcer Advisory Panel Guidelines.

The service had appointed a band six neuro practice development nurse on secondment until January 2019. They had been involved in a programme of neuro simulation training. This had allowed for new starters to gain neuro competencies from their first day of employment with increased supernumerary time. The practice development nurse had also introduced prompt cards to assist nursing staff working on their neuro competencies and these were placed by the patient’s bedside.
The service had gone from having 19 neuro competent staff in August 2017 to 29 in August 2018. It was projected that following the completion of the rotation running between July 2018 and December 2018, there would be 41 neuro competent nurses.

The cardiac intensive care unit had introduced a supernumerary shift leader and had submitted a business case to further increase staffing.

We were told during the inspection that the service was over recruiting for band five and band seven nurses to cover the shortage of band six nurses. At the time of the inspection the service had 86 band five nurses in training.

Maternity

Facts and data about this service

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

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

(Source: Routine Provider Information Request – Acute sites)

A comparison from the number of deliveries at the trust and the national totals during this period is shown below.

Number of babies delivered at Brighton and Sussex University Hospitals NHS Trust – Comparison with other trusts in England (April 2017 to March 2018)

A profile of all deliveries and gestation periods from January 2017 to December 2017 can be seen in the tables below.
### Profile of all deliveries (January 2017 to December 2017)

<table>
<thead>
<tr>
<th>BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Single</td>
<td>4,967</td>
</tr>
<tr>
<td>Multiple</td>
<td>98</td>
</tr>
</tbody>
</table>

#### Single or multiple births

- Single: 4,967 (98.1%), 98.5%
- Multiple: 98 (1.9%), 1.5%

#### Mother's age

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Deliveries (n)</th>
<th>Deliveries (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td>118</td>
<td>2.3%, 3.0%</td>
</tr>
<tr>
<td>20-34</td>
<td>3,382</td>
<td>66.8%, 74.8%</td>
</tr>
<tr>
<td>35-39</td>
<td>1,249</td>
<td>24.7%, 18.1%</td>
</tr>
<tr>
<td>40+</td>
<td>316</td>
<td>6.2%, 4.1%</td>
</tr>
</tbody>
</table>

#### Total number of deliveries

<table>
<thead>
<tr>
<th></th>
<th>Deliveries (n)</th>
<th>Deliveries (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>5,065</td>
<td>592,194</td>
</tr>
</tbody>
</table>

Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

### Gestation periods (January 2017 to December 2017)

<table>
<thead>
<tr>
<th>BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>8</td>
</tr>
<tr>
<td>Pre term 24-36 weeks</td>
<td>251</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>3,193</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td>132</td>
</tr>
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</table>

#### Total number of deliveries with a valid gestation period recorded

<table>
<thead>
<tr>
<th></th>
<th>Deliveries (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>3,584</td>
</tr>
</tbody>
</table>

Note: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

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

(Source: Hospital Episode Statistics - HES Deliveries (April 2017 - March 2018))

**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 made sure everyone completed it. During our previous inspection we saw that mandatory training had improved. This was still evident with recent training figures at 90.8% in August 2018 against a trust target of 75%.

Staff felt that they could access training when they needed to and that this had improved recently following a new Governance Group being formed. The group aimed to improve and monitor statutory and mandatory training compliance.

The trust had developed an improvement plan that worked with directorates and divisions to identify and support departmental improvement plans. This also included subject matter experts identifying hotspot areas of non-compliance and working with them to explore alternative methods of delivery for training in work areas. The improvement plan also aimed to improve attendance for new employees and temporary staff on corporate induction and update training events.
A breakdown of compliance for mandatory courses for nursing staff working in maternity at trust level as of September 2018 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Patients</td>
<td>26</td>
<td>26</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety Training</td>
<td>25</td>
<td>26</td>
<td>96%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention - Clinical</td>
<td>25</td>
<td>26</td>
<td>96%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>24</td>
<td>26</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety Training</td>
<td>23</td>
<td>26</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff met the target in four of the five mandatory training courses. The only course not to meet the target was fire safety training at 88% compliance, this equates to three staff members.

Staff told us that training was completed over five study days throughout the year. Dates were published 12 months in advance and this allowed extra staffing to be arranged in the absence of staff undertaking training. Training was both face to face and e-learning and staff reported it was of a high standard. Staff also received mandatory training in specific maternity safety systems, including responding to childbirth emergencies such as post-partum haemorrhage (excessive bleeding following delivery) and umbilical cord prolapse, a condition where the umbilical cord comes out of the uterus with or before the presenting part of the foetus.

**Safeguarding**

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

The BSUH Safeguarding Steering Group met on a quarterly basis. This meeting was attended by a multi-disciplinary team including leads for safeguarding children and adults, mental capacity act and domestic violence and learning disabilities. We saw minutes of this meeting which reviewed action plans based on local and national guidance. The meeting also involved reviewing serious case review (SCR) recommendations, local safeguarding children board requirements and audits. There was attendance from all the clinical divisions including the women’s and children’s division.

The safeguarding steering group also reported to the Patient Safety Group, in the new clinical governance structure this was chaired by the Nurse Director.

Women’s and children’s division had safeguarding as a standing agenda item for their monthly governance meetings. There is a named director, a named nurse, doctor and midwife responsible for safeguarding children. Staff we spoke with from all grades knew they had a responsibility for safeguarding children. There was a monthly safeguarding children newsletter which aimed to inform clinicians on topics of relevance.
A breakdown of compliance for safeguarding courses for nursing staff working in maternity at trust level as of September 2018 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults at Risk</td>
<td>26</td>
<td>26</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children and Young People Level 3</td>
<td>23</td>
<td>26</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff had 100% completion rate for safeguarding adults at risk training course and 88% for the safeguarding children and young people level three course, this equates to three staff members not completing the training.

There was active and appropriate engagement in local safeguarding procedures and effective work with other relevant organisations. We saw evidence that internal safeguarding audits were undertaken and joint audits as part of the Local Safeguarding Children Board monitoring and evaluation group.

We spoke with the Specialist midwife for safeguarding and reviewed seven referrals including birth plans which were completed and attached to women’s notes alongside being recorded on a database. The safeguarding midwife had also introduced a file divider to be placed in women’s notes which had a clearly visible yellow tag to ensure staff could easily see if a safeguarding referral had been raised.

The safeguarding teams were the point of contact for advice and support about Female Genital Mutilation (FGM). There was a BSUH, FGM policy which included flowcharts of how to respond with risk assessment forms included. The policy was linked to the Pan Sussex child protection procedures.

Staff reported that all pregnant women were asked if they are victims of FGM. There was also a consultant lead who woman could talk to if needed. In Maternity there were 11 disclosures from January to May 2017. All were reported as required.

The mandatory safeguarding children training included information on Child Sexual Exploitation (CSE) and how to report it. There was a section on the safeguarding children web page which specifically related to CSE & sexual abuse. Brighton and Sussex University Hospital had a specific referral form to report all types of safeguarding issues including CSE. Children who were known to be vulnerable to CSE had indicators in the notes with the social worker contact details. There was a local flagging system for children with a Child Protection Plan and the Child protection information system (CP-IS) system was in place in maternity.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. Personal protective equipment (PPE) was available in all clinical areas. Staff mostly followed correct use of PPE, we observed staff members following trust policy and National Institute for Health and Care Excellence (NICE) guidance in relation to this. Specific hand washing sinks were available in all
rooms and at the entrance to bays on wards. All sinks we saw were compliant with lever handles and taps positioned to cause the least amount of splash. Sinks also had hand washing technique posters displayed to ensure staff used the correct technique.

However, we did observe minimal hand washing and gelling between patient interactions and a consultant sitting on the beds of patients during a ward round. This could increase the spread of germs and was not in-line with recommended national guidance and did not follow trust guidance.

The department had a dress code that allowed all staff to wear their own clothes into work this was intended to fit with the departments ethos of promoting normality in pregnancy and birth. We reviewed the policy and saw some members of staff were not following it correctly. For example, we saw midwives wearing watches and incorrect footwear. This was raised during our previous inspection and was still not fully adhered too or embedded.

All areas we visited were visibly clean and dust free. We saw evidence that domestic staff followed guidance regarding the required cleaning standards, practices and frequency of cleaning. Cleaning schedules and monthly cleaning scores were on display. On the delivery suite, dedicated cleaners were available during the working day. Outside these times maternity staff would carry out the cleaning schedules. Compliance for cleaning was at 98% for August 2018. We spoke with three cleaning staff and observed correct cleaning procedures. Birthing pools were cleaned after every use, pools we saw on inspection were clean and we saw evidence of a cleaning checklist for staff to follow.

We saw correct segregation of clinical and non-clinical waste. This was in line with HTM 07-01, Control of Substance Hazardous to Health, and the Health and Safety at Work Regulations. We saw that sharps bins were labelled and that no sharps bins were overfull. This was important to prevent injury to staff and patients from sharp objects such as needle sticks.

Pregnant women were offered the influenza and pertussis vaccination. The service offered specific clinics to ensure it reached as many women as possible. Women were given leaflets to promote the service and we also saw these in the department.

There had been no methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile infections reported from January 2018 to August 2018. All departments within maternity were considered high risk or very high risk for infection control. The hospital was compliant with the Department of Health guidance recommending: ‘All patients admitted to high risk units and all patients previously identified as colonised with or infected by MRSA, should be screened for MRSA. In addition, local risk assessment should be used to define other potential high MRSA risk.’ Side rooms were available for women who had infection and needed isolation within the postnatal and labour wards.

**Environment and equipment**

The service had suitable premises and equipment and looked after them well. Staff reported they had enough equipment and that if needed replacements were quick.

The maternity and department consisted of antenatal clinic rooms, a day assessment unit and an early pregnancy unit on level 11. The antenatal ward and a post-natal ward and the triage facilities were on level 12, and the delivery suites and one theatre were on level 13. The theatre on level 13 was used for all planned and unplanned (emergency) caesarean sections. If the use of a second theatre was needed then patients had to be transferred to level 5 which was accessed via a staff lift. RCOG guidelines state that ‘Operating theatres dedicated for obstetrics should be close to the birth unit or preferably within it. One theatre is probably sufficient for the birth of up to 4000 babies a year, although there is no specific evidence for this figure’. As the department delivers fewer than 4000 births a year they were in-line with guidance.

During our previous inspection we had concerns over staff awareness of an over-ride key that allowed an emergency lift to be accessed if a woman needed to be transferred down to the second theatre on level five. The department had addressed this with further training and the override key had been highlighted to staff during safety huddles to emphasise its use. We asked several staff during this inspection and all were aware of the override key. Some staff were not fully aware of
the processes surrounding the override key, however, lead nurse co-ordinators and ward managers were aware.

The special care baby unit (Trevor Mann Unit) was located on the 14th floor within a short distance from the labour ward and post-natal ward. This allowed mothers on postnatal ward recovering from birth to visit and spend time with their babies and to enable breastfeeding.

The obstetric theatre ventilation system had been repaired. During our last inspection this had been in breach of national recommendations and posed an infection control risk. The ventilation system was now performing within the recommended number of air changes. At the most recent verification in August 2018 the airflow was compliant with 23.5 changes per hour.

We checked 28 pieces of equipment during our inspection and all had servicing maintenance sticker on to show when it was last checked, and the date of the next service. The department were not using any formal system to indicate when equipment had been cleaned. Staff reported that they were used so frequently that it was not needed. This could lead to some equipment not having been regularly cleaned as there was no indication of when cleaning had occurred.

A healthcare assistant (HCA) had recently taken on the role of equipment maintenance and staff reported that this had been a great help knowing that equipment was being monitored and maintained by them. There was a visible table displayed in the HCAs office indicating which equipment was on the ward and when it was due for servicing. The HCA also arranged for broken equipment to be fixed and undertook ordering of stock. There had been a recent delay in servicing as the Cardiotocography (CTG) machines were having to be sent to the Princess Royal site to be repaired. Cardiotocography is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy. There was currently a back log which had meant that some CTG machines were past the service date. However, it was clear these were known about and had been scheduled to be serviced.

The department had enough equipment to ensure safe care. All rooms on the labour ward had pod storage with essential equipment in, for example doppler fetal monitors and a hand-held ultrasound transducer used to detect the fetal heartbeat for prenatal care. We saw adequate emergency equipment and resuscitation trolleys throughout the maternity department. They were well maintained and had the correct equipment and checklists were completed daily. Trolleys for maternity specific emergencies were also available on labour ward. These were well organised, and checks carried out daily to ensure that all equipment was in date and available ensuring staff had quick access in an emergency. However, we found the emergency trolley on the labour ward had intravenous Sodium Chloride and Lignocaine stored in the drawers. The trolley was not tamper proof and could be accessed by patients and visitors. We told staff members and raised this with the trust, who immediately ensured that the trolleys had tamper evident tags placed on them. We checked a further three times and the tags were in place.

Fire safety was previously a concern across the department. During our previous inspection we saw outstanding actions and no trust wide collation of the actions being completed. During this inspection we saw all areas had up-to-date and actioned risk assessments and staff attended ward based fire evacuation simulation. All items identified by the CQC during the earlier inspection were prioritised and actioned. We saw a clear fire evacuation plan was displayed on each level and the division was 94% compliant with fire training as of August 2018. The maternity department had also trained several midwives to act as fire wardens and ensured one was available on each shift. The role included ensuring correct procedures were followed in case of a fire.

Assessing and responding to patient risk
Staff always had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. Risk assessments were undertaken at booking by the midwife. Further to this we saw a risk assessment undertaken at each point of contact with a health professional. We saw risk status altered accordingly and appropriate referrals, including an individual plan of care as required. This included social and medical assessment as well as assessment of maternal mental health.
Patients were continuously risk assessed using the Modified Early Obstetric Warning Score (MEOWS). We reviewed 13 sets of notes, most showed comprehensive completion of the MEOWS chart however in the majority of these the scores were not totalled. This could lead to midwives missing the deterioration of a patient as they could not quickly assess the chart. However, we saw clear evidence of escalation if a patient was seen to be deteriorating, such as consultant input or input from senior midwife in charge.

The service followed the ‘Five Steps to Safer Surgery’ World Health Organisation (WHO) checklist which included a sign in, time out and sign out checks. Patients had a copy of the ‘Five Steps to Safer Surgery’ WHO checklist in their notes and this was recorded on the theatre database. Where required, this had been fully completed in notes we reviewed. It was highlighted within the divisional clinical governance structure that the debriefing element of the ‘5 Steps to Safer Surgery’ checklist was not being completed in all cases. From 30th July 2018, the theatre management team instigated daily ‘briefing and debriefing’ audits by the theatre team as a means of ensuring compliance. This was supported by weekly ‘sign in, time out and sign out’ WHO audits (20 random patients). These audits were carried out as part of the recovery handover. We reviewed audits from the 30th of July until 16th of September 2018 which showed compliance with sign in, time out and sign out were between 95% and 100%. However, compliance with the briefing and de-brief was on average only 69% compliant across the same time period. This had been identified as still needing to be improved and as a result it was included as a reminder in daily hand-overs and staff were required to immediately ensure 100% compliance.

The matron ensured that employees who are involved in the performance of invasive procedures develop shared understanding and are educated in good safety practice. We saw the department had produced local Safety Standards for Invasive Procedures using the national Safety Standards for Invasive Procedures. This included all surgical and interventional procedures performed in operating theatres, outpatient treatment areas, labour ward delivery rooms and other procedural areas within an organisation. For example, surgical repair of episiotomy or genital tract trauma associated with vaginal delivery.

The department used a system of ‘fresh eyes’ on all cardiotocography monitoring (CTG). This is a system where a review of the cardiotocography printout is undertaken by another midwife or medical staff to check there is agreement in its interpretation. This system helped identify possible misinterpretation. We saw CTG interpretation discussed at the bedside and during an incident review meeting. This ensured staff were given opportunities to challenge and learn through a variety of means.

There were local agreements with the local NHS ambulance service on attendance at emergencies or when transfer was required. Paramedics also attended a homebirth emergency workshop reflecting women’s stories and experiences.

If women arrived in labour without having been booked staff were able access a database to see if they had any child protection or safeguarding flags. Staff checked on the national spine system to see if they had presented at any other hospitals, Spine supports the IT infrastructure for health and social care in England, joining together over 23,000 healthcare IT systems in 20,500 organisations. Follow up appointments were offered to these women and additional support from the specialist midwives or the homeless team that worked across the hospital if appropriate.

We saw the policy and procedures for pool evacuation in the event of an emergency and were told that drills had been performed to make sure everyone knew how to use the evacuation equipment.
Midwifery and nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

One to one care in labour was being achieved 99-100% of the time which was much better than the previous time we inspected. Staff reported increased staffing levels had dramatically helped. We found the tool informing the staffing and skill mix required on each shift was generally applied well and staff reported an improvement. However, the department had undertaken a nationally recommended maternity specific staffing review in January 2018. Following this the recommended staffing levels were one midwife to every 26 patients. The current staffing template was still one midwife to every 30 women. The department had put a business case to increase the staffing template but it had still not made any significant progress. The impact of this was that staff felt busy particularly on shift where they were a midwife short. Staff reported during these times they found it difficult to take breaks and often worked on past their contracted hours without extra pay. This could lead to an overworked and tired workforce.

The trust reported the following midwifery and nursing staff numbers in maternity for two snapshots in time; 31 March 2017 and 30 April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>Actual WTE staff</th>
<th>Planned WTE staff</th>
<th>Fill rate</th>
<th>Actual WTE staff</th>
<th>Planned WTE staff</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>All sites</td>
<td>195.0</td>
<td>201.2</td>
<td>96.9%</td>
<td>199.3</td>
<td>201.0</td>
<td>99.2%</td>
</tr>
</tbody>
</table>

The trust fill rate for midwifery and nursing staff in maternity on the 30 April 2018 was better than the trust fill rate on the 31 March 2017 (99.2% compared to 96.9%). The trust reported on the 30 April 2018, they had 1.7 fewer WTE midwifery and nursing staff in maternity than they had planned.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From May 2017 to April 2018, the trust reported an overall vacancy rate of 4.1% for midwifery and nursing staff in maternity. This is lower than the trust target for vacancy of 10.5% (as at March 2018). Vacancy rates at Royal Sussex County Hospital maternity services department were currently 2% and we were told the department had a waiting list of midwives that were wanting to work at the hospital.

From May 2017 to April 2018, the trust reported a turnover rate of 11.5% for midwifery and nursing staff in maternity. This is better than the trust turnover target of 14% that was set for March 2018 (the trust has said that they are aiming to reduce this target incrementally to 11.0% by March 2019). The trust was unable to provide this data at site level.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From May 2017 to April 2018, the trust reported a sickness rate of 4.3% for midwifery and nursing staff in maternity. The Royal Sussex County Hospital (RSCH) had a turnover of 3.6%. The trust has set a sickness target of 4.2% as at March 2018 reducing incrementally to 3.5% by March 2019. The maternity department at RSCH was meeting these targets.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Please note that the trust did not provide information on the minimum number of shifts needing to
be covered by bank and agency staff in all cases. Therefore, we have been unable to analyse bank and agency usage as a proportion of the total shifts needing to be filled.

The table below shows the numbers of shifts in maternity at a trust wide level from April 2017 to March 2018 that were covered by qualified nursing and nursing assistant bank and agency staff or left unfilled.

For qualified midwifery and nursing staff, 2,587 shifts were filled by bank staff and 6 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses. In addition, 248 shifts were not filled by either bank or agency staff.

For healthcare assistants, 1,100 shifts were filled by bank staff and no shifts were covered by agency staff to cover sickness, absence or vacancy for healthcare assistants. In the same period, 62 shifts were not filled by either bank or agency staff.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Qualified nurses</th>
<th>Healthcare assistants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>2,587</td>
<td>1,100</td>
<td>3,687</td>
</tr>
<tr>
<td>Agency</td>
<td>6</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Not filled</td>
<td>248</td>
<td>62</td>
<td>310</td>
</tr>
</tbody>
</table>

Unfortunately, we are unable to provide a site-specific breakdown of nursing bank and agency usage in maternity due to the format of the data provided by the trust.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

**Medical staffing**

The trust reported the following medical staffing numbers in maternity for two snapshots in time: 31 March 2017 and 30 April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>As at 31/03/2017</th>
<th>As at 30/04/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>All sites</td>
<td>59.4</td>
<td>55.4</td>
</tr>
</tbody>
</table>

The trust fill rate for medical staff in maternity on the 30 April 2018 is less than the trust fill rate on the 31 March 2017 (93.2% compared to 107.3%). On the 30 April 2018, the trust had 3.8 fewer members of midwifery and nursing in maternity (WTE) than they had planned.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

The trust reported an average vacancy rate of 4.3% from September 2017 the August 2018. However, the Royal Sussex County hospital site had now filled most consultant vacancies with only one consultant post unfilled. A locum consultant who was familiar to the trust and guidelines was employed on a regular basis. The trust target was 10.5% in March 2018, the trust planned to reduce its vacancy target incrementally to 9.0% by March 2019.

From September 2017 to August 2018 the trust reported an annual turnover rate of 17.8% for medical staff in maternity. The trust target was 14% in March 2018, the trust planned to reduce its turnover target incrementally to 11% by March 2019. Please note that training grade doctors were not included in the turnover rates as they participate in six monthly placement rotations.
From August 2017 to July 2018 the trust reported an annual sickness rate of 2.7% for medical staff in maternity. The trust target was 4.2% in March 2018, the trust planned to reduce its sickness target incrementally to 3.5% by March 2019.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

For the period covering April 2017 to March 2018, the trust reported that no shifts were covered by bank or medical locum staff in maternity.

In March 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.

Staffing skill mix for the 51.2 whole time equivalent staff working in maternity at Brighton and Sussex University Hospitals NHS Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>35%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>2%</td>
<td>9%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>55%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior*</td>
<td>8%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Consultant obstetricians provided 60-hour presence on delivery suite to support junior staff. This exceeded recommended Safer Childbirth and RCOG guidelines of 60 hours of consultant presence for 6000 births a year or greater. There was a consultant on call 24 hours, Monday to Friday. A consultant was resident from 8:30am - 8:30pm, Monday to Friday and 8.30am to 2.30pm on Saturdays and Sundays. Outside of these hours they were on call from home within 30 minutes of the hospital. There was a registrar and junior doctor for the labour ward 24 hours a day, seven days a week (shift time 8:30am to 8:30pm, 8:30pm to 8:30am). There was also a junior doctor covering the post-natal and day assessment unit.

A copy of the consultants on call rota was found at the nurse’s station. Staff had to call the switchboard to be transferred to the consultants. There were no reported problems getting hold of an on-call consultant.

Records

Staff kept appropriate records of patients’ care and treatment. The overall quality was good, notes were legible; entries were signed, dated and timed in line with best practice guidance. There was adequate use of the venous thromboembolism (VTE) score checklist, portogram (a composite graphical record of key maternal and foetal data during labour), World Health Organisation (WHO) checklist used in theatres, charts for growth and early warning scores. We reviewed 13 sets of
notes and found them generally well ordered although we did see some loose pages within notes that could have become separated from patient records. We also found records with missing information, examples included a fluid balance chart not fully completed and incomplete birth summaries and babies’ details. A dedicated audit of maternity records had not been done, however, maternity records were part of continuous audit undertaken within incident review meetings.

All women carry their own pregnancy and birth record throughout the antenatal period. Following the birth, the pregnancy and birth record is filed within the main hospital records. The maternity hand-held records we reviewed were multi-disciplinary. We saw all professionals who provided maternity care documented this within the hand-held records alongside clinical test results (including ultrasonic scans), antenatal screening tests, subsequent antenatal visits and examination.

Documented individualised antenatal risk assessments were also regularly reviewed throughout pregnancy and we saw individualised management plans for women where additional risks were identified during the initial clinical risk assessment.

**Medicines**

The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.

We looked at the arrangements for storing medication on the postnatal ward. We found that they followed best practice and had a locked controlled drug cupboard, inside another cupboard, and all the drugs we checked were in date. Medicines that needed to be stored within fridges were also all in date and stored at the correct temperatures. Fridges were checked daily and the minimum and maximum temperatures recorded. Staff signed to say these had been checked and we saw a protocol which was followed if the fridges were not in the correct temperature limits. This was in line with best practice guidelines.

Some clinical rooms had ambient temperatures that were higher than the recommended maximum temperature of 25 degrees Celsius. This had been risk assessed and fans had been placed in rooms to help. The pharmacy had also minimised the amount of stock that the department kept in the room to ensure a high turnover and minimise the prolonged risk of heat effecting the medicines.

The maternity department undertook safe and secure audits in June 2018 and produced a range of required action plans, for example, to record dates correctly on opened Oramorph bottles. We saw evidence the department then conducted walkabouts in August/September 2018, checking and giving feedback. Frequent re-audit and reporting and monitoring were due to be undertaken until processes were fully embedded.

The pharmacy team worked across the RSCH and were available Monday to Friday 9am to 5.30pm and Saturday and Sunday from 9am to 13.30pm. The maternity department received a visit from pharmacy staff twice a week. National Institute for Health and Care Excellence (NICE) technology appraisals were circulated to the formulary pharmacist and were reviewed at the Drugs and Therapeutics Committee. This committee had the final decision on what drugs were added to the formulary.

There was swipe card access to all medication/clinical rooms, ensuring medicines were stored securely. Patients were not provided with individual drugs for self-administration but could ask for medicine such as pain relief if needed. Staff told us when women brought their own medicines to the hospital that two nurses would check and record the medicines.

Antibiotics were prescribed in-line with NICE QS 61: people are prescribed antibiotics in accordance with local antibiotic formularies. We saw evidence of this within patient records.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team.
and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

All incidents were reviewed by the departments risk co-ordinator who led any investigations. This work was cross site and was fed back to the weekly incident meetings and the Patient Safety Team. We reviewed reports following on from reported incidents, they involved all the relevant staff, partner organisations and people who used the service. We also attended an incident review meeting where all recent reported incidents were discussed with a multidisciplinary team. Doctors, medical students, co-ordinators, midwives and support workers were present when we attended. We also attended a safety huddle which took place on labour ward. The meeting was not as well attended with only limited consultant presence. It was also in an office which acted as access to the other side of the ward. The meeting was interrupted several times and was not protected time. This suggested that this meeting was not fully embedded with the multidisciplinary team and messages could be missed due to the chaotic nature of the surroundings. We attempted to attend another huddle the following day which was due to start at 11:45, we waited until 12:15 but the huddle had still not occurred. Staff reported it was not always a set time as the ward activity was changeable.

The service understood the importance of reporting incidents and staff seemed to receive feedback through a various means. This was done verbally at handover and staff huddles as well as via email. The department had a ‘Message of the week’ alongside weekly incident review meetings. A recent message of the week included caring for minors, antibiotic use and paediatric early warning score charts. The trust published anonymised serious incidents (SI) investigations on its intranet so that any member of staff could access the learning. Every six months the Deputy Medical Director shared the learning from previous SI investigations with clinicians at the ‘Grand Round’. The chief nurse also shared any key messages from patient safety in her monthly briefing. Staff were aware of incidents from other departments within the hospital and shared learning from these was evident.

The department had recently undertaken a review of all cases of hypoxic-ischaemic, encephalopathy (HIE) cases within one year. The aim was to determine any common themes and to identify any learning points from them. The department did not discover any common themes but does now send all placentas from HIE cases to histology for sampling. They had also increased the training around CTG interpretation so all obstetric clinicians must attend annual training alongside midwives.

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 2017 to May 2018, the trust reported no incidents which were classified as never events for maternity.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in maternity which met the reporting criteria set by NHS England from June 2017 to May 2018. The incident was a screening issue meeting SI criteria which took place at antenatal clinic in RSCH. These centred mostly around a lack of ability to accurately track the booking cohort for the antenatal screening programmes. We spoke with the antenatal screening co-ordinator who explained that although the system remained the same the department was limited by the current IT systems within the department. They had introduced several extra ‘fail safe’
measures to ensure no women missed their screening. This included community midwives checking if women had attended ten days after their appointment, this was audited and communicated to the screening team. The department had recently submitted the first quarter dates and these were complete with no women missing their screening.

(Source: Strategic Executive Information System (STEIS))

The trust published anonymised serious incidents (SI) investigations on its intranet so that any member of staff could access the learning.

Safety thermometer

The service collected and reported safety monitoring results. However, there was not a specific maternity safety thermometer. The safety thermometer was not displayed however, it was explained that this was not really needed as much of the thermometer was not that relevant to maternity, for example, falls. Staff collected safety information monthly and sent it to the governance team, but there was little awareness of where it went from there or how the information was used. Safety thermometer results from September 2017 to August 2018 showed 99% of patients across the women’s and children’s division received harm free care. This was better than the trust average of 95%.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

We found from discussions with staff and patients as well as our observations that care was being provided in line with The National Institute for Health and Care Excellence (NICE) quality standard 22. This standard covers the care of all women up to 42 weeks of pregnancy. It covers all areas of ante-natal care including community and hospital settings. There was evidence to indicate that NICE Quality Standard 37 was being adhered to in respect to post-natal care. Examples included staff discharging patients with checks and with correct medicines. All patients we spoke with had been given infant feeding advice and support.

Newly published or updated National Institute for Health and Care Excellence (NICE) guidance was identified by the Safety & Quality Team each month. The guidance together with a gap analysis document was circulated to the lead clinician within maternity, the pharmacist and divisional management team. The lead clinician was responsible for reviewing the guidance to determine whether it is relevant to the department and for ensuring that the gap analysis document was accurately completed and returned to the Safety & Quality Team where the response was recorded on a database. National Institute for Health and Care Excellence guidance was incorporated into the draft Audit Forward Plans that were circulated to departments in March of each year. We saw evidence of recently updated protocols included new-born feeding and the management of surrogacy.

A paper audit of the WHO documents was completed monthly within the obstetric theatres. We saw evidence that observational audits were also conducted quarterly. There had been some issues with staff not signing the sign out section, which had been addressed by an increased focus and weekly auditing. Work had been done to improve debriefing with the introduction of new paperwork, training, communication and more regular auditing which had helped improve compliance. Each department used a paper audit of the WHO documents monthly, with observational audits quarterly. Any issues were escalated to the weekly audit meeting.
The National Institute for Health and Care Excellence (NICE) quality statement seven on skin to skin contact was adhered to in post-natal care. Skin-to-skin contact with babies soon after birth had been shown to promote the initiation of breastfeeding and protect against the negative effects of mother–baby separation. The department had a series of posters promoting ‘let’s get naked.’ The aim was to raise awareness of the advantages of skin to skin contact with babies.

Opportunities to participate in benchmarking and peer review were proactively pursued, including participation in approved accreditation schemes. Brighton Hospital University Trust was one of three pilot sites for the Healthcare Safety Investigation Branch (HSIB). HSIB became operational on 1st April 2017, its purpose was to improve safety through effective and independent investigations with no apportion of blame or liability. Within maternity they used the National Perinatal Mortality Review Tool (NPMRT) to review all eligible cases. The review included external members to ensure fresh eyes and input from the CCG.

The department had increased the numbers of midwives undertaking New-born Infant Physical Examination (NIPE) training. The training was delivered by Advanced Neonatal Nurse Practitioners and supported midwives being able to deliver NIPE checks at home. This allowed women to return home without delay when they were ready and allowed mothers who had birthed at home to remain there without the need to visit hospital. The department had also purchased Bilirubinometers (a device that directs light into the skin of the neonate and measures the intensity of specific wavelength that is returned to detect jaundice) to support babies with jaundice to remain at home avoiding hospital visits.

**Pain relief**

Women had access to a range of pain relief methods in accordance with National Institute for Health and Care Excellence (NICE) guidance CG190. This included Entonox (gas and air) and Pethidine (a morphine-based injection) for medical pain relief during labour. Epidurals were available 24 hours, seven days a week. Women generally received epidurals within 30 minutes of request.

Alternative pain management was encouraged including the use of transcutaneous electrical nerve stimulation (TENS) machines, (these are machines which are used as an alternative to medication, and they can ease pain in some people with certain types of pain). Aromatherapy oils were kept in fridges for all women to use throughout birth. Aromatherapy could also be used postnatally but only by women in side rooms to ensure isolation.

Women we talked to during our inspection reported their pain was managed well. Pregnant women had hand held notes which provided information on pain relief. There were also leaflets available in the clinics and on the trust website. Patient information also encouraged the use of birthing pools for pain relief and management.

Women requesting an induced abortion were routinely offered pain relief in line with RCOG guidance ‘the care of women requesting induced abortion’. We saw guidance that women should routinely be offered pain relief such as non-steroidal anti-inflammatory drugs (NSAIDs) during surgical abortion.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients’ religious, cultural and other preferences.

Patients were invited to help themselves to a variety of breakfast items from the day room onwards; if a woman was not mobile then staff helped her choose and delivered it to the bedside. Women were given appropriate advice prior to surgery about fasting if attending for an elective caesarean.
All patients we spoke to said they had received support to breastfeed soon after birth, and that this had continued on the post-natal ward. Breastfeeding initiation was consistently above the trust target of 85% with figures averaging 87%. Patient information of breastfeeding support was seen throughout the department. We also saw information on the drop-in breast-feeding service. There was a breastfeeding room for women to use with accessible breast pumps and a fridge to store breastmilk. If women wished to bottle feed, sterilisers were readily available.

**Patient Outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The department had been recently identified as an outlier for third and fourth degree tears. These tears are referred to as Obstetric Anal Sphincter Injuries (OASI). The department had undertaken a piece of work called the ‘ORB’, which stands for OASI Reduction at BSUH. The project encompassed research and evidence from other trusts and focused on position, guidance, protection and pace of delivery. Since the introduction of the project the rates of OASI had reduced significantly with rates of 2.3%. This is much better than the previous high of 7.7% and was also better than the trust target of 5%.

Previously the maternity dashboard showed that the department had not met expected targets in some patient outcome indicators. We saw an improvement in many of these indicators, and where the department was not meeting targets there were action plans in place to ensure patient outcomes remained high. An example of this was the number of women who experienced shoulder dystocia 2.7% against a target of 0.5%. The department had understood the challenges of this and was undertaking a deep dive and audit to ensure no learning opportunities were missed.

Successful VBAC procedures were slightly below the target of 75% at 70% success, however this was an improvement from the previous 2016/17 figures which indicated only 62% were successful.

The department had an awareness that maternity specific tools were needed throughout the department as women’s maternity needs were different to that of other patients within the hospital. For example, the maternity department had a separate sepsis screening tool that was completed and placed in all women’s notes. This had maternity specific questions such as if a woman may be suffering with mastitis (infection of the milk ducts).

In the 2017 National Neonatal Audit **Royal Sussex County Hospital**’s performance in the two measures relevant to maternity services was as follows:

- **Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?**

  There were 165 eligible cases identified for inclusion, 88.3% of mothers were given a complete or incomplete course of antenatal steroids.

  This was within the expected range when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.

  The hospital met the audit’s recommended standard of 85% for this measure.

- **Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?**

  There were 53 eligible cases identified for inclusion, 52.8% of mothers were given magnesium sulphate in the 24 hours prior to delivery.
This was higher than the national aggregate of 43.5%, and put the hospital in the middle 50% of all units.

(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)

From January 2017 to December 2017 the total number of caesarean sections was as expected. The standardised caesarean section rates for elective sections as expected and rates for emergency sections as expected.

<table>
<thead>
<tr>
<th>Standardised caesarean section rate (January 2017 to December 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of caesarean</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Elective caesareans</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Emergency caesareans</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Total caesareans</td>
</tr>
</tbody>
</table>

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries. Delivery methods are derived from the primary procedure code within a delivery episode.

In relation to other modes of delivery from January 2017 to December 2017 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

<table>
<thead>
<tr>
<th>Proportions of deliveries by recorded delivery method (January 2017 to December 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Delivery method</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Total caesarean sections</td>
</tr>
<tr>
<td>Instrumental deliveries</td>
</tr>
<tr>
<td>Non-interventional deliveries</td>
</tr>
<tr>
<td>Total deliveries</td>
</tr>
</tbody>
</table>

Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

1 Includes elective and emergency caesareans
2 Includes forceps and ventouse (vacuum) deliveries
3 Includes breech and normal (non-assisted) deliveries

Delivery rates at the trust for all three delivery methods described in the chart above were similar to the England average.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

As of 14 August 2018, the trust reported no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

The maternity department was involved with the trusts ‘Learning from Deaths Programme’. The trust appointed the Chief Medical Officer and a Non-Executive Director to oversee any learning from deaths across the trust. The Deputy Medical Director for safety and quality presented to the Grand Round any learning from deaths, this included case presentations on neonatology mortality. For neonatal mortality Brighton and Sussex University Hospital was the 6th best level three unit (with surgery) out of 26 in the country.

The trust took part in the 2017 Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE) audit and their stabilised and risk-adjusted extended perinatal mortality
rate (per 1,000 births) was 5.72. The trust’s performance for this audit was much better than the national comparator group. It showed the trust was more than 10% lower than the average for the comparator group rate of 6.71.

(Source: MBRRACE UK)

Maternity achieved an average of 4.4% births at home. In recent months (April to July 2018) this had further increased to 5.1%. This was better than the national average of 2.1%.

Progress against safety alerts was monitored by the Safety and Quality Lead who escalated any concerns regarding implementation to the Deputy Medical Director for Safety and Quality. These were reviewed in detail to determine whether the trust was currently compliant with the alert. Where the trust was not compliant, actions were taken or planned to ensure future compliance. In the last 12 months, there had been 8 alerts published that are relevant to BSUH.

All safety alerts are incorporated into the draft audit forward plans that are circulated to departments in March of each year. From recent alerts published the trust had undertaken an audit of resources to support the safety of girls and women who are being treated with Valproate. Valproates are medications primarily used to treat epilepsy and bipolar disorder and to prevent migraine headaches.

The trust were taking part in the Maternal and Neo-Natal Health Safety Collaborative. This was a national initiative to reduce the rates of maternal deaths and stillbirths and brain injury. The introduction to this scheme was attended by the matron, obstetric lead and labour ward leads. The obstetric consultant at the trust was the lead for the county on this initiative. This showed a commitment to achieve better rates of Intrauterine fetal death and stillbirth.

**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.

A practice development midwife and a clinical skills facilitator worked across maternity to ensure staff had access to training and worked within the department to offer midwives support when needed. Staff took part in skills drills and had regular workshops the latest of which included bereavement, cardiac care, In vitro fertilisation (IVF) and Suturing.

Supervision of midwives was withdrawn from statute and has been replaced with Professional Midwifery Advocacy (PWA). There were 11 midwives trained to deliver clinical supervision and carry out the PWA role in the department to ensure midwives were continuing to have support.

The department offered a comprehensive induction. We spoke with a recently promoted band 7 midwife who had a six-week supernumerary period. This gave her the confidence and experience to carry out her role. Recently a Maternity Care worker (MCW) had identified a need to ensure training and competencies for MCWs were met. She developed a competencies checklist and orientation list for all new MCWs.

Staff were actively encouraged to undertake training to further their skills, for example, staff had attended the Royal College of Midwives labour ward leader course. This was a multi-professional course to develop midwives to undertake improvement projects. Staff had also been involved in developing regional teaching for nursery nurses and extended training in advanced neo-natal life support.

An appraisal policy was due to be created to give more directive detail beyond current guidance and to ensure a framework for accountability. Issues and action plans from divisions, pertaining to the staff development review and staff survey, were also reviewed to establish further improvement opportunities.
From May 2017 to May 2018, 81.2% of staff within maternity at the trust received an appraisal compared to a trust target of 78%. The trust then set a stretch target of 90% compliance by 30th June 2018. During our inspection we saw that maternity had achieved an appraisal rate of 95.2% which was the highest across the trust.

Below is a split of appraisal completion rates by staff group in maternity from May 2017 to May 2018.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals complete</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>151</td>
<td>129</td>
<td>85.4%</td>
<td>78%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>72</td>
<td>55</td>
<td>76.4%</td>
<td>78%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>6</td>
<td>2</td>
<td>33.3%</td>
<td>78%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>229</td>
<td>186</td>
<td>81.2%</td>
<td>78%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. Staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. Care was delivered and reviewed in a coordinated way when different teams were involved in patients care. Staff we spoke to reported good multidisciplinary working relations between midwives, midwifery support workers, doctors in the maternity day unit, and other staff. Midwives told us they contacted consultants if they needed advice, for example, around risk assessments, and found consultants approachable.

Meetings across the department were attended by multidisciplinary teams, for example the weekly risk meeting was attended by midwives, matrons, consultants, student midwives and specialist midwives.

We heard about good cross sector working within the paediatric safeguarding team and neonatal intensive care unit. Women had access to a range of specialist midwives who worked alongside other departments and neighbouring trust for the best outcomes. For example, the breastfeeding midwives was due to speak at a breastfeeding conference in October 2018 and the mental health midwife was due to talk at the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) conference the day after our inspection.

In July 2018 the trust was recognised as one of the top performing hospitals in the UK for helping diabetes patients control their glucose levels. The trust offered a diabetic clinic for women identified as at risk of gestational diabetes. This was a one stop clinic located in the antenatal department. The clinic was multi-professional and included dieticians, obstetricians, and specialist diabetes midwives. It allowed women to be seen by a range of specialists within one clinic visit. On the day of our inspection there were 40 women accessing the service. Mothers had dedicated diabetes notes and a new diabetes protocol which aimed to reduce inductions of labour for women with gestational diabetes. In the two years since this was first developed there had been no diabetes birth defects experienced by mothers.
Seven-day services

Obstetric theatres were staffed by a separate theatre team across a 24 hour period. This team were solely dedicated to support obstetrics and were not included in the staffing of the main theatres across the hospital. Each team member carried an internal pager which linked as a group so that they simultaneously received notification of an obstetric emergency.

Midwife support, consultants and anaesthetists were available on site 24 hours a day seven days a week. This ensured women had access to support and advice at all times. Maternity services offered a 24-hour telephone triage service. This service could be accessed at any stage of pregnancy.

There was a day assessment unit in maternity which was run by a dedicated team that worked 24 hours, seven days a week. This was supported by community midwives if available.

Pathology services were available at all times. Foetal anomaly screening was available Monday to Friday and routine ultrasounds examinations were available on the day assessment units at all times.

Health promotion

Staff were consistent and proactive in supporting people to live healthier lives. There was a focus on early identification and prevention and on supporting people to improve their health and wellbeing. The community team offered a range of antenatal classes and had recently identified the need to include a healthy eating class for women with a raised body mass index as well as a class for women suffering from pelvic pain.

We saw information on what to eat during pregnancy and advice on smoking cessation available to women. A smoking cessation service provided flexible and accessible support to help women stop smoking. A specialist midwife was available to women throughout their pregnancy.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

As of September 2018, midwifery staff working in maternity have an 87% completion rate for mental capacity act training which is slightly lower than the trust target of 90% while medical staff have a 53% completion rate.

We saw staff verbally gaining consent before commencing any treatment. Staff were seen fully explaining procedures and the associated risks of accepting the treatment or not. For example, we saw a woman who was refusing Heparin. Heparin is an anticoagulant (blood thinner) that prevents the formation of blood clots. The consultant took the time to explain all the risks while supporting her decision and respecting her choice.

Staff followed the trusts Policy for Consent to Examination or Treatment dated 18th February 2016. We reviewed this document which was detailed and highlighted the duty to appoint an Independent Medical Capacity Advocate (IMCA) for patients who lacked capacity. The document also outlined the use of ‘Gillick competencies’ in relation to children. Gillick competence reflects a child’s increasing development to maturity. The parents cannot overrule the child’s consent when the child is judged to be Gillick competent. The understanding required for different interventions will vary considerably and therefore a child under 16 may have the capacity to consent to some interventions but not to others. Staff we spoke with understood their roles in relation to this.

Staff were aware and followed the trusts Mental Capacity Act Policy (Incorporating Deprivation of Liberty Safeguards) dated March 2016. We were shown how to access this policy through the staff intranet, if they needed it for reference. Mental Capacity Act, Mental Health Act and Deprivation of
liberty safeguards were covered in mandatory training days. We were given several examples where staff had used this learning in interactions with patients and their partners.

We spoke with staff members about the Mental Capacity Act 2005 and staff demonstrated a good awareness of consent procedures. One midwife explained she had recently had concerns about a patient in her care and had escalated them to the consultant who was going to see the woman accompanied by perinatal mental health specialist.

The trust has, in accordance with the Department of Health (DoH) Guidance (2009), adapted the previous DOH standard consent forms. There were two versions of the standard consent form one for adults or competent children/young people and one for parental consent for a child or young person. There was also the assessment of capacity form for adults found unable to consent to investigation or treatment following an assessment of capacity.

We saw staff verbally gaining consent before commencing any treatment. Staff were seen fully explaining procedures and the associated risks of accepting the treatment or not.

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**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. We spoke with 12 patients and their relatives who all had positive reports of the care they had received.

We reviewed 25 plaudits from June to August 2018 all were overwhelmingly positive included comments such as “We felt in safe hands throughout, even though there were one or two complications.” And “We will always remember your kindness, support and amazing care on the most special day of our lives.”

**Friends and family test performance (antenatal), Brighton and Sussex University Hospitals NHS Trust**

From June 2017 to June 2018 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average.

There was no available data for the trust for eight of the 13 months included in the chart below and this is the reason the dips in the chart. Where data was available the trust scores were 100% for all months other than September 2017 where the trust score was 83% compared to the England average score of 97%.
Friends and family test performance (birth), Brighton and Sussex University Hospitals
NHS Trust

From June 2017 to June 2018 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was in line with or greater than the England average for all months other June 2018, where the trust’s score fell to 94% (compared to the England average of 97%).

Friends and family test performance (postnatal ward), Brighton and Sussex University Hospitals NHS Trust

From June 2017 to June 2018 the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average. In the latest month of available data (June 2018) the trusts FFT performance for its postnatal wards was 91% compared to the England average of 95%.

Friends and family test performance (postnatal community), Brighton and Sussex University Hospitals NHS Trust

From June 2017 to June 2018 the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally worse than the England average. In the latest month of available data, the trusts FFT performance for postnatal community was 94% compared to the England average of 98%.
The trust performed in line with other trusts for 14 out of 16 questions in the CQC maternity survey 2017 and better than other trusts in the other two questions.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>8.67</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>8.81</td>
<td>Best performing trusts</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.88</td>
<td>Best performing trusts</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>9.44</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.44</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>8.38</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.49</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.45</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you used the call button how long did it usually take before you got the help you needed?</td>
<td>8.68</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.48</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.41</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>9.23</td>
<td>About the same</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>7.80</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>8.13</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>8.56</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>9.04</td>
<td>About the same</td>
</tr>
</tbody>
</table>

The trust was amongst the best performing trusts for two of the four survey question metrics relating to labour and birthing areas.

- During your labour, were you able to move around and choose the position that made you most comfortable?
- If your partner or someone else close to you was involved in your care during labour and birth,
were they able to be involved as much as they wanted?

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

We saw staff taking time to interact with patients and saw examples where staff demonstrated the importance of gaining the trust of women they were treating. When asked, patients could tell us the midwife that was in charge of their care on that day along with the named consultant. We saw photographs of all staff displayed within the department. This helped patients to identify staff members during their stay. All ward area display board featured thank you cards from patients and families for the care they had received.

**Emotional support**

Staff involved patients and those close to them in decisions about their care and treatment. We saw staff talking with woman to ensure they were comfortable and confident with the decisions they were facing. We spoke with several patients who were all positive about the care they received. “We trusted every staff member, even though our baby arrived in an emergency.”

Women we spoke with confirmed that staff explained processes in detail, spent time with them and provided reassurance. Women using maternity service could access support for specific health related issues including diabetes or mental health needs. Midwives assessed women for anxiety and depression during their initial antenatal appointment and then they were given continuous support as required once admitted. Women had access to counselling and could be referred to by consultants, if needed. We saw patient information on these services and advice to women about support services available.

There was a dedicated bereavement lead at RSCH and Princess Royal Hospital. They worked hard to improve the service over the last two years. Bereavement services now included home visits and telephone access to the bereavement team. The service also helped with funeral arrangements, referrals for specialist counselling and arranging follow up consultant care (dedicated pregnancy loss consultants were based at both sites).

A recently completed bereavement suite enabled women to give birth in a separate delivery room and then spend time with their baby in a fully furnished bedroom with kitchenette and bathroom facilities. The suite had been designed and furnished with input from families that had suffered loss within the department. Families could spend as long as they needed within the suite and it was away from the labour ward to protect mothers from labouring women.

We were told of a homeless couple who had recently used the suite following a bereavement, the staff were able to connect them with other support services and they stayed for a week. The couple fed back that “it was the kindest anyone had ever been to them”.

Staff were given a checklist and a flow chart which we reviewed and was easy to understand and gave clear instructions of what to do at each stage of the bereavement process. Staff were also offered support from the bereavement team including phone numbers for local charities that support the unit.

The bereavement midwife liaised with other relevant specialist teams to coordinate ongoing care. This included Health visitors, GP’s, community midwives, registry office staff, chaplaincy team, mental health teams, homelessness team, substance use team. They also worked with hospitals out of the area if needed.

Stillbirth and Neonatal death charity (SANDS) training, had been undertaken by a total of 80 Maternity, Gynaecology & Neonatal staff. Bereavement training was also now included in all mandatory training within the department.
Staff understood patients’ needs and respected their individual wishes. We witnessed a consultant minimizing the number of staff entering a patient’s room during a ward round, as they knew that this would cause her distress.

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

Staff provided emotional support to patients to minimise their distress. Staff communicated with women and their families and care partners making sure they understood the treatment they were to receive and the risks associated with this. We witnessed staff members explaining the risks of induction to a lady. They outlined both the positive and negative aspects of the care plan and allowed time for the patient to ask questions.

We asked women across this service if they felt well informed and involved in decisions about their care and treatment. All confirmed that midwifery, nursing and medical staff informed them of their choices of treatment before proceeding with any care and they felt they could ask for more detail if they did not understand anything. They commented particularly how their birth plans were frequently discussed and felt their preferences and needs were considered.

**Is the service responsive?**

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

The trust planned and provided services in a way that met the needs of local people. The importance of flexibility, informed choice and continuity of care was reflected in the services. We saw that people’s needs and preferences were considered and acted on. An example of this was the One Stop Clinic. This provided care and support for women with issues around drug and alcohol use. The clinic had midwives, doctors and other specialists and offered an open-access service. The One Stop Clinic was flexible allowing women to have all their antenatal care there or come in for a one-off appointment. Women could also access the service over the phone for help and advice.

Newly pregnant women self-referred via the e-referral system on the ‘my pregnancy matters’ website. The GP surgeries signposted them to this process. A scan appointment was then generated and women were booked with their named community midwife who was linked to the GP surgery. At the booking appointment a booking questionnaire was completed by the midwife with the woman (demographics, medical, social, psychological, obstetric history). This questionnaire was then sent to the community midwives office for checking then to the Day Assessment Unit (DAU) at the relevant site.

Where people’s needs and choices were not being met we saw this was identified and used to inform how services were improved. An example of this was the development of a transgender and non-binary protocol. This included building the teams presence at relevant local events and working alongside local transgender support groups to encourage and support those who wished to have a family.

From October 2016 to March 2018 the bed occupancy levels for maternity were generally higher than the England average, with the trust having 92.0% occupancy in quarter 4 of 2017/2018 compared to the England average of 58.5%.
The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

Women had access to an Early Pregnancy Unit, this was for women with a positive pregnancy test with pain and/or bleeding in early pregnancy and required referral from either the women’s GP or midwife. Women could also be referred to Day Assessment Unit (DAU) for various reasons throughout pregnancy if their GP or community midwife had concerns. Women could also self-refer to DAU if women had concerns for example, reduced baby movements, pain or bleeding.

The service was currently undergoing a re-development to move some services out of the main hospital. This aimed to improve the patient experience and locate services alongside the community midwives for a more cohesive service.

Women had access to a range of antenatal care. Antenatal care, parent craft and postnatal clinics were provided in a variety of locations including GP surgeries and children’s centers throughout the area. This encouraged attendance by taking services closer to where women lived. Community midwives provided antenatal classes on a variety of topics, including water birth, vaginal birth after cesarean (VBAC), breastfeeding and homebirth.

Partners could stay for one night following birth. Where possible the service placed women, who did not have partners staying, in the same bays to ensure they felt comfortable. Men had to follow strict guidelines for appropriate behavior and were not allowed to bring in air beds or intrude into other bed areas.

The department had access to the homeless team and had a specialist homeless midwife to ensure that patients were treated with kindness and dignity. They also offered help and advice on how to access other useful services.
Meeting people’s individual needs

The service took account of patients’ individual needs. Reasonable adjustments were made and action taken to remove barriers when people find it hard to use or access services.

We saw leaflets showing patients how to access the Learning Disability Liaison nurse and team. Women with learning disabilities were referred or signposted to a specialist midwife and safeguarding midwife, who liaised with the appropriate team leaders. The specialist midwife also liaised with labour and postnatal wards to ensure care plans were circulated, followed and appropriate support was in place. This included women who wished to deliver at home where the birth options midwife would also be contacted for further support. The trust learning disability liaison team were also involved in these cases.

Women with specific needs or care needs due to physical disabilities or wheelchair access were referred by community midwifery to the labour ward leads who met with the woman and her support, to develop plans to best support the woman. This included discussing the use of appropriate rooms, whether self-transfer to chairs or beds was possible and bathroom facilities. Information was also passed to the postnatal team to ensure care plans continued when patients were transferred to the ward. All facilities were wheelchair-accessible.

Women had access to translation services if English was not their first language. The department tried to ensure this was face to face, but if this was not available then they could access language line for immediate translation. We were given examples where women were offered double appointments to ensure detailed discussion could take place. A health visitor also ran a support group for women whose first language was not English to encourage social engagement and integration.

A range of specialist midwives were available to support women. These included a specialist birth stories midwife who helped women who had experienced trauma during labour and birth. It provided a one to one session counselling session with patients’ obstetric notes available and was an opportunity to understand events, talk through feelings, raise any concerns for a subsequent pregnancy or labor. A teenage pregnancy midwife was available to offer support for young women and their partners who were under 20. The service helped with antenatal care, arranged scans and any other appointments needed. The service also had many other specialist midwives who offered support to staff and patients who used the service.

A specialist perinatal mental health midwife provided support to women with mental health issues and more recently those with tokophobia (an intense anxiety or fear of pregnancy and childbirth). Women had access to a perinatal mental health clinic which provided advice, assessment and treatment for women with a past or current history of severe mental illness, for example, bipolar disorder, schizophrenia or severe depression. We spoke with a midwife who showed real passion for the service they provided, but also felt that it needed to extend the service as she often had to work long hours to ensure she could complete her workload.

Women could attend a ‘Vaginal Birth After Caesarean’ (VBAC) clinic. This served to help women who wished to have a VBAC and offered information and advice from an obstetrician and a midwife. An average of 27% of women opted to try for a VBAC, the trust did not set a target for this but this figure was less than our previous inspection where 46% of women attempted VBAC.

Access and flow

People could access the service when they needed it. Women had 24-hour access to the triage phone line for advice or if they were in labour or experienced any immediate problems, such as
bleeding. The triage system for all women went through a dedicated triage midwife on labour ward.

There was an average of 20 transfers between units within the trust each month. None of these were women with babies in-utero. There had been no unit closures in the past 6 months. We reviewed the trusts transfer policy ‘Brighton and Sussex University Hospitals Transfer Policy’ dated March 2016. This included numbers for the local ambulance service in cases of emergency transfers. Babies requiring level three support were often transferred into the unit where the special care baby unit (Trevor Mann Unit) could support the babies postnatally. We were told this had an impact on whether the unit transferred to the Princess Royal hospital, for example if women were in early labour with a potentially premature baby who may require further support.

Women are told at initial booking that the maternity service was a one hospital trust which provided maternity care over two sites. Women are made aware that they may be asked to attend a different hospital site if one maternity unit was full. We saw no complaints relating to women having to attend a different site to the one they requested.

The department recently undertook training with the local NHS ambulance team to agree terminology to be used when calling for an ambulance for transfer. All staff now have a laminated card for reference. The aim was to ensure a consistent approach considering human factors to minimise risk of miscommunication.

Community teams worked shifts and were not on call, there was a separate homebirth team working across the hospital. Staff in the community worked in the acute setting if there were no calls within the community. However, they were not placed in charge of labouring women or given duties that would restrict them leaving if they were called away. Community midwives were positive about the service they provided and the homebirth rate at RSCH was much better than the national average, with 6.5% reported against a national average of 2.3%

The unit was currently undergoing a process of change. The existing antenatal clinic, early pregnancy unit and community midwives were moving to another location. The entrance to the post-natal ward was also under development to incorporate a triage area and day assessment unit. The work was already underway and completion was due within weeks. This aimed to give the unit the ability to see women in private rooms allowing for more privacy and dignity.

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

Booking was paper based. Women booked via an online referral for ultrasound scans. Anyone who was not scheduled, was highlighted at initial booking by the community team.

There was patient car parking on the hospital site for maternity patients. However, the parking was limited and during busy times we saw long queues formed. During our inspection we witnessed a father who missed the birth of their child as the women laboured quickly and he was stuck in the queue for the car park.

We also spoke with women who had concerns at the length of time it takes to get the lift to arrive and get up to the 13th floor. This was often delayed by patients stopping to get in and out of the lifts on the way up and could be distressing for women who were experiencing labour.

**Learning from complaints and concerns**
The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. We saw it displayed in ward areas and inpatient
information how to complain. This included talking to the hospital’s Patient Liaison Service (PALS) and how to formally complain. Advocacy services are available to support patients and carers who wish to pursue a complaint about NHS treatment or care. Support can include helping to draft a complaint and attending meetings. Services are free, confidential and independent.

From April 2017 to March 2018 there were 31 complaints about maternity at the trust. The trust took an average of 56.9 days to investigate and close complaints.

The table below shows that 68% of complaints relating to the maternity services at the trust were regarding access to treatment of drugs.

<table>
<thead>
<tr>
<th>Complaint subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to treatment or drugs</td>
<td>21</td>
</tr>
<tr>
<td>Patient care</td>
<td>4</td>
</tr>
<tr>
<td>Communication</td>
<td>3</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>2</td>
</tr>
<tr>
<td>Staff numbers</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>

A breakdown of complaints by site for maternity services can be found below.

- Royal Sussex County Hospital: 22 complaints
- Princess Royal Hospital: eight complaints
- Royal Alexandra Children’s Hospital: one complaint

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

From April 2017 to March 2018 the trust received 956 compliments; 23 (2.4%) of these related to the maternity services at the trust.

We reviewed five recent complaints and felt they had been taken seriously and responded to in a timely way. The Head of Midwifery had streamlined the complaints process over the last year as it was previously not effective. She felt that there was still work to be done but that the process had been much improved. The Head of Midwifery reviewed all complaints personally and if possible arranged a face to face meeting to ensure the needs of the complainant were fully met.

Is the service well-led?

Leadership

The trust had managers at all levels with the right skills and abilities to run the service.

The division is led by a three-person leadership team, the Chief of Service, Head of Nursing and Director of operations. Maternity forms part of the Children’s and Women’s division which incorporates gynaecology, maternity, neonatal, obstetrics and paediatrics.

There were three matrons across the service: one at Royal Sussex County Hospital, a community matron and a matron at Princess Royal Hospital. These were supported by ward managers and risk leads.

All staff we spoke to felt supported by their line manager. Midwifery staff spoke positively about the leadership of the department and the support they were offered. Positive comments included “We
are a team and all help each other out” and “I love working here, things have definitely improved, I wouldn’t want to leave.”

Staff reported knowing who the head of midwifery was and although they did not always see her on the wards, they knew her door was always open and that she was very approachable.

The department had direct access to the trust board every month through the divisional governance board meeting. Several meetings fed into this meeting including the patient safety team, audit meeting and safety and quality meeting. This allows information to be fed up to the board but also back to the frontline staff.

Staff across the department including the community teams felt they could access the leadership team and were able to describe how this happened.

**Vision and strategy**

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff and patients.

The division worked with the trust to contribute to a revised BSUH clinical strategy. They had outlined their key objectives which included upgrading the obstetric theatre on level 13, securing access to a second obstetric theatre, and developing an alongside Midwifery Led Unit at Princess Royal Hospital. The objectives also included review of the physical environment and facilities following the completion of trust wide building work and to realise potential to develop as a regional centre of excellence for clinical services, teaching and research.

Staff could tell us what trust vision was and could describe how the department was a part of this. Patient First initiative was being rolled out across the trust, this was a quality improvement strategy which put the patient at the heart of improvements and gave frontline staff the opportunity to implement change. Staff we spoke with knew about the Patient First initiative and felt it was likely to further improve the service. They commented that it was exciting as they had heard such positive things from other departments. The head of midwifery and ward managers were currently undertaking the ‘Patient First Fundamentals’ programme.

**Culture**

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff told us they felt supported. We heard staff talk about how the department had changed in recent years and it felt like a safe place to work now. Staff described feeling able to suggest changes and that the planned introduction of Patient First initiative had further helped staff to feel empowered to make changes.

We heard from some staff that the culture sometimes allowed staff to work longer than their paid hours and staff would often miss breaks. Staff reported that this could lead to a tired workforce, however, it was generally acknowledged that this was much improved and that low vacancy had helped.

The inspection team were welcomed into the unit by all staff members. Staff were willing to talk to us and be open about what the service was like. This showed an open work force who welcomed review.

We were approached by a member of the housekeeping team who expressed concern around how she had been treated by managers within the facilities department. She had spoken to the Matron who had told her to approach the Freedom to Speak up Guardian within the trust. The matron had also printed off a photograph of the guardian and offered to go with her for support. This showed that staff cared about each other.
However, we were told that there had been reported dismissive behaviours from a consultant working within the department. Staff had reported this and incident forms had been completed. We were told by the matron that this was currently being investigated but no conclusion had been reached.

**Governance**

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care.

Clinical services managers and the head of midwifery sat on the trust's Safety and Quality Meetings for the women’s directorate. The committee met monthly and provided quality and safety assurances to the trust board via the divisional governance board meeting. The quarterly governance meetings were used to demonstrate effectiveness and progress. Governance meetings were usually cross-site so that learning could be shared. They were chaired by the department governance lead and were well attended by all levels of clinical staff. Issues discussed included new clinical guidelines, the results of incident investigations, complaints and updates to the risk register. We saw that matrons received copies of the minutes and disseminated any learning points or changes of practice to all relevant staff. We heard from staff that they were informed about any changes in ward meetings or via e-mail.

The maternity department recently demonstrated full compliance with the NHS resolution and Clinical Negligence Scheme for Trusts (CNST) premium incentive scheme. This meant maternity had met the ten strict national safety criteria including clear and effective plans for staffing levels, training, and ensuring that patients had effective ways to give feedback.

All staff were invited to attend the safety and quality committee and the audit meeting which were held monthly. We saw evidence of a ‘Quality newsletter’ which all staff could access. These were advertised on governance noticeboards in every clinical area within maternity. These noticeboards also contained information on the risk register, recent serious incident investigations and recent learning from complaints among other information.

**Management of risk, issues and performance**

The trust had systems for identifying risks and planning to eliminate or reduce them. There was a demonstrated commitment to best practice performance and risk management. Risk was reviewed through a series of local and trust wide meetings. We saw there were comprehensive assurance systems, and performance issues were escalated through clear structures and processes. The directorate lead for operations and the risk manager held monthly meetings within the maternity department. They discussed developing risks and progress on the current risk register.

We reviewed the maternity risk register and saw the top risks included staffing, lack of a second theatre and IT systems across the department. These risks were communicated to staff and there was a good grasp of where improvements were needed. There was an alignment between the recorded risks and what staff said they were worried about.

The maternity department was involved with the trusts ‘Learning from Deaths Programme’. The trust appointed the Chief Medical Officer and a Non-Executive Director to oversee any learning from deaths across the trust. The trust published its policy for learning from deaths in September 2017; this closely integrated the Medical Examiner Programme and Serious Incident Investigation to ensure all opportunities for learning were identified.

All deaths that were mandated in the guidance had been identified and had either undergone a case note review or were in the process of undergoing a review. The Deputy Medical Director for safety and quality presented to the Grand Round on the subject of learning from deaths including
case presentations on neonatology mortality. For neonatal mortality BSUH is the 16th out of all 57 level three units in the country.

The department attended Mortality and Morbidity meetings monthly. The meetings reviewed mortality statistics including crude mortality and Summary Hospital-level Mortality Indicator (SHMI) Mortality. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on averages. They also had clear actions and who should undertake them, and any future strategy and changes in practice regarding mortality.

The Antimicrobial Stewardship Group is accountable to the Infection Prevention Committee and the Drugs & Therapeutics Committee the Chief of Pharmacy was professionally accountable to the Medical Director with respect to Trust-wide Medicines Optimisation.

During our previous inspection we had concerns over staff awareness of an over-ride key that allowed an emergency lift to be accessed if a woman needed to be transferred down to the second theatre on level five. We saw evidence that the department had addressed this with further training and, in response to our feedback, had now provided override keys for the antenatal and postnatal ward and for the on call obstetric anaesthetist. However, there had been no formal risk assessment or business continuity plan if the lifts were to fail across the department. This showed that the department had not fully explored the risks associated with access to theatres or the department as a whole.

We saw evidence of the clinical and internal audit processes working well. The department were aware of the impact of audit and how audit can be used to further the development of better systems within the department. However, we were aware that key members of staff we spoke with were not always aware of how audits were used to improve the service. An example of this was a lack of gap analysis following national audits such as the recent MBRRACE audit report.

**Information management**

The IT systems used in maternity were not effective at collecting data efficiently. We were given several examples where this was a barrier to staff being able to do their job effectively. The community team had now received laptops that had improved access to test results but they were still having to complete paper records as they were not compatible with the current system.

Antenatal screening compliance was reliant on many failsafe to ensure women did not miss their blood tests. The current IT systems were unable to update teams if women were not screened on time. We also saw that one to one care in labour was calculated using a paper based system that relied on midwives completing a paper based form every four hours. The department were aware of the issues and were currently seeking a new system. We also saw this highlighted on the risk register which showed that department were aware of the risks.

Relevant information was displayed on notice boards within the maternity unit. We saw posters about training opportunities, development opportunities for staff, infection control, parenting advice and educational material for new parents.

Guidelines were stored on an electronic resource on the intranet. There was a focus on not printing off copies so that the most up to date policy was always accessed. Staff told us they could access policies, protocols and other information they needed to do their job through the trust intranet. Staff also had internet access to evidence-based guidance from bodies such as NICE and the Nursing & Midwifery Council (NMC). We saw computers available to allow staff to do this.
Patients confidentiality was protected at all times. During our inspection we observed computer stations around the department were left locked, this meant that unauthorised persons could not gain access to patient records.

**Engagement**

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

‘Caring for you’ trolleys had been introduced in staff changing rooms, these included hairbands, deodorant and other things to support staff if they needed.

Staff were consulted of any changes across the department and felt they had a voice. For example, the majority of staff were against the recent proposed initiative called ‘helping hands’ on call rota system, so this did not go ahead. We also heard staff were consulted about the changes to the location of services and given a choice where they worked and had input into the changes.

Regular ‘Pulse’ check surveys are held to see how staff were feeling this has improved from 3.63 to 4.11 from 2017 to August 2018. It was reported this was the biggest improvement in the trust and better than the national average.

Members of the Maternity Voices Partnership (MVP) and the Maternity Services Liaison Committees (MSLCs) both engage with the maternity with six monthly meetings and regular ‘walk the patch’ reports. Women also attended workshops and antenatal classes for homebirth and VBAC to give a patient experience viewpoint.

There were a number of ways patients and visitors could provide feedback. They could fill in an online patient survey, complete a ‘thank you’ form, raise a complaint or concern, rate the trust on the National Health Service Choices website or complete the Friends and Family Survey.

Bereavement leads engaged with local charities to ensure funding for the bereavement suite to be built and counselling for mothers and had formed strong relationships with them.

**Learning, continuous improvement and innovation**

The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. Maternity managers and matrons were enrolled on the ‘Patient First Fundamentals’ programme and had started to focus on the next steps.

A women centred WHO checklist had been developed in obstetric theatres. The aim was to make the woman the centre of the checklist by making sure all staff introduced themselves by name and designation to the woman and her partner. They were also part of the nationwide initiative called the theatre cap challenge, where staff names and roles are printed on their theatre caps. The aim was to flatten hierarchies, open communication channels and reduce the number of incidents in theatres.

Alongside this the maternity staff were in the process of filming a simulation setting from the woman’s perspective. They planned to use this both internally for training and also to promote best practice externally.

The department were launching the ‘bobble hat’ initiative, which identified babies who were at risk of hypothermia and hypoglycaemia through different coloured pompoms on top of knitted hats. The hat not only provided warmth but also acted to quickly identify if the babies needed extra care.
The department had a commitment to inclusive care. This included building the teams presence at relevant local events and working alongside local transgender support groups to encourage those who previously thought having a family wasn’t possible.

The department were voted the best allied health professional teacher by fourth year medical students in 2018.

The maternity services had moved from ‘needs improvement’ to ‘outstanding’ for performance within the NHSE Maternity Transformation Programme. The programme measured maternal smoking at time of delivery, stillbirth and neonatal outcomes, patient experience and patient choice.

### Outpatients

#### Facts and data about this service

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

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

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

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

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

The trust had 647,084 first and follow up outpatient appointments from May 2017 to April 2018. The graph below represents how this compares to other trusts.

(Source: Hospital Episode Statistics - HES Outpatients)

Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from May 2017 to April 2018.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Sussex County Hospital</td>
<td>354,339</td>
</tr>
<tr>
<td>Princess Royal Hospital</td>
<td>192,492</td>
</tr>
<tr>
<td>Sussex Eye Hospital</td>
<td>98,037</td>
</tr>
<tr>
<td>Royal Alexandra Children’s Hospital</td>
<td>75,054</td>
</tr>
<tr>
<td>Brighton General Hospital</td>
<td>55,504</td>
</tr>
<tr>
<td><strong>This trust</strong></td>
<td><strong>942,638</strong></td>
</tr>
<tr>
<td><strong>England</strong></td>
<td><strong>106,555,970</strong></td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from May 2017 to April 2018. The percentage of these appointments by type can be found in the chart below:
Number of appointments at Brighton and Sussex University Hospitals NHS Trust from May 2017 to April 2018 by site and type of appointment

(Source: Hospital Episode Statistics)

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

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

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

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

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Staff working in outpatient services either operated as part of the Central Clinical Services Division or within a specialist division. General outpatient services operated within the Central Clinical Services Division and mandatory training figures were reported on this group of outpatient staff. This included outpatient nursing, allied healthcare professionals and administrative
staff working in outpatients. The mandatory training compliance for this division was 95%, which was better than the trust target of 85%.

The trust did not have dedicated medical staff working within the general outpatient department. All medical staff running clinics were assigned to different specialities within the trust and mandatory training was reported within those specialities.

Staff we spoke with told us the online training resource was easily accessible and up to date. The system flagged when staff were approaching their refresher date and some of the training sessions were also available as face to face sessions.

Mandatory training covered a variety of topics including fire safety, health and safety, infection prevention and control, information governance, manual handling and safeguarding adults and children.

**Safeguarding**

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it. All the staff in the Central Clinical Services Division had received safeguarding training. The trust advised us that clinical members of staff were trained in safeguarding adults level two, and safeguarding children level two. Staff working in more specialist areas of outpatients, where children may be treated routinely were trained to safeguarding children level three. For example, nurses working in the ear, nose and throat department where children would regularly be seen were trained to level three.

According to the Safeguarding children and young people: roles and competencies for health care staff Intercollegiate document, all non-clinical and clinical staff who have any contact with children, young people and or parents and carers require level two safeguarding children training. In addition to this, staff should be able to access a level three trained professional at any time during their work.

There were no safeguarding referrals made in the 12 months between April 2017 and March 2018 by outpatient staff working at the Royal Sussex County Hospital.

Staff we spoke with had a good understanding of who the named safeguarding lead for the trust was and they were able to describe how they would raise concerns. One member of staff told us of a recent example where they had concerns over a disclosure of abuse from a patient. As a result, they sought support from the safeguarding team and an appropriate referral was made for the patient.

Staff working in sexual health that were providing care and treatment to patient's under the age of 18 were trained to child safeguarding level 3. They followed national guidance for assessing patients under the age of 18 and demonstrated a good understanding of Gillick competencies, the law and confidentiality. For example, one member of staff told us they inform patients that they may have to disclose information if they believed the patient or someone else was at risk of harm. Staff also demonstrated a good understanding of the risks of child exploitation and asked appropriate questions as part of their assessment processes. Staff told us they felt supported to raise concerns. Patients identified as vulnerable were followed up in the community if they did not attend scheduled appointments. Staff working in sexual health were also trained to recognise areas of risk such as female genital mutilation (FGM).

**Cleanliness, infection control and hygiene**

Standards of cleanliness and hygiene were maintained, and cleaning schedules were in use in all clinic areas. There were systems and processes to prevent and control infection. Staff kept the
environment, equipment and premises clean. Standards of cleanliness across the department were maintained, with reliable systems to prevent healthcare associated infections.

All areas we visited were visibly clean and tidy and there were infection prevention and control processes. We observed staff following national guidance on infection control. For example, staff with long hair had tied it back and all staff were ‘bare below the elbows’ at all times to enable effective hand hygiene and minimise the risk of contamination. We observed staff following National Institute of Health and Care Excellence (NICE) QS61: Statement 3: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. Alcohol hand sanitiser was seen throughout the department and staff and visitors were observed using it.

The service completed weekly hand hygiene audits. Results of these showed that an average score of 96% was achieved in main outpatients, 98% in Maxillofacial and Oral outpatients, and 96% in Ear, Nose and Throat outpatients. Results were discussed in safety huddles and displayed in staff and patient areas to raise awareness and drive improvements.

There was sufficient personal protective equipment (PPE) available in line with trust policy. There were sufficient hand washing facilities available with sinks with lever arch taps in clinical/treatment areas. This was in line with Health Building Note (HBN) 00-09: Infection control in the built environment. Soap and hand towels were available next to hand basins to facilitate effective hand washing. Information was displayed by hand washing sinks, demonstrating the World Health Organisation (WHO) guidance (2009) ‘Five moments for hand hygiene’.

Cleaning audits were undertaken and showed high levels of compliance, with the general outpatient department achieving scores between 96% and 99% between April 2018 and September 2018. Clinical cleaning audits were consistently at 100% during this time. We observed re-usable privacy curtains in treatment areas which had been changed in the last six months in line with national guidance. Records showed that all outpatient areas, including specialty clinics had records of six monthly curtain changes. This complied with Hospital Building Note 00-09, infection control in the built environment. This demonstrated that staff regularly changed the curtains to minimise the risk of the spread of infection.

Patient Led assessments of the Care Environment (PLACE) audits are a system for assessing the quality of the patient environment. Patient representatives go into hospitals as part of teams to assess how the environment supports patients’ privacy and dignity, cleanliness, dementia and disability access and general building maintenance. The PLACE assessment for cleanliness across five outpatient areas for the period 2018 ranged between 99% and 100%. This was higher than the national average for cleanliness in 2018 which was 98%.

We spoke with staff in the ear, nose and throat clinic who were able to describe a process of decontamination of reusable medical equipment in accordance with Department of Health Decontamination of surgical instruments (CFPP 01-01) (chapter 6) and trust policy. We observed labelled and packaged equipment waiting to be collected for decontamination by the central sterile services department (CSSD).

Waste was seen to be handled appropriately. Waste bins were emptied regularly and seen to not be overfilled. Sharps bins included completed labels with the signature of staff and the date they were assembled. Sharps bins were available in treatment rooms and areas where sharps may be used. Sharps bins were not overfilled and were managed in line with Health and Safety Regulations 2013 (the sharps regulations), 5 (1) d. This requires that appropriate and secure sharps containers for the safe disposal of medical sharps, be placed close to the work area where sharps are being used.
Infection control risks were assessed and expert advice sought where necessary. For example, in the ear, nose and throat outpatient clinic a risk had been identified relating to the differentiation between the clean and dirty areas. This had been reviewed by the infection control team and removed from the risk register as it had been assessed that the space between the two areas was sufficient to work safely.

**Environment and equipment**

The outpatient service was provided from a range of premises. This included older buildings where ophthalmology and general outpatient services operated, as well as more modern buildings which housed specialist outpatient clinics such as ear, nose and throat, and cancer services.

The fabric of the main outpatient department was challenging due to its age and as a result there were interim arrangements to assess and mitigate risks. We observed challenges relating to restricted space in areas such as the sexual health clinic and ophthalmology waiting area during walk in clinics. In addition, the top floor of general outpatients had limited space along corridors and in clinic rooms. This had been risk assessed by the service and it had been identified that the top floor clinic rooms were not suitable for some patients. For example, it was not possible for patients in wheelchairs to be seen on the top floor so arrangements were made for ground floor facilities to be used in this situation. As part of the clinical strategy work, the service was reviewing options to potentially relocate outpatients into new premises as they were being developed.

We viewed fires and control of substances hazardous to health (COSHH) risk assessments within the outpatient department. The fire risk assessment included 11 action points that had been identified to mitigate the risk. All 11 action points had been completed. We found the COSHH folders had risk assessments and safety data sheets pertaining to all the cleaning chemicals found in the cleaning cupboards. All risk assessments and safety data sheets were in date and all had a review date. All cleaning chemicals were stored securely.

Resuscitation trolleys were available in all areas of the outpatient department and in all outpatient clinics throughout the hospital. The trolleys included tamper resistant seals on each of the drawers for additional security while ensuring that the emergency medicines and equipment were easily accessible to staff. Emergency equipment and medicines stored on the resuscitation trolleys were subject to regular checks. This included daily checks that included ensuring that the seals were secure and that oxygen cylinders were sufficiently full. Weekly checks of the trolleys included expiry dates of medicines and a detailed check of all equipment and single use items that may be required in a medical emergency.

We checked four resuscitation trolleys; two in general outpatients, one in the cancer centre, one in the ear, nose and throat clinic and one in the ophthalmology clinic. All resuscitation medicines and consumables kept on the trolley were in date. Oxygen cylinders next to the trolleys were in date, more than half full and there were both child and adult masks easily accessible. Daily and weekly checks of the resuscitation trolleys were consistently clearly recorded and there were no gaps in checks.

Medical devices maintenance was carried out by the in-house medical engineering team. Medical devices were registered to an equipment management database where planned maintenance and demand maintenance work was recorded. We checked three items of equipment in general outpatients and the cancer centre all were seen to have been checked and maintained, with labels indicating a future date for re-testing. However, we reviewed equipment in ophthalmology outpatients that had test due labels for dates that had passed or had test labels that showed the equipment had been tested more than three years before. For example, an item of video
equipment had a due date of June 2018 and an automated blood pressure monitor had a label with a last test date of July 2015. In clinic room five a slit lamp (used for examining the interior of the eye) did not have a label indicating the service due date, however records provided by the trust indicated that this particular slit lamp had been tested in January 2018. A tonometer (used to measure the internal pressure of the eye) had a test due date label of May 2018; however, records provided by the trust did not include this item of equipment as having been tested during the current year.

At our previous inspection we found that one of the laser machines in the ophthalmology clinic had gone beyond its annual service date. At this inspection we found that all lasers had been serviced annually and there were annual audits. Actions from audits had all been completed or were in progress. Worn protective eyewear used in outpatients and diagnostic imaging had been replaced.

**Assessing and responding to patient risk**

There were systems and processes to assess, monitor and manage risks to patients. Staff had a good understanding of how to respond to risk and had clear pathways and processes to follow, including the use urgent referrals if required.

Reception staff had site of patients sitting in the waiting area and reported to the nursing staff if anyone appeared to be unwell or was in need of support. We also saw nursing staff monitoring the waiting areas. Reception staff had a good understanding of how to manage risks in relation to patients, including how to call for help and alert staff to an emergency. They were also aware of the location of the resuscitation equipment should they need to access it.

Nursing staff had received training in sepsis management. Sepsis was the theme of the week across the trust at the time of our inspection. This was discussed in safety huddles and was on the agenda for a staff meeting.

Safety huddles were held every morning in general outpatients. All staff working in outpatients met at the same time every morning to discuss current safety issues relating to the premises, patient care and other relevant issues that could impact on patient safety.

We saw evidence of learning from safety discussions and changes to practice. For example, in general outpatient’s staff had discussed awareness of patients experiencing low blood sugar. Nursing staff had reviewed practice and improvements had been made to the labelling of the cupboard where the kit was kept so that everyone knew where it was. In addition, staff had ensured that there was orange juice stocked in the fridge and biscuits accessible within the department.

Reception staff had received training in signposting patients to the correct place. Staff told us that patients would sometimes go to outpatients when they couldn’t get and appointment with their GP and didn’t want to wait in the accident and emergency department. Staff were aware of processes to follow and were able to get support from senior staff if needed.

Staff had a good understanding of referral pathways for use in situations where patients were displaying signs of mental ill health. They had access to a mental health liaison team. Staff in the sexual health clinic had a good understanding of mental health issues. We observed the use of general anxiety disorder and depression assessment scores. These were audited annually to ensure they were used appropriately and consistently. In the HIV clinic, nurses had been trained to care for patients identified at risk of suicide; four nurses had received specific training to provide this support.
World Health Organisation (WHO) five steps to safer surgery, checklists were seen to be in use for patients undergoing surgical procedures. We saw that the checklist was reviewed by the team together prior to the procedure. These ensured that appropriate checks were taken before procedures were carried out, and minimised the risk of incorrect procedures being carried out.

Risks were assessed and mitigating action was taken. For example, staff working in outpatients had been trained in basic life support and resuscitation trolleys were available on each floor of general outpatients.

**Nurse staffing**

The trust has reported their staffing numbers below for two different times; March 2017 and April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>As at 31/03/2017</th>
<th>As at 30/04/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>All sites</td>
<td>28.6</td>
<td>32.5</td>
</tr>
</tbody>
</table>

In March 2017 the trust reported they had filled 97.2% of their planned staffing. This rose to 98.2% in April 2018.

No site breakdown is available as the trust did not report the data at site level.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From May 2017 to April 2018, the trust reported a vacancy rate of 5.8% over establishment in outpatients. This was lower than the trust target of 10.5% in March 2018, reducing incrementally to 9.0% by March 2019.

Below is a breakdown by site:

- Princess Royal Hospital outpatient department: 5.8%
- Royal Sussex County Hospital outpatient department: 6.3%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

At the time of our inspection we were told that one, part time vacant nursing post in general outpatients had recently been recruited to with the new appointee due to take up their post in the weeks after our inspection.

**Turnover rates**

From May 2017 to April 2018, the trust reported a turnover rate of 22% in outpatients. This was worse than the trust’s overall target turnover rate of 14% in March 2018 reducing incrementally to 11% by March 2019.

No site breakdown is available as the trust did not report the data at site level.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)
Sickness rates

From May 2017 to April 2018, the trust reported a sickness rate of 5.6% in outpatients. This was worse than the trust overall target sickness rate of 4.2% in March 2018 reducing incrementally to 3.5% by March 2019.

A site level breakdown is shown below:

- Princess Royal Hospital: 3.1%
- Royal Sussex County Hospital: 5.2%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

Please note that the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff in all cases. Therefore, we have been unable to analyse bank and agency usage as a proportion of the total shifts needing to be filled.

The table below shows the numbers of shifts in this core service from June 2017 to May 2018 that were covered by qualified nursing and nursing assistant bank and agency staff or left unfilled.

For qualified nurses, 1,356 shifts were filled by bank staff and no shifts were reported to be covered by agency staff to cover sickness, absence or vacancy for qualified nurses. In addition, 116 shifts were not filled by either bank or agency staff.

For nursing assistants, 818 shifts were filled by bank staff and no shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants. In the same period, 127 shifts were not filled by either bank or agency staff.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Qualified nurses</th>
<th>Healthcare assistants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>1,356</td>
<td>818</td>
<td>2,174</td>
</tr>
<tr>
<td>Agency</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Not filled</td>
<td>116</td>
<td>127</td>
<td>243</td>
</tr>
</tbody>
</table>

Unfortunately, we are unable to provide a site-specific breakdown of nursing bank and agency usage in this core service, due to the format of the data provided by the trust.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

The outpatient nurse manager told us that no bank or agency staff were used within general outpatients and that data provided included figures for speciality clinics at other locations within the hospital. They also told us that regular staff would sometimes work additional Saturday clinics when different specialities were putting on additional clinics to focus on their 18-week targets.
Medical staffing

The trust has reported their medical staffing numbers below for two different times; March 2017 and April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>As at 31/03/2017</th>
<th></th>
<th>As at 30/04/2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
</tr>
<tr>
<td>All sites</td>
<td>15.1</td>
<td>15.5</td>
<td>97.8%</td>
<td>16.0</td>
</tr>
</tbody>
</table>

In March 2017 the trust reported they had filled 97.8% of their planned medical staffing. This rose to 102.3% in April 2018 showing they had exceeded their planned fill rate for medical staff.

No site breakdown is available as the trust did not report the data at site level.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Medical staff working within outpatients were employed within different divisions based on their specialities. There were no medical staff directly employed within general outpatients. Some clinics we visited had experienced medical staffing difficulties that were impacting on areas such as appointment waiting times. For example, staff working in Maxillofacial told us that the department had grown significantly in recent years and that two consultants had left resulting in added pressures. They told us that job plans were in the process of going out for advert and that the recruitment process had begun.

Vacancy rates

From May 2017 to April 2018, the trust reported a vacancy rate of 4% over establishment in outpatients. This was lower than the trust target of 10.5% in March 2018, reducing incrementally to 9.0% by March 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

For the period covering May 2017 to April 2018, the trust did not provide any data on turnover for medical staff in outpatients.

Sickness rates

From May 2017 to April 2018, the trust reported a sickness rate of 0.8% in outpatients. This was better than the trust overall target sickness rate of 4.2% in March 2018 reducing incrementally to 3.5% by March 2019.

Site level detail was not available from the trust to report a site breakdown.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)
Bank and locum staff usage

From April 2017 to March 2018, the trust reported that three shifts within this core service were filled by bank staff and no shifts were filled by locum staff. There were no shifts which were not filled by either bank or locum staff. A breakdown of bank and locum usage by staff type at the trust is shown below.

Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
<th>Unfilled shifts</th>
<th>Total shifts (bank + locum + unfilled)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Junior</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

Site level detail was not available from the trust to report a site breakdown.

(Source: Routine Provider Information Request (RPIR) – Medical agency locum)

Records

People’s individual care records, including clinical data was written and managed in a way that kept people safe. Between January and August 2018, less than 1% of patients were seen without their full medical record across the trust. When the full medical record was not available, staff could access the majority of results such as radiological and haematological results on electronic systems, and referral letters could be printed from other electronic patient information systems. Staff told us that access to patient’s full medical record was consistent and that they rarely had incidents where notes were unavailable. For example, a nurse working in a vascular clinic told us that access to and availability of medical records had improved in recent months.

Staff we spoke with in outpatients told us that access to electronic information systems was consistent and they reported having few problems with them. One specialist nurse working in a clinic at the time of our inspection told us that when there had been issues they had been able to flag them with the IT service and they were resolved quickly without impacting on patient care.

The sexual health and HIV clinics had use of a full electronic patient record and we were told they were preparing to go paperless. Paper records were in the process of being archived. Records within the HIV clinic were audited against national HIV standards.

The trust did not monitor the quality of the content of patient records in general outpatients. As part of a routine data request we asked for patient records audits. We were provided with the latest audit which was completed in 2016 and informed that there was no plan to continue with the case note audit going forwards. At our last inspection we saw that the audit identified that results were worse than the trust target. Following this there had been no further audits, so it was not possible to assess whether all records were in good physical order and contained all of the necessary history, referral sheets and other documentation. As part of our inspection we reviewed four sets of patient’s notes all of which were legible, contained appropriate demographic information, consent documented where appropriate (circled on template) and signed and designated.
Patient records were stored securely. This had improved from the previous inspection. Notes were stored within a medical records store with a tracking system in place. All notes we saw in the clinic areas were in secure cupboards with digital-code locks. Staff told us they had been able to suggest changes to the way patient notes were managed to ensure easier access. For example, patient notes that were needed elsewhere (for example, another appointment) within 24 hours had historically had a white slip attached to them indicating the record needed to be available. However, staff told us this slip had been easy to overlook which had affected the availability of notes. As a result the slip was changed to yellow paper in order to make it more visible and improve availability and accessibility of the patient record.

**Medicines**

Medicines in outpatients were managed safely. Medicines were kept in a treatment room that was locked when not in use. Cupboards containing medicines were locked, and the keys for these were checked out at the beginning of the day and checked back in at the end of the day by a registered nurse. The registered nurse responsible for holding the keys was designated at the beginning of the shift and indicated on a staff board so that all staff were aware who this was.

Fridges containing medicines were routinely locked, however we noted that in the HIV clinic that one medicines fridge was unlocked at the time of our inspection. This fridge was stored in an area not accessible to patients and staff took action immediately to ensure the fridge was locked and that staff were reminded of the importance of this.

FP10 and hospital prescription pads were stored securely in locked cupboards with serial numbers recorded so that all forms could be tracked throughout the department. This was in line with NHS Counter Fraud Authority Management and control of prescription forms: A guide for prescribers and health organisations, March 2018.

There were non-medical prescribers working in clinics in the trust. There were pharmacists prescribing in renal clinics and HIV clinics. All non-medical prescribers had completed a recognised qualification. They were supported and monitored when they complete the course and once they have been signed off as competent by the trust they have an annual appraisal and submitted a portfolio each year.

Not all outpatient areas had pharmacy input for stock control. For example, in ear, nose and throat and the general outpatient department stock control was the responsibility of nursing staff. Monthly stock audits were undertaken and records maintained of who carried them out. In general outpatient’s a box of slow release injections were found to have expired at the time of our inspection. The manager addressed this by removing the stock from circulation and placing it in a pharmacy drop box to be collected by the pharmacy team. The issue of expired stock being overlooked during the checking process was discussed at the daily huddle at the time of our inspection. It was also discussed with the individual who carried out the most recent stock check and there was a focus on learning in order to minimise the risk of it happening again.

Fridge and ambient room temperatures were monitored to ensure that medicines were stored within the correct temperature range. We reviewed temperature monitoring records in general outpatients; ear, nose and throat outpatients; and, sexual health and HIV clinics. However, in ophthalmology outpatients we reviewed records of ambient temperatures in room one where eye drops were kept and saw that there were some gaps in monitoring. For example, there were four gaps in checks for one week at the beginning of September 2018. Fridge temperatures were seen to be in range and medicines were stored at the correct temperature throughout all of the cold chain storage facilities we observed.
In ophthalmology outpatients eye drops were administered to patients for single use and the remaining bottle discarded. Medicines for patients to take home, including eye drops, were pre-labelled and doctor’s recorded instructions on them.

Patient Group Directions (PGDs) were not used in general outpatients. Medicines for patients being seen in clinic were either prescribed on an FP10 or hospital prescription for medicines to take home or by prescribing clinicians in the patient’s notes if medicines were to be administered in clinic. In the sexual health clinic Patient Group Directions were seen to be in use. Batch numbers and expiry dates were recorded in patient notes where medicines were administered against a patient group direction. Patient group directions in use in this clinic were audited for governance and adherence purposes by one of the clinical nurse specialists and non-medical prescribers working within the department. Controlled drugs were not in use within the department.

Incidents

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 2017 to May 2018, the trust reported no incidents classified as never events for outpatients.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SI) in outpatients which met the reporting criteria set by NHS England from June 2017 to May 2018. One was a diagnostic incident including delay (including a failure to act on test results) while the other was categorised as a HCAI/Infection control incident.

(Source: Strategic Executive Information System (STEIS))

Between September 2017 and September 2018, the department reported 26 incidents, 24 of which were recorded as having caused no harm and two as having caused low harm. Six of the incidents were identified as communication failures, of which five were outside of the outpatient team. A further six were due to inadequate documentation or poor recording, three were due to issues with the availability of patient records, two were due to transport or transfer delays, and two were due to test or treatment delays.

Staff told us that incidents were discussed at the daily huddles and we viewed records of these. For example, in the ear, nose and throat department a proforma was in use to record any incidents that had occurred and were discussed. Staff we spoke with knew about the online reporting system and were able to give us examples of using it. Staff told us that they received feedback for the incidents that they reported and they had the opportunity to reflect on these during practice reflection sessions that were held on alternate months within the department.

In the sexual health clinic, we viewed minutes of meetings where incidents had been discussed. Staff told us there was open discussion with the team and an emphasis on learning. In general outpatient’s staff told us that discussions about specific incidents would be raised on several occasions at safety huddles over the course of a few days. While staff told us this could be repetitive they thought this was good as it reminded them and ensured the discussion reached
everyone. In addition, we were told that the outpatient nurse manager followed up these discussions with emails to all staff.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. There were no incidents in general outpatients that were scored as causing moderate harm and therefore triggering the duty of candour.

Following a patient fall outside of main outpatients, staff had reviewed the incident as part of a team reflective practice session that was facilitated by the outpatient nurse manager. Staff told us this helped to ensure they had a consistent approach to supporting patients and that all staff knew what to do in case a similar incident occurred again.

Is the service effective?

Evidence-based care and treatment

The department provided care and treatment based on national guidance. Policies and procedures were available and accessible to staff via the trust intranet. Policies we viewed as part of our inspection were in date.

Staff in the outpatient department participated in external audits. Audits were developed against the quality standards and clinical guidelines from the relevant guiding body, for example The National Institute for Health and Care Excellence (NICE). Most audits were the responsibility of the speciality that oversaw that condition, for example the Endocrine and Thyroid National Audit was overseen by the speciality medicine division, with some of the pathway occurring in outpatient clinics. Other audits with outpatient contribution included the Getting It Right First Time (GIRFT) Audit and the National Cancer Patient Experience Survey.

We saw a database containing an overview of National Institute for Health and Care Excellence (NICE) guidance for different specialities. The database indicated when the guidance or quality standards were due for updates and any areas where action was required to enable compliance. For example, we saw that in the rheumatology speciality, a specialist physiotherapy service, nurse specialist helpline and psychology input was required to enable compliance with NG 100: Rheumatoid arthritis in adults: management.

Patients who were referred on a two week wait appointment for suspected colorectal cancer were referred ‘straight to test’. This was in line with National Institute for Care excellence (NICE) clinical guidance (CG 131) colorectal cancer: diagnosis and management.

Staff working in the sexual health clinic followed British Association for Sexual Health and HIV (BASH) national guidelines. Audits were undertaken annually against the standards by consultants and the data management team. The sexual health team also participated in research studies in areas such as bacterial vaginosis, rapid HIV and syphilis testing and HIV post exposure prophylaxis.

Within the cancer centre staff were adopting the United Kingdom Oncology Nursing Society’s 24-hour triage tool. The tool had been developed for staff who manned advice lines for patients who were receiving anticancer therapy or may be suffering from related immunosuppression. Staff working in the cancer centre had undertaken a study day on the use of the triage tool. Following the study day, the service was in the process of carrying out an audit of telephone calls to the helpline to better understand the types of calls they received. Following the audit, they planned on reviewing the best way to manage the helpline in the future including which staff were best placed to man the helpline and utilise the tool.
A pre-operative nurse led clinic running in outpatients had been set up against NICE guideline NG45 Routine preoperative tests for elective surgery, where the guidance highlighted the increasing role of nurse-led assessments pre-operatively.

Nursing staff in the ear, nose and throat clinic told us that enhanced recovery pathway work was ongoing. However, there were some difficulties balancing demands on staff time. Audits in ophthalmology were seen to be either fully or partially implemented. For example, NG81 Glaucoma: diagnosis and management was assessed as being fully implemented. NG82 Age-related macular degeneration was assessed as being partially implemented due to the identified need for funding for a patient education evening and administrative support to collate evidence.

**Nutrition and hydration**

Patient’s nutrition and hydration needs were identified and met. There was access to dietary and nutritional specialists in some speciality clinics such as diabetes clinics.

Water machines were available in the waiting areas. Patients could access refreshments from a café in the outpatient clinic. Staff told us that patients whose appointments were delayed would be offered refreshments if they were unable to purchase these from the café. During our inspection there was a delay in ophthalmology outpatients and as a result staff and managers provided tea and refreshments to patients who had been waiting longer than expected.

Dietary and nutritional advice and support programmes were provided through clinics within general outpatients. For example, patients with irritable bowel syndrome could access one to one or group support around dietary changes to help manage their symptoms. Patients who had been a critical care inpatient could access a multidisciplinary outpatient clinic that included dietetic support for their ongoing recovery.

**Pain relief**

Patient’s pain was assessed and managed. As part of outpatient assessment processes staff told us they would assess patient’s pain level as appropriate depending on their condition and symptoms, or procedures they were having done. Staff told us that pain assessment tools were available on the intranet, including those for patients with learning disabilities or those with dementia.

Stocks of simple analgesia such as paracetamol were available in general outpatients. Staff told us that if a patient was in pain they were assessed and a one-off prescription was issued by a medical practitioner and analgesia supplied. Pain clinics were held within the general outpatient service.

**Patient outcomes**

**Follow-up to new rate**

From May 2017 to April 2018:

- The follow-up to new rate for Royal Sussex County Hospital was similar to the England average.
- The follow-up to new rate for Sussex Eye Hospital was higher than the England average.
- The follow-up to new rate for Princess Royal Hospital was higher than the England average.
- The follow-up to new rate for Brighton General Hospital was lower than the England average.
- The follow-up to new rate for Royal Alexandra Children’s Hospital was similar to the England average.
The trust did not participate in the Improving Quality in Physiological Services (IQIPS) accreditation run by the United Kingdom accreditation service (UKAS). The IQIPS programme is professionally led with the aim of improving services, care and safety for patients undergoing physiological tests (such as audiology or sleep studies), examinations and procedures. There were no plans to participate in this accreditation scheme.

The dietetics department had developed a programme where they supported patients with irritable bowel syndrome to manage their symptoms through diet. Dietetics staff were trained to provide support through the low FODMAP diet where certain foods were eliminated and then reintroduced overtime to identify the impact on irritable bowel syndrome symptoms. The programme provided group, one-to-one and telemedicine sessions. The service had been evaluated to include patient reported outcomes. For example, there was an overall 82% reduction in total symptom score; 81% reduction in bloating; 67% reduction in abdominal pain; 55 and 59% reduction in flatulence & belching; and, a 58% reduction in lethargy.

In ophthalmology outpatients a one stop age-related macular degeneration (AMD) clinic was in operation to improve patient outcomes throughout the clinic. Patients were able to access scans, fluoroscopy (imaging) and clinical consultations within the same appointment.

In the HIV clinic there was a focus on providing lifelong care. Staff worked closely with clinical nurse specialists in the community to ensure patients had an individual plan of care that was outcome focused.

Competent staff

The service made sure staff were competent for their roles by ensuring that appraisals were completed at regular intervals.
Appraisal rates

From May 2017 to May 2018, 76.9% of staff within this core service at the trust received an appraisal compared to a trust target of 78%. The trust target was correct at March 2018, however the trust commented that the target would increase incrementally to 90% by June 2018. Below is a split of appraisal completion rate by staff group.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals complete</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to ST&amp;T staff</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>78%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical &amp; dental staff</td>
<td>110</td>
<td>100</td>
<td>90.9%</td>
<td>78%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>12</td>
<td>9</td>
<td>75.0%</td>
<td>78%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>28</td>
<td>15</td>
<td>53.6%</td>
<td>78%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>15</td>
<td>8</td>
<td>53.3%</td>
<td>78%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>11</td>
<td>2</td>
<td>18.2%</td>
<td>78%</td>
<td>No</td>
</tr>
<tr>
<td>Grand Total</td>
<td>182</td>
<td>140</td>
<td>76.9%</td>
<td>78%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

It was not possible to break outpatient staff appraisal rates by site. Trust wide, data we were provided with demonstrated that 94% of staff had an appraisal in the last 12 months. This was better than the trust target of 78%. Records within the general outpatient department showed that all nursing and clinical support staff had received an appraisal in the last 12 months.

The outpatient nurse manager told us that all qualified nursing staff working in the general outpatient department had received an appraisal in the last 12 months. Nursing appraisal rates within general outpatients had been stable at 100%, where all eight staff who work there received annual appraisals on an ongoing basis.

Staff working in the general outpatient department confirmed that they had received clinical supervision with the outpatient nurse manager on alternative months. The outpatient nurse manager had access to external supervision alongside the nurse manager based at Princess Royal Hospital. In the ear, nose and throat outpatient clinic we saw records that showed all nursing staff had received appraisals in the last year.

All new staff working in general outpatients received induction plans. For example, middle grade doctors working in the maxillofacial clinic received an induction handbook that contained information about how the clinics ran and included relevant contact numbers. One doctor we spoke with told us the information was useful to them and provided guidance for clinics and on call duties. The same doctor told us they attended regular teaching days on alternate weeks at the Queen Victoria Hospital.

Specialist staff were given a welcome letter to inform them how clinics ran. Information contained in the letter reminded them about things such as security of notes and general room security such as locking clinic room doors when leaving the room.
There were trust-wide competencies for staff working in outpatient clinics from a band two to a band six nurse. We observed competency frameworks for staff working within the maxillofacial and ear, nose and throat clinics. Specialist competencies were developed in different departments, for example, in ear, nose and throat an advanced nurse practitioner had created a competency framework for a range of ear, nose and throat procedures. Also in the ear, nose and throat department a medical student told us that they received excellent teaching and a band six nurse told us they had the opportunity to undertake a leadership course when they were a band five which encouraged them to apply for promotion.

In the main outpatient department, nursing staff were supported with their revalidation. We viewed a notice board in a staff area that contained a range of information about revalidation, including guidance from the Nursing and Midwifery Council (NMC). The outpatient nurse manager had commenced reflective practice sessions on a bi-monthly basis to support revalidation. This gave nursing staff an opportunity to focus on areas of practice and ensure that opportunities for learning were addressed. Reflective practice topics included new asthma treatments, improving student placements and ways to make improvements to an anticoagulation clinic following a patient complaint. Healthcare assistants working in general outpatients were supported to complete the care certificate.

In the sexual health clinic all new band six nurses were offered the opportunity to attend a sexual health/contraception course through Greenwich University. Staff were also able to complete a diploma in sexual and reproductive health module. Staff were supported through this by senior staff and were able to complete electronic knowledge assessments. The sexual health service also hosted a national foundation course for sexually transmitted diseases which staff had the opportunity to attend. In both sexual health and HIV clinics staff had access to one-to-one clinical supervision and six weekly group supervision sessions.

Nurses working in the general outpatient department also had access to some specialist training. For example, the regional vascular network funded training and conference attendance to support nurses’ continuous professional development. Nursing staff told us this helped to improve their knowledge, skills and understanding when supporting specialist vascular clinics within the general outpatient department.

No staff in the outpatient departments had received Mental Health Act 1983 (MHA) training. The trust informed us that a programme of Mental Health Act training had been in place which was run in prioritised areas of mental health activity by the Lead Educator for this area. However, this had not included any areas of outpatients. However, there was 24-hour specialist mental health support on site at the Royal Sussex County Hospital. Staff were aware of how to access this support.

Multidisciplinary working

All necessary staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. There were one stop clinics in operation within some speciality areas such as sexual health and ophthalmology outpatients. The one stop approach allowed patients to have their consultation, diagnostic tests and some results on the same day. This meant that care was coordinated and patients were able to see a range of professionals in one appointment.

Staff working within other areas of the outpatient clinics also told us there was a multidisciplinary approach to care across the different specialities. For example, within the ear, nose and throat
department medical staff told us that the multidisciplinary approach enabled the department to run more efficiently and improved care for patients.

Weekly multidisciplinary meetings were held to review cancer patients. We were told that treatment and cancer wait times were discussed at these multidisciplinary meetings. We viewed minutes of multidisciplinary meetings within the sexual health clinic where action points relating to patient care were identified and followed through. Within the HIV clinic staff met regularly with professionals from other services, including clinical nurse specialists working in the community.

We observed multidisciplinary working in outpatient clinics where specialist staff worked with outpatient staff to provide care for patients. This included cancer specialist nurses working with staff within the cancer centre to review patients.

A weekly vascular multidisciplinary meeting took place where patients were reviewed, including those being seen within outpatients. Records of these meetings were maintained and accessible to all relevant staff across the vascular network so that up to date records of decisions and care plans were available.

There was a multidisciplinary approach to a range of services offered by the service. This included the development of new ways of working such as clinics for patients who had been discharged home following a critical care admission. The service involved physiotherapy and dietetic input for patients as part of their recovery. In trauma and orthopaedics imaging results were being reviewed by surgeons, physiotherapists and radiologists to agree treatment plans virtually.

**Seven-day services**

General outpatient clinics were in operation between 8.30am and 6.00pm Monday to Friday. Additional clinics were also run regularly on a Saturday and sometimes on a Sunday. X-ray and phlebotomy services were available when clinics were run during weekends.

**Health promotion**

National priorities to improve the population’s health were supported by the service. Information about issues such as stopping smoking and improving heart health were available.

There was educational literature for patients, placed around different parts of the outpatient department. Information based on national guidance and best practice was provided by clinics and in many cases, was given to patients as part of their consultation. We viewed information prepared for clinics being run on the day of inspection and saw that the types of information to give to patients had been prepared in advance.

Specific health promotion material we saw placed in waiting areas around the clinics included advice and signposting information relating to different conditions and information about the clinics and various procedures patients may be having. For example, there were comprehensive patient and carer resources for cancer and other long term health conditions such as Parkinson’s. There was also information about other services such as those specifically to support older people and carers.

Within the HIV clinic we saw that there was a focus on ways of supporting patients with other conditions to maintain their health. This included the use of virtual systems and an app to support patients to monitor their health.
Mental Capacity Act and Deprivation of Liberty training completion

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Mental capacity and deprivation of liberty (DOLS) training was included as part of safeguarding adults level two training and as part of a data request the trust informed us that 95% of clinical staff (nursing, allied healthcare professionals and healthcare assistants) had received this training.

Staff demonstrated a good understanding of the Mental Capacity Act (2005) and were able to discuss issues relating to presumed consent and the use of mental capacity assessments when someone was thought not to have mental capacity. For example, staff working in the ear, nose and throat outpatient clinic told us they had involved Independent Mental Capacity Advocates (IMCAs) when caring for patients in order to make decisions that were in the best interests of the patient. Staff knew who to contact for support.

Is the service caring?

Compassionate care

People were treated with compassion, kindness, dignity and respect, when receiving care. Feedback from people who used the service was positive about the way staff treated people.

We observed patients arriving in the department and being supported by reception staff. We observed staff identifying themselves and asking patients if they needed help with anything when being collected from waiting areas. This is in line with NICE QS15 Statement 1: Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.

All clinic rooms had signs on asking to knock and wait before entering to ensure patient’s privacy and dignity was maintained. Doors also had ‘hello, my name is …..’ signs so that staff running the clinics could insert their name onto the sign. This helped patients to remember the name of the clinician they were seeing.

At the main reception area where patients checked in, we observed receptionists speaking quietly to ensure other patients may not overhear their personal details. Patients were also asked to stand back from the reception desk until it was their turn in order to ensure privacy.

During each appointment, a nurse or healthcare assistant accompanied the patient and acted as their advocate during appointments. The trust’s chaperone policy set out the requirement for all patients to have access to a chaperone of the same sex if required. Nurses or healthcare assistants acted as chaperones when necessary. There were chaperone notices in waiting areas informing patients of the option for a chaperone.

The Patient led assessments of the Care Environment (PLACE) for the period 2018 for privacy, dignity and wellbeing across four outpatient areas ranged from 28% to 75%, which was worse than the national average of 84%.

Staff acknowledged that the outpatient environment did not always lend itself to privacy being maintained. However, staff took action to improve the dignity of individual patients within the clinic areas. For example, in the sexual health clinic there was a radio playing in the reception/waiting area so patients could speak to staff without being overheard. Also, patients were asked to complete a form so that staff had a record of their needs rather than having to ask them about it in a public waiting/reception area.
Staff had created a team photo board in the waiting area of main outpatients so that patients would know who they were. The board included information about staff, such as that one member had recently run a marathon. The outpatient nurse manager told us this was so that patients would feel more comfortable with staff and that they hoped it would break down barriers between patients and staff.

At our previous inspection we found that patients were being weighed in corridors. At this inspection we saw that this issue had been addressed and a room had been developed for staff to conduct all physiological assessments, including weighing patients.

The trust participated in the Friends and Family Test (FFT). The test is a single question survey which asks patients whether they would recommend the service they received to friends and family who need similar treatment or care. The validated and published results as published on the NHS England website of the outpatient department FFT results are shown in the below table.

<table>
<thead>
<tr>
<th>Month</th>
<th>Percentage Recommended</th>
<th>Percentage Not Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jun-18</td>
<td>94%</td>
<td>2%</td>
</tr>
<tr>
<td>May-18</td>
<td>92%</td>
<td>3%</td>
</tr>
<tr>
<td>Apr-18</td>
<td>94%</td>
<td>2%</td>
</tr>
<tr>
<td>Mar-18</td>
<td>96%</td>
<td>3%</td>
</tr>
<tr>
<td>Feb-18</td>
<td>96%</td>
<td>3%</td>
</tr>
<tr>
<td>Jan-18</td>
<td>91%</td>
<td>2%</td>
</tr>
</tbody>
</table>

**Emotional support**

Patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. A healthcare assistant or nurse was present with patients during their appointments. This ensured that the patient had an advocate during their appointment that would check that they understood what was being said. Staff we spoke with told us they would always check patient’s understanding at the end of the appointment before they left the department. Staff told us they could take patients to a different area if they needed extra support or time.

Staff we spoke with demonstrated an understanding of the need to assess and support patients from a psychological and social perspective as well as a physical one. This was in line with National Institute of Health and Care Excellence (NICE) QS15 Statement 10: Patients have their physical and psychological needs regularly assessed.

Staff demonstrated the need to respond in a compassionate, timely and appropriate way to people’s experience of emotional distress. This was in line with NICE QS15 Statement 2: Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills. For example, some nursing staff in the HIV clinic had been trained to support patients who were suicidal.

In the cancer centre there were volunteer buddies who sat with patients who were waiting for appointments and treatment. The volunteers were from a voluntary sector advice and information service that was opposite the cancer centre.
Understanding and involvement of patients and those close to them

Staff communicated with people so that they understood their care, treatment and condition. At the end of their appointment patients were informed of the next steps, such as when they would receive test results or when their next appointment would be and with whom.

People who used the outpatient services and those close to them were involved as partners in their care. Patients told us they had the time and opportunity to talk to staff about any concerns or treatment options. For example, patients in the ophthalmology clinics told us that staff took the time to explain their treatments. This was in line with NICE QS15 Statement 5: Patients are supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences.

We spoke with a cardiac pre-operative assessment nurse in main outpatients who told us the team had developed a 9 minute video for patients on what to expect when they were admitted for surgery. Patients were given a link to the video that contained practical information about their journey to theatre and the environment in which they would be cared for. The video also included information about their recovery. Patients were encouraged to ask questions about the video during their appointment.

Is the service responsive?

Service delivery to meet the needs of local people

Outpatient services ensured people’s needs were met through the way services were organised and developed.

The outpatient department environment was appropriate to the needs of patients and provided comfortable seating, sufficient toilets and a water dispenser. There was a café in the department which served a variety of refreshments.

General outpatient clinics operated between 8:00am and 6pm Monday to Friday. There were some additional clinics run on Saturday mornings which staff told us were usually run by the specialities staff as opposed to outpatient staff.

Patients checked into their appointments via a reception desk, for example, in main outpatients, ophthalmology and the cancer centre. From there, the receptionist would advise the patient which area they needed to be seated in to wait. There were no volunteers working in the department to guide patients where they needed to go, however we observed both administrative and clinical staff fulfilling this role. There was clear signposting at the entrance to the department.

Following our previous report, it was highlighted that the outpatient service should develop play facilities in line with national best practice. Children were seen at the children’s hospital rather than the main outpatients; however, the service had developed a play box containing toys for children who were accompanying an adult who was attending an appointment.

Patients could access the hospital using local bus and taxi services. There was information on the website regarding the different bus services available, along with a link to a journey planner for patients to use. The hospital site was on a main bus route with frequent services every few minutes. There was also a car park on the hospital site and pay and display street parking on the roads surrounding the outpatient department. Patients we spoke to on our inspection told us that they had been able to park, although they had to allow additional time to find a suitable parking space or to walk from the hospital car park which was some distance away. A patient transport
service was available for patients who were unable to access private or public transport for medical reasons.

The service made use of telemedicine appointments via telephone and video link appointments as an alternative to face to face appointments. This was an area of development for the service and a key priority in relation to the ongoing strategy.

Specialist clinics were provided to meet the needs of the local population. For example, in the sexual health there were under 25 and transgender clinics. These were provided through a combination of booked and walk-in appointments. Some emergency appointments were also available within the sexual health clinic.

The service did not monitor clinic start and finish times. Staff told us they had monitored them for a period of time but that the results weren’t acted on so this practice was stopped. Senior staff told us the monitoring of clinic start and finish times was a draft indicator for the outpatient department Patient First Improvement System driver improvement project which started in September 2018 and was running for five months into 2019.

There were boards in clinic waiting areas advising who the relevant nurse and healthcare assistant attached to that clinic was. The white boards all had standard text printed and displayed advising patients of the potential for delays in clinics and apologised for this. We saw specific details of waiting times within the cancer centre and observed staff updating these and informing patients verbally of delays and the reason for these. Patients were also offered refreshments at this time. In addition, we observed a busy clinic in ophthalmology where patients were verbally informed of delays and refreshments were offered. Patients we spoke to on the days of our inspection told us that the wait times were variable, with some patients being seen promptly and others waiting up to an hour before being seen.

Patients received text message reminders of their appointments. Patients told us the reminders were helpful.

**Did not attend rate**

From May 2017 to April 2018:

- The ‘did not attend’ rate for Brighton General Hospital was lower than the England average.
- The ‘did not attend’ rate for Princess Royal Hospital was lower than the England average.
- The ‘did not attend’ rate for Royal Alexandra Children’s Hospital was similar to the England average.
- The ‘did not attend’ rate for Royal Sussex County Hospital was similar to the England average.
- The ‘did not attend’ rate for Sussex Eye Hospital was lower than the England average.
The chart below shows the ‘did not attend’ rate over time.

Proportion of patients who did not attend appointment, Brighton and Sussex University Hospitals NHS Trust

![Chart showing the 'did not attend' rate over time for various hospitals.](image)

(Source: Hospital Episode Statistics)

A patient administration system with text reminders had been rolled out across all specialities in 2017. This meant that patients were able to respond to the text to indicate if they were cancelling, confirming or rebooking their appointment. Staff told us that 78% of patients were registered with a mobile phone and that DNA rates had improved since the system had been implemented.

Meeting people’s individual needs

The service took account of patients’ individual needs. The trust had a dementia strategy that was due for review in September 2018. However, there were no specific goals or assessments specific or relevant to the outpatient setting.

Dementia training was part of the trust training programme for all staff. Data provided to us by the trust suggested training compliance cross site was at 88% compliance. This was better than the trust target of 85%.

The Patient Led Assessments of the Care Environment (PLACE) for dementia period 2018 over two outpatient areas ranged between 66% and 70%, both of which were worse than the national average of 78.9%.

The trust was aware of the Accessible Information Standard. The Accessible Information Standard came into effect in 2016 and requires that all NHS trusts offer reasonable adjustments to help support people with disabilities or sensory loss to fully understand the information given to them. Some of the aids available at the trust were British Sign Language (BSL) interpreting for appointments, Listening Devices, and braille for patients with visual impairment. There were communication boxes kept in staff areas within outpatients. The box contained information to help staff communicate with patients. For example, there were picture cards and word prompts in different languages and pictorial instructions on basic sign language signs. Staff told us they were able to access interpreters on the same day if needed.

We saw “How do you communicate?” posters on display asking patients if they needed information in a different format or additional support.

Staff knew about translation services for patients who did not speak English as a first language and interpretation services could be arranged either to be face to face or via a telephone device.
There was a multi faith chapel in the Barry building on site that patients, visitors and staff could use.

Since our previous inspection a disabled toilet had been developed in the main outpatient area. Services in main outpatients were located on two floors. The first floor level had limited accessibility for patients with a physical disability. This was identified on the outpatient risk register and staff mitigated the risk by ensuring that ground floor facilities were used for patients unable to access the first level.

Patient led assessments of the Care Environment (PLACE) for disability period 2018 over five outpatient areas ranged between 40% and 79%, all of which were worse than the national average 84.2%.

There was no bariatric equipment held in general outpatients or the ear, nose and throat clinic. However, staff told us they could access equipment from other departments as needed. A nurse in the ear, nose and throat clinic also told us they were able to offer domiciliary clinic appointments in patient’s own homes if necessary. Staff in main outpatients told us they received information before patient appointments if the need for bariatric facilities. For example, at the time of our inspection patient transport services made contact to inform staff that they were transporting a bariatric patient later in the week for an appointment. Staff told us they had allocated and ground floor room for the appointment so as to provide access and maintain the privacy and dignity of the patient.

Staff working in outpatients had access to a learning disability liaison nurse. In the ear, nose and throat clinic we were told that they obtained patient notes in advance so knew if the patient had a learning disability. They would make contact with the liaison nurse for advice and input about how best to support the patient.

**Access and flow**

From 1 October 2018 all outpatient referrals nationally were to be received via the NHS e-Referral System (ERS). Senior staff told us that in September 2017 the proportion of e-referral utilisation was 1% and was the lowest in the South East and nationally. In August 2018 this utilisation rate had increased to 96%. At the time of our inspection all outpatient referrals were processed and triaged electronically, ahead of the 1 October deadline.

Consultants reviewed all referrals and accepted, rejected or redirected as appropriate. Any rejected referrals had to be returned to the patient’s GP within three working days. If a rejected referral was not returned to the GP in this time then the receiving clinician would see the patient as booked.

Patients could not always access the service when they needed it. Overall waiting times from referral to treatment were worse than the England average. Non-admitted pathways were overall more than 10% below the England average and performance had consistently reduced over the course of the year.

The trust had met with commissioners, NHS Improvement and NHS England for a Referral to Treatment Time (RTT) summit in early September 2018. Following this meeting the trust were constructing a range of costed options to reduce the non-admitted backlog to improve RTT performance and were due to submit these options to NHS England and NHS Improvement by the end of October 2018. At the time of our inspection the trust was in the process of analysing performance data and workforce implications to develop a plan to reduce the non-admitted backlog.
Other action that the trust had taken included using a company to provide support to specialities with short term workforce constraints that had affected the 18 week pathways. Insourcing services had been used in areas such as endoscopy; ear, nose and throat; and, vascular services. In addition, different specialities met weekly to discuss their RTTs and identify action to address them.

An independent pharmacy service was located within the outpatient department. The pharmacy dispensed all hospital outpatient prescriptions from a range of clinics. The pharmacy monitored the amount of time patients had to wait for their prescriptions. For example, between April 2018 and July 2018 the average waiting time was between 10 and 13 minutes. Pharmacy opening times were between 9 a.m. and 6 p.m. on a Monday, Wednesday and Friday; between 9 a.m. and 7 p.m. on a Tuesday and Thursday; and, between 9.30 a.m. and 1.30 p.m. on a Saturday and Sunday.

Referral to treatment (percentage within 18 weeks) – non-admitted pathways

From July 2017 to June 2018 the trust’s referral to treatment time (RTT) for non-admitted pathways was consistently worse than the England overall performance. The latest figures for June 2018 showed 75.1% of this group of patients were treated within 18 weeks versus the England average of 88.5%.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Brighton and Sussex University Hospitals NHS Trust

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

Five specialties were above the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>100.0%</td>
<td>91.7%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>98.0%</td>
<td>95.6%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>97.0%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>94.3%</td>
<td>92.9%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>88.1%</td>
<td>84.2%</td>
</tr>
</tbody>
</table>

Fourteen specialties were below the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>83.4%</td>
<td>91.1%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>79.3%</td>
<td>84.4%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>78.2%</td>
<td>89.6%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>71.8%</td>
<td>88.7%</td>
</tr>
<tr>
<td>General surgery</td>
<td>71.5%</td>
<td>89.0%</td>
</tr>
<tr>
<td>Urology</td>
<td>71.4%</td>
<td>87.6%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>71.1%</td>
<td>86.5%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>69.0%</td>
<td>86.5%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>68.0%</td>
<td>89.3%</td>
</tr>
<tr>
<td>ENT</td>
<td>62.4%</td>
<td>86.6%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>60.3%</td>
<td>87.5%</td>
</tr>
<tr>
<td>Neurology</td>
<td>57.6%</td>
<td>80.5%</td>
</tr>
<tr>
<td>Ear, nose and throat (ENT)</td>
<td>48.6%</td>
<td>85.6%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>37.6%</td>
<td>81.7%</td>
</tr>
</tbody>
</table>

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) – incomplete pathways

From July 2017 to June 2018 the trust’s referral to treatment time (RTT) for incomplete pathways was consistently worse than the England overall performance. The latest figures for June 2018, showed 83.0% of this group of patients were treated within 18 weeks versus the England average of 87.4%. Data provided by the trust from August 2018 showed that the figures remained stable at 83.0%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Brighton and Sussex University Hospitals NHS Trust

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Seven specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>99.7%</td>
<td>93.2%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>99.4%</td>
<td>96.2%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>97.4%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>93.8%</td>
<td>89.4%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>91.5%</td>
<td>90.5%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>89.0%</td>
<td>85.4%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>88.8%</td>
<td>88.5%</td>
</tr>
</tbody>
</table>
Twelve specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>88.3%</td>
<td>90.3%</td>
</tr>
<tr>
<td>Urology</td>
<td>85.3%</td>
<td>87.1%</td>
</tr>
<tr>
<td>General surgery</td>
<td>82.6%</td>
<td>84.8%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>82.3%</td>
<td>89.9%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>81.2%</td>
<td>89.4%</td>
</tr>
<tr>
<td>ENT</td>
<td>80.3%</td>
<td>86.9%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>79.3%</td>
<td>84.8%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>77.8%</td>
<td>82.5%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>75.8%</td>
<td>92.9%</td>
</tr>
<tr>
<td>Neurology</td>
<td>71.3%</td>
<td>87.5%</td>
</tr>
<tr>
<td>Ear, nose and throat (ENT)</td>
<td>70.4%</td>
<td>85.4%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>62.0%</td>
<td>82.9%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Staff told us that sometimes clinics were overbooked in order to reduce the referral to treatment and waiting times for patients. We observed a 10 week rolling booking utilisation report and saw that some clinics were overbooked on an ongoing basis such as clinical immunology and nutrition and dietetics. Other clinics such as gynaecology and ophthalmology were overbooked on occasion.

Feedback from patients we spoke with in outpatient areas was that initial appointment can take a long time. For example, two dental patients told us they had waited for eight months for an initial appointment. They were not aware of the reason for the delay. Other patients told us there were delays with follow up appointments. One patient seen in a digestive diseases clinic told us their scan had showed an issue and that the doctor who gave them the results had told them they would be seen in four months. At the time of our inspection the patient had been waiting for three months and still hadn’t received the appointment. Another patient waiting in the cancer centre told us that their consultant had told them they needed to be seen in four months which was due very soon. The patient told us they had phoned the booking team two or three times as the four months had nearly passed but they still hadn’t been given an appointment. They told us that although they would eventually get an appointment, they described this experience as stressful.

Patients took outcome forms to reception for booking following their appointment. Reception staff told us that it wasn’t always possible to book patients at the time as there were no available appointment. in this situation patients would be partially booked but wouldn’t actually receive an appointment as this would be sent onto them at a later date. Where follow up appointments were urgent, for example within a couple of weeks, reception staff would have to follow this up themselves. If it was longer than that then the appointment booking would return to the booking hub. Staff told us that the situation could be problematic for patients and time consuming for staff.

The service did not monitor clinic start and finish times. Nursing staff working in general outpatients told us they had monitored them for a period of time but that the results weren’t acted on so this practice was stopped. Senior staff told us the monitoring of clinic start and finish times was a draft indicator for the outpatient department Patient First Improvement System driver improvement project which started in Sept 2018 and was running for 5 months into 2019.

The trust monitored the turnaround time of letter sent to patient’s GPs following their outpatient appointment. This was not broken down to site level. There was no target turnaround time for this
according to the trust Patient Access Policy. The majority (28%) of letters sent between March and August 2018 were sent within seven and 13 days. The worst performing specialities, with over 50% of their letters taking 14 or more days, were breast care, gynaecology, renal and spinal surgery. The three best performing specialities with 50% or more of the letters turnaround between zero and two days were the hand service, neuro psychology and nutrition and dietetics.

During our inspection we saw that some clinics were very busy and that waiting times for patients were long. For example, ophthalmology outpatients were very busy at the time of our inspection with patients waiting in the main waiting area and on chairs in corridors outside of treatment rooms. Staff working in ophthalmology told us that patients would sometimes have to wait for several hours, particularly during drop in clinics.

Within the booking centre key performance indicators had been developed with daily reporting to trust key stakeholders. Call centre staff had a target of answering 90% of all calls and answering 90% of calls within two minutes. Data provided by the trust showed that the target was being achieved some of the time. For example, data for a 10 day period in April and May 2018 showed that the target for overall call answering had been met three times. The target for answering calls in two minutes had been met three times.

We visited the call centre at the time of our inspection and saw that 76% of calls had been answered but that 90% of these had been answered within two minutes. All internal and two week wait (urgent) calls had been answered. Staff told us that a daily huddle helped them to identify issues and ensure a team approach. At the time of our inspection we were told that there were some issues with follow up appointments in digestive diseases, neurology and chest specialities. Appointment bookings were prioritised based on clinical urgency and chronological order.

A number of different specialities had identified new ways of delivering outpatient services in order to improve access and flow and patient outcomes. For example, in the HIV clinic there was a focus on early access for patients to prevent admission. Clinic staff worked closely with GPs locally as part of a Locally Enhanced Service (LES). This included training for local GPs to prevent admission. In addition the clinic was participating in a research study into the use of an app to help patients manage their disease. This enabled more stable patients to be seen less frequently, leaving more capacity within the clinic for those who were unwell.

The dietetics department provided a programme for patients with irritable bowel syndrome referred directly from their GP or other healthcare professional. The aim of the programme over time was reduce the digestive diseases waiting list by 10% and to provide an alternative pathway from medical appointments for eligible patients where appropriate. Work had been undertaken with primary care colleagues on referral pathways and patient access and service reviews had led to an increase in telemedicine appointments with a view to improving access.

Physiotherapy clinics included a virtual triage programme where patients could self-refer without having to go through a GP or consultant first. Following the initial triage patients would receive telephone advice, group or one-to-one support. In trauma and orthopaedics activities to reduce waiting times included a virtual fracture clinic. In the clinic all patients were reviewed virtually by a surgeon, radiologist and physiotherapist and only those with issues needed to attend a consultant follow up appointment in person.
Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust has performed consistently better than the 93% operational standard for people being seen within two weeks of an urgent GP referral since 2017/18 quarter 2. 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), Brighton and Sussex University Hospitals NHS 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), Brighton and Sussex University Hospitals NHS 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.
Senior staff we spoke with told us that their aim was to continue to improve the overall pathway with a view to addressing the low performance in people waiting less than 62 weeks from urgent referral to treatment. In addition, weekly cancer meetings were held where the patient tracking list was reviewed to identify issues impacting on referral to treatment times. Pathway and multidisciplinary coordinators were involved in these meetings.

Senior staff told us that there had been a 50% increase in urgent GP referrals in recent years and that demand had sometimes outweighed the capacity of the service. As a result, the trust were aiming to improve output across the whole pathway, however issues such as delays in imaging and diagnostic blocks had impacted on this. We were told this was a result of staffing changes and difficulties recruiting radiologists. However, the trust had recently been successful in their recruitment.

The service had participated in a national lung pathway redesign pilot. This involved patients being booked into a scan by trust staff where this was identified as needed following a chest x-ray. The GP would then be contacted and asked to do an urgent referral and notified that the patient already had a scan appointment or was on a waiting list for a scan.

A one-stop breast clinic was removed in May 2017. The trust told us this was due to the volume of patients being referred outstripping the capacity of the service. This had resulted in patients receiving on the day imaging dependant on when they were referred in to the service rather than being based on clinical need. This meant that, irrelevant of likely clinical risk, patients were waiting some weeks for imaging (Ultrasound and Mammogram). As a result of this review, a clinical decision was made in conjunction with the surgeons, nurses and radiologists to cease the one stop clinic arrangement and instead manage patients based on their assessed clinical risk at their outpatient appointment. This meant that clinical risk would be assessed using a physical examination and as a result patients would receive a scale rating where P1 represents normal tissue; P2 benign tissue; P3 probably benign: P4 probably malignant; P5 malignant. Patients would then be referred for imaging based on their clinical risk score. We were told that this arrangement was reviewed on an ongoing basis through discussions and presentations at clinical governance meetings. We reviewed a divisional risk register and found screening and symptomatic imaging issues were highlighted on the register, however the cessation of the one-stop breast clinic was not detailed as a risk or as mitigating action. We also reviewed clinical governance meeting minutes and saw evidence of discussion of case presentations where diagnostic delays were as a result of a lack of imaging availability. However, minutes did not provide enough detail to identify if these cases related to the breast service or if the arrangement for the breast service was regularly reviewed as part of the governance meeting structure.
Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results. However, trust wide not all complaints were responded to within the timeframe set in the trust guidelines.

At the Royal Sussex County site, the trust received 52 complaints and 37 compliments during the last 12 months. However, we were told that there had been no complaints relating to patient’s experience of the main outpatient service, rather that the majority had been about accessing appointments within different speciality clinics.

We observed patient advice and liaison (PALS) and ‘how to make a complaint’ leaflets available in waiting areas.

Summary of complaints

From April 2017 to March 2018 there were 83 complaints about outpatients. The trust took an average of 44 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be closed within 25 days.

Analysis found that 54.2% of complaints relating to outpatient services at the trust were regarding access to treatment of drugs.

The breakdown by site is shown below.

- Princess Royal Hospital: 12 complaints
- Royal Sussex County Hospital: 52 complaints
- Other sites: 19 complaints

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

Staff told us they tried to resolve issues as they arose within the outpatient department. There was information about complaints displayed on the wall in general outpatients and the main theme identified was around patients experiencing difficulties accessing appointments.

Number of compliments made to the trust

From April 2017 to March 2018 there were 89 compliments within outpatients.

The breakdown by site is shown below.

- Princess Royal Hospital: 14 compliments
- Royal Sussex County Hospital: 37 compliments
- Other sites: 38 compliments

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

Since our previous inspection where outpatient services sat within the head and neck directorate, a divisional restructuring had taken place across the trust. Since April 2018 general outpatients and central administration services (CAS) had operated within the central clinical services division.

The central clinical services divisional leadership team consisted of a chief of service, a head of professions, a deputy director of operations (vacant) and divisional project support. There was a directorate manager responsible for both outpatients and the central administration service and the lead cancer nurse was the professional lead nurse for the service. There was a vacant band 8 matron post that was scheduled to be recruited to by November 2018. A band 7 nurse managed the outpatient department operationally.

The band 7 nurse manager reported to the professional lead for the service; however, this was a new structure that had been put in place three weeks before our inspection. Prior to that, since the divisional restructuring in April 2018, line management arrangements for the nurse manager were not formalised. This meant that supervision and support arrangements were not in place, although the nurse manager was clear about whom they could report to if the need arose. In addition, there were informal support structures between the nurse manager at the Royal Sussex County Hospital and the nurse manager at the Princess Royal Hospital.

Staff working within the outpatient department reported not seeing senior leaders very often. Two members of staff told us they had met the divisional chief for the first time three weeks prior to our inspection; however other senior staff were not familiar to them. Staff reported that while there had been no matron in post for the previous few months, they felt supported by the band 7 nurse manager.

Trust wide, the two departmental managers across both the Royal Sussex County and Princess Royal Hospital sites supported each other but with the matron vacancy had not had direct line management support between April 2018 and the beginning of September 2018.

Vision and strategy

The trust values were communication; kindness and understanding; fairness and transparency; working together and excellence. The trust vision was to be locally and nationally renowned for delivering safe, high quality and compassionate care and being the regional centre of clinical and academic excellence. There was no specific vision or values for the outpatient team. However, the outpatient team had developed their philosophy of care. This involved patients; knowing that staff care, that they felt looked after, listened to and involved; for them to understand who was looking after them and what was going to happen during their appointment; and, for them to feel confident in the service from booking their first appointment until their last appointment had ended.

The trust was rolling out the Patient First Improvement System which was an organisation system to manage and improve quality and performance. Outpatients had been designated as the next department to engage in this system. This was being rolled out initially on the Royal Sussex County site. Staff working in outpatients had an understanding of the Patient First programme and those we spoke with had participated in the training that had taken place in the three weeks prior to our inspection. We viewed information about the programme displayed in staff areas within the department and saw that it had informed internal discussions in the weeks since the training had
commenced. Staff had a good understanding of the rationale behind the programme and had visited another hospital site in a neighbouring trust where the programme was in use. Staff told us that as a result of this visit they had ‘bought into’ the programme and were looking forward to implementing it.

As part of a data request, the trust informed us that outpatients services were included as part of the review process within the trust-wide clinical strategy. However, this had not yet been approved by the trust board and was due to be ratified in October 2018. As a result of this, we could not ascertain whether the trust wide clinical strategy had realistic objectives applicable to the outpatients department. However, there were some clear priorities identified for delivering good quality and sustainable care within outpatients. These included:

- The implementation of e-referral and continued development of centralised booking services
- Potential re-provision of current main outpatient department at the Royal Sussex County Hospital as part of the 3Ts estates development
- Digitisation and implementation of new technologies including virtual clinics, text remind, one-stop consultation and diagnostic/treatments services such as a urology treatment centre at Princess Royal Hospital.

**Culture**

Staff we spoke with during our inspection were focused on the needs of patients and the culture was centred on the needs and experience of people who use the services. There was a commitment to providing high standards of care and to put patients first. We saw this consistently across clinics and staff teams. Staff working in the general outpatient clinic spoke of a very close knit team who worked well together. Staff demonstrated pride in their work and were committed to improving the experience of patients.

Staff working within outpatients were flexible and motivated to provide high quality care and a positive patient experience. We observed staff taking time to engage with patients, focusing on their needs and offering assistance.

The culture within the general outpatient department encouraged openness and honesty at all levels within the organisation. Staff told us they felt able to raise concerns with the department manager and that the appropriate learning and action was taken as a result of concerns raised. Staff demonstrated an understanding of the requirements of the duty of candour. There were no specific incidents where the duty of candour applied but staff were aware of how it related to them. There was a general culture of openness and honesty. For example, when a clinic was cancelled with short notice, all patients spoken with individually, an apology given and explained that it was human error but should not have happened. Staff had also given patients information on how they were going to prevent it from happening again.

There were cooperative, supportive and appreciative relationships among staff within the outpatient departments we visited. Staff and teams worked collaboratively and shared responsibility. For example, in general outpatients the nursing team had identified team goals and regularly reviewed their achievements. We viewed quarterly reviewed of what had been achieved. Achievements included the development of a notice board so that patients knew who the members of the team were, the development of a distraction box for children in the waiting area and the completion of spirometry competencies for two members of the team.
Governance

The trust wide governance structure had been reconfigured since our last inspection. The structure now had six sub-committees that fed into the trust board (the audit, charitable funds, finance, quality and risk, appointment and remuneration and patient experience committee. Patient Experience committee (proposed) purpose: would be to provide assurance to the Board that the Trust managed comments, compliments, concerns and complaints from patients and the public in a sensitive and effective manner and that a process of organisational learning was in place to ensure that identified improvements were embedded within the organisational framework.

The central clinical services division held quarterly governance meetings. We saw one agenda, action log and report from the August meeting which demonstrated that patient safety, patient experience and risk were discussed. However, only by senior members of the leadership team attended this and no general outpatient staff, such as the department manager were in attendance.

As part of a data request we were told that team meetings at each site had a standing discussion item of governance and this was fed into the divisional meetings. We reviewed three sets of minutes from June to August 2018 and saw that some governance issues had been discussed. These included learning from incidents and the identification of departmental risks as incorporated into the divisional risk register. However, it was not clear how the issues discussed in outpatient meetings were fed into divisional meetings as no outpatient staff attended the divisional meetings. This meant that governance issues from the department may not have been fed into the divisional governance group and vice versa.

Divisional governance meetings were held across different specialities. For example, staff working in maxillofacial clinics and ear, nose and throat clinics told us they attended regular governance meetings within their divisions. This included mortality and morbidity meetings across the cancer network.

Outpatient improvement meetings took place where key performance indicators and information such as the proportion of cancelled clinics and missed outcomes per speciality were discussed. The terms of reference of the group indicated that the manager for outpatients should be involved in these meetings. However, neither of the current band 7 outpatient nurse managers at the Royal Sussex County Hospital or Princess Royal Hospital had attended the meetings and were not included in the circulation list.

Up until March 2018 there was a regular outpatient lead nurse forum, bringing together outpatient leads from a range of general and speciality services. Due to the divisional restructure in April 2018 these meetings had stopped. This meant that formal arrangements for trust wide outpatient governance were not currently evident. However, there were plans to reinstate these when the outpatient matron post was recruited to in November 2018.

In the main outpatient department, the nursing team had monthly meetings led by the band 7 outpatient nurse manager. In addition, staff had alternate month one-to-one meetings and alternate month reflective practice group sessions. Staff told us that department governance meetings were not yet set up and there were no structured audit meetings due to the new divisional structure not yet being embedded.
Management of risk, issues and performance

There were environmental risk assessments, including those for control of substances hazardous to health (COSHH) and the limited use of the first floor clinic due to a lack of space for patients in wheelchairs. There was a folder containing all risk assessments with mitigating actions and we saw that all staff had signed to state that they had read and understood their responsibilities in relation to this.

An outpatient’s risk register identified two risk areas. One of these related to inaccessibility of the first floor in main outpatients and included mitigating actions such as ensuring patients with physical disabilities have appointments on the ground floor. The second risk related to potential impacts on patient treatment due to the risk of equipment being out of date in ear, nose and throat outpatients. It had been identified that financial investment was required to address the issue and the risk was due for further review in December 2018.

Staff working in general outpatients told us there was limited audit data shared to improve performance. For example, staff told us they had collected data on clinic start and finish times to try and improve waiting times for patients. However, they told us that the processes for collation of the data and feedback from this had not been in place; therefore they had stopped collecting the data. Patient outcome forms were used within the department; however there were no audits of these so therefore it was unclear how these were monitored to improve performance.

The Patient First Improvement System was being implemented across the trust. Patient First is a continuous process of improvement within existing processes and pathways that leads to measurable improvements for patients and staff. The focus of the system is on empowering front-line staff to make improvements themselves. Staff were given training in the tools to work out where opportunities for improvement are in their daily work and to develop the skills to make sustainable change happen. The outpatient team at the Royal Sussex County Hospital were piloting the system as the first outpatient team to do so. At the time of our inspection the pilot had been in operation for three weeks. Staff had begun the process of training and had visited another outpatient department in a neighbouring trust to see how the system worked. Staff were positive about the system and training and told us they were looking forward to implementing it and addressing issues as part of their daily work.

Information management

The trust used secure electronic systems with appropriate security safeguards. It was widely recognised that paper based information needed to be transferred into electronic formats to ensure a more accurate and timely capture of data to support patient pathways. For example, referral processes from GPs were now fully electronic and both the HIV and sexual health clinics were in the process of transferring to fully electronic patient record systems.

Clinical staff had access to pathology results, imaging results and referral letter via electronic systems. Staff told us that the systems worked well generally and that the information was accessible when they needed it. Nursing staff working within the general outpatient department had attended information governance training.

There were arrangements for information used to monitor, manage and report on quality and performance across the administrative functions of the outpatient department. We observed data being used through an outpatient dashboard that monitored performance in areas such as waiting times, cancelled clinics and responding to referrals.
Engagement

Patient information boards were in use in the waiting areas of outpatients and included feedback comments from patients in a 'you said, we did' format.

The outpatient department participated in the Friends and Family Test which gave patients an opportunity to feedback simply whether they would recommend their department to their friends and family. Patients were able to give audio feedback via the test rather than completing a written form. There were no other surveys in use within the department.

The trust participated in the NHS Staff Survey. In the most recent 2017/18 survey, 47% of staff recommended the trust as a place to work. This had improved by 9% from the 2016 survey. The score for recommending the trust to a friend or relative needing treatment had also improved by with a score of 58%. This had improved by 6% from the 2016 survey. Responses from the staff survey increased by an average of 18% in the 2017/18 survey.

The trust undertook snap shot staff surveys on a monthly basis within each division. Results from these showed some ongoing improvements across the trust as a whole. Within central clinical services there was evidence of an improving picture of staff engagement with an increased average engagement scores from 3.63 to 3.86 between 2018 and August 2018. Other areas of the survey also showed improvements. However, there was a reduction within central clinical services of staff feeling able to make suggestions to improve the work of their team or department.

Staff in all the outpatient areas we visited told us they had regular team meetings. Staff told us that they were able to raise any issues in these and found them useful. In addition to this, all outpatient area teams had daily safety huddles where any issues could be raised. Staff told us that this made it easy to feel engaged and part of the team.

The trust website had a dedicated section for outpatients. This included information about who to contact if patients had any queries or wanted to change their appointment. There was also an online form available for those wishing to cancel or re-schedule their appointment online, provided this was completed two working days prior to the appointment. There was a guide to waiting times on the web pages, which explained that all patients should be seen within 18 weeks of a referral, and that some specialities were experiencing longer delays than others.

Learning, continuous improvement and innovation

The dietetics department had developed a programme that provided group, one-to-one and virtual sessions for patients with irritable bowel syndrome. The aim of the programme was to take the pressure off of consultant appointments where patients may be better suited to seeing a dietician. The service had been evaluated to include patient reported outcomes and there was evidence of significant improvements in symptoms as a result.

The sexual health and HIV clinics actively participated in research to improve care for patients. This included the use of an app to help support patients to better manage their HIV.

The virtual hand fracture clinic was introduced to the trust in 2016. An audit was carried out in 2017 which demonstrated a 50% reduction in standard clinic visits following the introduction of a virtual system.

Between January and March 2018, the services only method of feedback was from FFT cards given to patients at their appointment, which generated an average of 0.5% response rate. In April 2018, more cards were given out at the point of contact at the appointment, which generated an increase in response rates. In May 2018, the service switched on the ability for patients to text their FFT feedback following their appointment, which resulted in a large increase in response rates.
The below graph demonstrates the increase in the number of responses gained for the Friends and Family Test from January to June 2018:

<table>
<thead>
<tr>
<th>Month</th>
<th>Total Responses</th>
<th>Total Eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-18</td>
<td>290</td>
<td>49,673</td>
</tr>
<tr>
<td>Feb-18</td>
<td>217</td>
<td>49,299</td>
</tr>
<tr>
<td>Mar-18</td>
<td>207</td>
<td>49,299</td>
</tr>
<tr>
<td>Apr-18</td>
<td>1,479</td>
<td>49,299</td>
</tr>
<tr>
<td>May-18</td>
<td>2,839</td>
<td>49,011</td>
</tr>
<tr>
<td>Jun-18</td>
<td>2,640</td>
<td>49,011</td>
</tr>
</tbody>
</table>
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.

**Acute services**

**Urgent and emergency care**

**Facts and data about this service**

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

The department consists of:

- An ambulance assessment area with two cubicles for patients who arrive by ambulance,
- A walk-in triage assessment room.
- A three-bay resuscitation room.
- A major treatment area with room for eight patients
- A children’s examination area with space for two children and full resuscitation facilities.
- A mental health assessment room.
- Two examination rooms for patients with minor injuries
- Two consultation rooms for patients with minor injuries and illnesses.
- A six-bedded clinical decision unit.
We last inspected the emergency departments in April 2017 and rated them as ‘Requires Improvement’.

During this inspection we visited the ED at Princess Royal hospital from 25 to 26 September 2018. We spoke with two patients and their relatives, approximately 24 staff at different levels and in different roles. We looked at 23 patients records and observed how the ED functioned and how patients were managed and cared for.

**Activity and patient throughput**

**Total number of urgent and emergency care attendances at Brighton and Sussex University Hospitals NHS Trust compared to all acute trusts in England, April 2016 to March 2017**

From April 2016 to March 2017 there were 161,026 attendances at the trust’s urgent and emergency care services as indicated in the chart above.

*(Source: NHS England)*

There were approximately 39,000 ED attendances at the Princess Royal Hospital in the year ending August 2018. 6,000 of these were children of 17 years or younger.
The percentage of A&E attendances at this trust that resulted in an admission remained similar in 2016/17 compared to 2015/16. In both years, the proportions were higher than the England averages.

(Source: NHS England)

In the year ending August 2018 25% of ED patients at the Princess Royal hospital were admitted to a ward.

Urgent and emergency care attendances by disposal method, from March 2017 to February 2018

* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)
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 ensured that everyone completed it for most modules.

Mandatory training completion rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data at core service level.

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

Mandatory training includes topics such as fire safety, control of substances hazardous to health, information governance and basic safeguarding. The trust had set a target for 85% of staff to complete mandatory training. The number of staff receiving mandatory training had improved since our last inspection. Between 81% and 100% of nurses and healthcare assistants had received mandatory training in the last year. A range of 75% - 90% of doctors had received the same training.

However, although there had been increased attention paid to resuscitation training since our last inspection, the number of nursing staff who had completed this remained lower than the trust target. Records showed that 64% of nurses had completed adult immediate life support training and 67% had completed paediatric immediate life support training. The trust managed this risk by insuring there was a skill mix that included immediate life support and paediatric immediate life support training. The duty rota showed that there was always at least one nurse on duty with this training. All senior doctors had an advanced qualification in the resuscitation of children (advanced paediatric life support) and adults (advanced life support).

Clinical staff received mandatory training on how to recognise and provide a first response to patients with mental health needs, learning disabilities, autism or dementia. The training was included in the safeguarding module which included the Mental Capacity Act and deprivation of liberty safeguards training. Data sent by the trust showed that 85% of clinical staff had been trained. However, staff we spoke with had limited knowledge of mental health issues and how best to support different needs that people might present with. A recent internal audit of mental health patients had identified the need for staff to have more understanding of mental health issues, and future face-to-face training was being planned.
Safeguarding

Safeguarding training completion rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data at core service level.

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

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

There was a clear system and process in place for identifying and managing patients at risk of abuse. Nursing staff we spoke with were able to explain the process of safeguarding a patient and provided us with specific examples of when they would do this. Staff were aware of how to contact the safeguarding leads.

Staff had training on how to recognise and report abuse and they knew how to apply it. Eighty five percent of doctors and 98% of nurses and healthcare assistants had received recent training in safeguarding adults at risk.

The Intercollegiate standards for children and young people in emergency care settings state that doctors and nurses who assess children should have received level three safeguarding training. At the Princess Royal emergency department only 58% of doctors had received level three training in children’s safeguarding. Ninety eight percent of nurses and healthcare assistants had received this advanced level of training. The lead children’s nurse was qualified to level six.

Training included information to help staff identify women or children at risk of female genital mutilation. Staff understood their responsibilities to report this.

All clinical records for children contained a risk assessment screening tool aimed at quickly identifying any concerns regarding child welfare. These were completed correctly in the records that we reviewed. An up-to-date version of the local child protection register was available via the unit’s computer system. Records that we looked at showed that it was checked for each child who attended to ensure that they had not been identified as at risk of abuse.

The department had a designated safeguarding lead who worked closely with specialists at the Royal Alexandra hospital for Children in Brighton.

Cleanliness, infection control and hygiene

There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained.

The department was visibly clean and we saw support staff cleaning the department on a regular basis. Staff told us there was an improved out-of-hours cleaning service.

We observed staff using antibacterial hand gel regularly and before and after patient contact. ‘Bare below the elbow’ policies were adhered to and staff wore minimal jewellery in line with the trust infection control policy. Personal protective equipment such as gloves and disposable aprons were used in accordance with the trust’s infection prevention policy. Waste was segregated and stored correctly in line with national guidance. We observed domestic staff regularly changed waste bags to ensure they did not overflow.
Results from weekly hand hygiene audits for the previous three months showed that staff’s compliance with hand hygiene policy varied between 95% and 97%.

There were two isolation rooms for patients with suspected infectious diseases. We observed a healthcare assistant contacting the hospital’s “deep clean team” when one of the rooms had been vacated. One of the team arrived promptly to clean the room before another patient used it.

**Environment and equipment**

Considerable re-building and refurbishment had taken place since our last inspection. There was a new resuscitation room and enlarged major treatment area. A new assessment area had been built so that patients arriving by ambulance could be rapidly assessed. All had piped oxygen and suction and there was built-in cardiac monitoring equipment for all patients. There were dedicated consultation rooms to allow GPs to see patients who did not have emergency conditions.

At the time of inspection, the mental health assessment room was being re-decorated and so was out of use. We were informed this work had started two days previously and would last for a further seven days. The room being used in the interim period was not appropriate for people who were at risk of harm to themselves or others and did not meet the quality standards best practice guidance of the Psychiatric Liaison Accreditation Network.

This was because there were ligature points, inappropriate furniture and crockery in place. There was also only one door to the room, whereas two are needed, and the alarm in use was only accessed on one point in the room, not via a strip around the room. No risk assessment had been carried out in order to promote the safety of staff and patients. We raised this with managers who carried out a risk assessment the following morning. All the risks had been addressed and appropriate measures had been put in place to reduce them. Staff that we spoke with were aware of the precautions they needed to take to improve safety for themselves and their patients.

Since the refurbishment of the department staff told us that they had access to the equipment that they needed to care for patients in the emergency department. We saw records that show the maintenance programme for this equipment. We checked a range of specialist equipment, including adult and children’s resuscitation equipment. It was clean, clearly organised and well maintained. It had been checked on a daily basis to ensure that it was ready for use.

Clinical waste and specimens were appropriately labelled and segregated. They were stored safely and disposed of according to hospital policy.

An adjacent imaging department provided X-rays and scans for walking patients and those on trolleys.

**Assessing and responding to patient risk**

Risks to patients who had not arrived by ambulance (self-referred) were not always assessed in a timely manner when they first arrived, although risks to patients who arrived by ambulance were assessed.

Patients who walked into the department, or who were brought by families or friends, reported to the reception desk. Once initial details had been recorded patients were asked to sit in the waiting room while they waited to be assessed by a nurse. This assessment was required to determine the seriousness of the patient’s condition and to make immediate plans for their on-going care. This is often known as triage. Standards set by the Royal College of Emergency Medicine states that this should take place within 15 minutes.
We looked at the records of eleven patients who had been triaged in the week prior to our inspection and found the assessments to be detailed and, on the whole, effective. Nurses told us they had completed specific training in triage and had been assessed as competent before undertaking the role.

However, of the eleven patients’ records reviewed, only five patients had been triaged within 15 minutes. Of the eight children who had arrived, only two had been triaged within 15 minutes. The others had waited up to 21 minutes. Some of the children had attended with conditions such as head injuries and broken bones and were at risk of deteriorating while they waited. During our inspection delays of longer than 15 minutes started to happen after 11am and rarely improved during the rest of the day.

There was no receptionist between 10.30 pm and 7.30 am the next morning and so the time of arrival of patients could not be accurately recorded. Therefore, measurement of delays for triage may not have been accurate. We were told that a nurse went into the waiting room every 15 minutes during the night but it was not possible to check that this always happened every night.

The Trust worked to a standard of assessing patients within 15 minutes of arrival. During the inspection we observed delays when patients waited approximately 20 minutes for triage.

Audits of triage times by the emergency department matron in August 2018 had showed similar delays to those that we observed during our inspection. It was noted that the longest delays occurred when there was a shortage of nurses on duty. Information sent to us by the trust showed that, for the period October 2017 through September 2018, the median (average) wait for self-presenting patients to be clinically assessed was 19 minutes. The trust has provided evidence of improvements to self-referred patient triage times in October 2018. However, this does not provide evidence over a long enough period to evaluate whether the improvement was sustainable.

Adult patients arriving by ambulance were rapidly assessed by the nurse in charge of the department. A more detailed assessment of the patient then took place in the new ambulance assessment area which had started to be used at the end of July 2018. The assessment included observations of blood pressure, respirations and temperature and the calculation of an early warning score. For many patients it also included recording an ECG (electrocardiogram or heart rhythm tracing). This information was recorded on the departmental computer system so that all staff could view it if necessary.

**Median time from arrival to initial assessment (emergency ambulance cases only)**

The median time from arrival to initial assessment was not reported by the trust from July 2017 to June 2018.

(Source: NHS Digital - A&E quality indicators)

Following our inspection, the trust sent us data showing that, in September 2018, 72% of ambulance patients had been fully assessed within 15 minutes. This was an improvement from the beginning of July 2018 when only 34% had been fully assessed. The computer system was not able to record the immediate assessment by the nurse in charge as the patient had not been registered at that point.

The ambulance service did not take children to this emergency department and so ambulance data applies to adult patients only.
Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

Princess Royal Hospital

From July 2017 to June 2018 there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Princess Royal Hospital.

Ambulance: Number of journeys with turnaround times over 30 minutes - Princess Royal Hospital

Ambulance: Percentage of journeys with turnaround times over 30 minutes - Princess Royal Hospital

May-17

(Source: National Ambulance Information Group)
Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From June 2017 to May 2018 the trust reported 1,068 “black breaches”.

The trust has had fluctuating performance in terms of black breaches which it accounts for by challenges with hospital capacity and flow. The highest number was 63 in week commencing 22 October 2017 and the lowest number was three in week commencing 27 August 2017.

(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

Emergency Department Survey 2017

Figures for the Princess Royal emergency department show that, in the year ending August 2018, there was an average of nine black breaches each month. This varied from one in September 2017 to 17 in January 2018. However, staff told us that all patients had been assessed by the nurse in charge when they arrived. If immediate treatment was required this had been arranged. We observed this practice throughout our inspection.

Patients who walked into the department, or who were brought by families or friends, reported to the reception desk. Once initial details had been recorded patients were asked to sit in the waiting room while they waited to be triaged by a nurse. We looked at the records of eleven patients who had been triaged in the week prior to our inspection and found the assessments to be detailed and, on the whole, effective. Nurses told us they had completed specific training in triage and had been assessed as competent before undertaking the role.

However, of the eleven patients’ records reviewed, only five patients had been triaged within 15 minutes. Of the eight children who had arrived, only two had been triaged within 15 minutes. The others had waited up to 21 minutes. Some of the children had attended with conditions such as head injuries and broken bones and were at risk of deteriorating while they waited. During our inspection delays of longer than 15 minutes started to happen after 11am and rarely improved during the rest of the day.

There was no receptionist between 10.30 pm and 7.30 am the next morning and so the time of arrival of patients could not be accurately recorded. Therefore, measurement of delays for triage may not have been accurate. We were told that a nurse went into the waiting room every 15 minutes during the night but it was not possible to check that this always happened every night.
Audits of triage times by the emergency department matron in August 2018 had showed similar delays to those that we observed during our inspection. It was noted that the longest delays occurred when there was a shortage of nurses on duty. Information sent to us by the trust showed that, for the year ending September 2018, the median (average) wait for self-presenting patients to be clinically assessed was 19 minutes. The trust has provided evidence of improvements to self-referred patient triage times in October 2018. However, this does not provide evidence over a long enough period to evaluate whether the improvement was sustainable.

The service included round the clock access to mental health liaison nurses and other specialist mental health support. Nurses used a risk assessment tool when patients with mental health problems first arrived. This helped them to decide whether the patient was at low, moderate or high risk. However, we noted that the level of risk was not always described when the patient was referred to the liaison team.

Liaison nurses undertook psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Where a patient needed an assessment under the Mental Health Act 1983, the liaison staff said they were able to access an Approved Mental Health Professional to arrange for this to take place. However, senior emergency department staff told us that this often took several hours and that very distressed mental health patients could disrupt the care of other patients.

Some mental health patients spent prolonged periods of time in the emergency department. Nurses in the clinical decision unit told us about patients spending three to five days there until a bed in a mental health unit became available. Staff in the department were not able to describe the different levels of observation that patients might require, or how those (such as 15-minute observations) were recorded. Although psychiatric liaison staff drew up risk management plans, those we viewed did not clearly describe the support that patients would receive with their mental health needs. This particularly applied where patient stayed overnight or longer in the clinical decision unit. We saw simple plans such as ‘give PRN (as required) medicine’, or ‘review by senior nurse practitioner’ but no detailed guidance to assist general nurses in caring for patients with mental health needs.

National Early warning scores (NEWS2) were used for adults and paediatric early warning scores (PEWS) for children. This was a quick and systematic way of identifying patients who were at risk of deteriorating. Clinical observations such as blood pressure, heart rate and respirations were recorded and contributed to a total score. Once a certain score was reached a clear escalation of treatment was commenced. We found that early warning scores for adults and children were not always recorded when a patient arrived and that ongoing recording was variable. This was a particular issue when children were treated. When we reviewed notes of children who had attended the previous week, six required an early warning score to be calculated but it had only been used for three children.

The matron had carried out recent audits of early warning scores for adults and children and was aware of the problem. Staff were being reminded of the importance of regular scoring to detect the early signs of a deteriorating patient. Screening for sepsis (a serious blood infection) was carried out for all patients with an early warning score of five or more. We observed two patients being rapidly screened and treated for sepsis in line with guidelines produced by National Institute for Health and Care Excellence (NICE).

A patient safety checklist had recently been introduced. This was aimed at reminding nursing staff to undertake hourly safety checks of all patients in the major treatment area. The checklist included a variety of checks, which included but were not limited to; vital signs measured,
identification wristband on patient, suspected sepsis (infection) screening, blood tests and pain score. However, some patients had not had all the safety checks applied. We reviewed four safety checklists during the inspection and only two had had all the checks completed. The trust scored about the same as other trusts for all five Emergency Department Survey questions relevant to safety.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

**Nurse staffing**

There was a risk that there were not always enough nurses to care for the number of patients that attended the emergency department.

Data sent to us by the trust after the inspection showed that an annual staffing review was undertaken by the chief nursing officer. It was unclear whether an evidence-based tool had been used to inform the review.

Current NHS guidance (Safe, sustainable and productive staffing in urgent and emergency care November 2017) refers to a ratio of one nurse for every two patients in the resuscitation room. At the Princess Royal there was one nurse for three patients throughout our inspection. Staff rotas confirmed that this was the normal staffing level. We were told that the acuity of patients in the resuscitation room had been taken into account when staffing levels had been reviewed.

The new ambulance assessment area had been designed for the rapid assessment of two newly-arrived ambulance patients. The rotas from the month before our inspection showed there were six days or nights when staff were not allocated to this area. There were a further three occasions when a nurse who should have been looking after patients in the major treatment area was transferred to the ambulance assessment area. The trust reported that cover was managed by the matron who would escalate to the Head of Nursing if there was a safety concern related to nursing. On the second day of our inspection two inspectors repeatedly observed the ambulance assessment area. We observed five occasions when there was no nurse to look after the two newly arrived patients. The period of time that a nurse was absent lasted between five and twenty minutes.

Data from the trust shows that, from July 01 2018 to September 16 2018 only 59% of ambulance patients received a full nursing assessment within 15 minutes. The trust has provided evidence of improvements to ambulance patient triage times in October 2018. However, this does not provide evidence over a long enough period to evaluate whether the improvement was sustainable.

At our previous inspection we found that there were not enough nurses with specific training in the care of sick children. Since then, an experienced emergency department nurse with a special interest in children has taken on the role of Lead Children’s Nurse. They had spent three months working at the emergency department at the Royal Alexandra Hospital for Children in Brighton and continue to spend one day a month there. Strong links have been established with the matron at the children’s hospital. There are plans for the role to include a post-graduate qualification in children’s nursing.

The Lead Children’s Nurse has ensured that all nurses in the department had undertaken paediatric immediate life support training and that healthcare assistants have been trained in basic paediatric life support. Two nurses have advanced paediatric life support qualifications and one had completed a post-graduate course in acute care of children. There was a regular programme of paediatric study days and practical simulations to increase the skills and knowledge of
emergency department nursing staff. In addition, three nurses have undertaken a two-month secondment to the emergency department at the children’s hospital in order to gain confidence in their new skills.

The department continues to advertise for specialist children’s nurses but has not yet been successful.

There was at least one emergency nurse practitioner on duty during the day. These were experienced and specially trained nurses who were qualified to diagnose and treat minor injuries. They worked from 10am to 10pm when there was the greatest need for this service.

The trust has reported their staffing numbers below for two different times; March 2017 and April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>As at 31 March 2017</th>
<th></th>
<th>As at 30 April 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Planned</td>
<td>Fill rate</td>
<td>Actual</td>
</tr>
<tr>
<td></td>
<td>WTE staff</td>
<td>WTE staff</td>
<td></td>
<td>WTE staff</td>
</tr>
<tr>
<td>All sites</td>
<td>225.1</td>
<td>242.5</td>
<td>92.8%</td>
<td>222.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>237.6</td>
</tr>
<tr>
<td></td>
<td>Fill rate</td>
<td></td>
<td></td>
<td>93.8%</td>
</tr>
</tbody>
</table>

In March 2017 the trust reported they had filled 92.8% of their planned staffing. This increased to 93.8% in April 2018.

No site breakdown is available as the trust did not report the data at site level.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From May 2017 to April 2018, the trust reported a vacancy rate of 3.7% for qualified nursing staff in urgent and emergency care. This was lower than the trust target of 10.5% in March 2018, reducing incrementally to 9.0% by March 2019.

The breakdown by site was as follows:

- Princess Royal Hospital emergency department: 13.9%
- Royal Sussex County Hospital emergency department: 4.1% over establishment.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

During our inspection senior staff told us that there were currently four vacancies for band 5 nurses. Two had been filled but the successful applicants had not yet commenced. Two were still being advertised.

Turnover rates

From May 2017 to April 2018, the trust reported no staff turnover in urgent and emergency care. This was better than the trust’s overall target turnover rate of 14% in March 2018 reducing incrementally to 11% by March 2019.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)
**Sickness rates**

From May 2017 to April 2018, the trust reported a sickness rate of 3.9% in urgent and emergency care. This was better than the trust overall target sickness rate of 4.20% in March 2018 reducing incrementally to 3.50% by March 2019;

A site level breakdown is shown below:

- Princess Royal Hospital: 5.3%
- Royal Sussex County Hospital: 4.0%
- Royal Alexandra Children’s Hospital: 2.6%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and agency staff usage**

Please note that the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff in all cases. Therefore, we have been unable to analyse bank and agency usage as a proportion of the total shifts needing to be filled.

The table below shows the numbers of shifts in this core service from June 2017 to May 2018 that were covered by qualified nursing and nursing assistant bank and agency staff or left unfilled.

For qualified nurses, 1,465 shifts were filled by bank staff and 1,475 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses. In addition, 1,100 shifts were not filled by either bank or agency staff.

For nursing assistants, 1,823 shifts were filled by bank staff and four shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants. In the same period, 628 shifts were not filled by either bank or agency staff.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Qualified nurses</th>
<th>Healthcare assistants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>1,465</td>
<td>1,823</td>
<td>3,288</td>
</tr>
<tr>
<td>Agency</td>
<td>1,475</td>
<td>4</td>
<td>1,479</td>
</tr>
<tr>
<td>Not filled</td>
<td>1,100</td>
<td>628</td>
<td>1,728</td>
</tr>
</tbody>
</table>

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

We reviewed the staffing rota for August 2018. No agency nurses had been used.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

All medical staff rotate between the emergency departments at the Princess Royal hospital and the Royal Sussex County hospital in Brighton. Each department had a clinical lead that spent the majority of their time at one department. Senior staff told us that there were no vacancies at any level. They felt this was mainly due to an innovative self-rostering system that helped doctors to have an improved work-life balance.

There was a consultant present in the department for 14 hours a day during the week and 16 hours a day at weekends. When there was no consultant in the department there was always one
available at Brighton for telephone advice. There was no consultant with special responsibility for children even though they represented 15% of the patients treated in the department.

Junior doctors spoke positively about working in the emergency department. They told us that the consultants were supportive and always accessible. In-house teaching was well-organised and comprehensive. Doctors told us their rota was well-structured and provided them with valuable experience balanced with sufficient rest days.

We saw consultants working clinically in the department. They led the treatment of the sickest patients, advised more junior doctors and ensured a structured clinical handover of patient’s treatment when shifts changed. Handovers between different teams of doctors was well-structured and detailed.

The trust has reported their staffing numbers below for two different times; March 2017 and April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>As at 31 March 2017</th>
<th></th>
<th>As at 30 April 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
</tr>
<tr>
<td>All sites</td>
<td>104.3</td>
<td>109.9</td>
<td>94.9%</td>
<td>117.2</td>
</tr>
</tbody>
</table>

In March 2017 the trust reported they had filled 94.9% of their planned staffing. This decreased to 87.4% in April 2018.

No site breakdown is available as the trust did not report the data at site level.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From May 2017 to April 2018, the trust reported a vacancy rate of 4% for medical staff in urgent and emergency care. This was lower than the trust target of 10.5% in March 2018, reducing incrementally to 9.0% by March 2019.

This data is at trust level as it was not reported with site level detail.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From May 2017 to April 2018, the trust reported no staff turnover in urgent and emergency care. This was better than the trust’s overall target turnover rate of 14% in March 2018 reducing incrementally to 11% by March 2019.

This data is at trust level as it was not reported with site level detail.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From May 2017 to April 2018, the trust reported a sickness rate of 0.4% in urgent and emergency care.

This was better than the trust overall target sickness rate of 4.20% in March 2018 reducing
incrementally to 3.50% by March 2019.

This data is at trust level as it was not reported with site level detail.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

From April 2017 to March 2018, the trust reported that 101 shifts within this core service trust-wide were filled by bank staff and no shifts were filled by locum staff. There were 62 shifts which were not filled by either bank or locum staff. A breakdown of bank and locum usage by staff type at the trust is shown below.

Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
<th>Unfilled shifts</th>
<th>Total shifts (bank + locum + unfilled)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>24</td>
<td>0</td>
<td>0</td>
<td>24</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>68</td>
<td>0</td>
<td>60</td>
<td>128</td>
</tr>
<tr>
<td>Junior</td>
<td>9</td>
<td>0</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>101</td>
<td>0</td>
<td>62</td>
<td>163</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

There had been no locum doctors employed by the department in the month before our inspection.
Staffing skill mix

From December 2017 to December 2017, the proportion of consultant staff reported to be working at the trust were lower than the England average and the proportion of junior (foundation year 1-2) staff was also lower.

Staffing skill mix for the 101 whole time equivalent staff working in urgent and emergency care at Brighton and Sussex University Hospitals NHS Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>20%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>9%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>58%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>13%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff kept detailed records of patients’ care and treatment. However, the records were not always easy to follow, and some of them did not contain all the information required. The records of patients who had who had been admitted rarely contained copies of observation charts or admission documents.

When a patient arrived at the department their details were entered onto a computer system that showed how long people had been waiting and the investigations they had received. Patient records and information stored on computer was protected by passwords and backed-up to keep it secure.

Staff entered initial clinical information onto the computer system but further medical and nursing information was paper-based. Paper records were kept for a month. Most records were then scanned into the computer system and could be viewed on screen if a patient returned to the department. However, if a patient was admitted to a ward, most of their records accompanied them and stayed in the main hospital patient file. No copy was made in the emergency department. If the same patient returned to the emergency department there would be significant delay before clinical staff could find out what had happened previously.

The computer screen displayed symbols indicating vulnerable or high-risk patients. Symbols included those for patients with sepsis, learning disabilities, dementia, risk of falls and those at risk of abuse.
We reviewed 23 sets of patient records. We found that doctors and emergency nurse practitioners recorded detailed and logical accounts of their examinations, diagnoses and investigations. However, doctors did not always record the time they had seen a patient and it was sometimes difficult to distinguish accounts written by ED doctors from visiting specialists. Nursing notes were variable. Some were comprehensive and clearly written but others were fragmented and safety checklists were not always completed hourly. The trust told us that there had been no audits of patient record since 2016.

Medicines

The department followed best practice when prescribing, giving, recording and storing medicines. This had improved since our last inspection as large oxygen cylinders were no longer used and so their storage no longer caused problems. Patients received the right medication at the right dose at the right time.

We saw that staff handled and recorded controlled drugs correctly. Controlled drugs are medicines liable for misuse that required special management. Spot checks on recorded controlled drug balances showed that the contents of the controlled drug cabinet matched the register.

Medicines were stored securely within locked rooms and cupboards with access restricted to authorised staff. Patients own medication was placed in a green pharmacy bag as soon as they arrived. The bag was placed in a locked cupboard at the staff base and a green sticker was placed on the patient record to remind staff where the medicines had been stored. Fridge temperatures were checked daily and were within safe limits.

Resuscitation trolleys containing medicines and equipment required in an emergency were accessible. The trolleys were all safely secured with tamper proof seals. Checks were in place to ensure emergency medicines were available and safe to be used.

There department used Patient Group Directions (PGDs) for some medicines. PGDs are agreements which allow some registered nurses to supply or administer certain medicines to a pre-defined group of patients without them having to see a doctor. We saw that the PGDs were up-to-date and there was evidence that staff had been appropriately assessed and signed off as competent to use them.

The majority of prescriptions were computer generated but a stock of paper FP10 prescriptions were kept in case of computer failure. These were stored and supplied securely and were checked on a regular basis.

Incidents

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 2017 to May 2018, the trust reported no incidents classified as never events for urgent and emergency care.

(Source: NHS Improvement - STEIS)
**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 26 serious incidents (SIs) in urgent and emergency care at Royal Sussex County Hospital which met the reporting criteria set by NHS England from June 2017 to May 2018.

This most common incident type was commissioning incidents meeting SI criteria (24 reported). These incidents took place at the Royal Sussex Hospital and so are not discussed in this report.

*(Source: NHS Improvement - STEIS (01/06/2017 - 31/05/2018))*

The service managed patient safety incidents well. Staff recognised incidents and reported them in line with trust policy.

Incidents and accidents were reported using a trust wide electronic system. All staff had access to this and knew which incidents required reporting. We looked at the ED incident reports for two months prior to our inspection. They had been logged correctly, were clearly described and remedial action had been taken when necessary.

Staff told us that they received feedback from incidents reports when they requested it. They also told us that there was a “no blame” culture which made it easier to report incidents and near misses. Learning from incidents was discussed at daily safety huddles and quarterly governance meetings. For example, changes had been made to the acute chest pain protocol to make it easier to follow.

Senior staff reviewed all incidents on a daily basis and commenced detailed investigation when needed. All deaths were reviewed by a consultant, usually the following day. If a secondary review was required, this would be undertaken by a multidisciplinary team. Mortality and morbidity reviews were discussed at weekly and quarterly meetings.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke with had a good knowledge of duty of candour and, senior staff were clear about their responsibilities in relation to the guidance. We saw examples of when the regulation had been applied.

**Safety thermometer**

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 ten days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, one fall with harm and two new urinary tract infections in patients with a catheter from May 2017 to May 2018 within urgent and emergency care.

*(Source: Safety thermometer - Safety Thermometer)*
Is the service effective?

Evidence-based care and treatment

The emergency department (ED) provided care and treatment that was based on national guidance. This included National Institute for Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM) standards. Guidance was available for staff to access on the intranet and in paper format at the staff base. They up to date and referenced best practise guidance. Managers checked to make sure staff followed guidance. We observed a charge nurse discussing NICE guidance with a junior doctor while reviewing a patient with a heart condition.

The matron and other senior nurses carried out audits of early warning scores, patient safety checklists and nursing documentation. When deficits were found action plans were put in place to improve practice.

There was a clinical audit programme that monitored the implementation of guidance from national clinical organisations. The programme included audits of NICE guidance such as head injuries. We were shown the results of eight other clinical audits which included the treatment of paracetamol overdose, pneumothorax and meningitis in adults. The department also took part in national benchmarking clinical audits including national annual RCEM audits. Following audits, action plans were put in place if any shortcomings were discovered. For example, additional training had been arranged for junior doctors in the recognition and treatment of meningitis.

Nutrition and hydration

Emergency Department Survey 2017

Staff gave patients enough food and drink to meet their needs whilst in the emergency department.

In the CQC Emergency Department Survey, the trust scored 7.0 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

We observed patients and their families being offered refreshments when needed although this was not always recorded in the patient records.

Following the assessment of a patient, intravenous fluids were prescribed, administered and recorded when clinically indicated.

Pain relief

Staff did not always undertake systematic assessment or monitoring of patients to see if they were in pain. During our inspection we saw no patients in obvious pain although very few pain scores had been recorded. Pain scores are used to record the severity of pain when patients arrived. They are later used to assess how effective any pain relief medication has been.

We reviewed 17 patient records from the week before our inspection. Only five had had pain scores recorded and only one had a second pain score recorded to assess whether pain relief had been effective. None of the children’s records included pain scores even though two children
had broken bones and two had sustained head injuries. Therefore, they did not meet the Intercollegiate Standards for children in emergency care settings (standard 23). The lead children’s nurse had recently carried out a similar review and was aware of the problem. Further education in the assessment of pain in children was being arranged.

**Emergency Department Survey 2017**

In the CQC Emergency Department Survey, the trust scored 6.0 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was about the same as other trusts.

The trust scored 7.4 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

*(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)*

**Patient outcomes**

Senior staff monitored the effectiveness of care and treatment and used the findings to improve them. The department took part in national audits to compare treatment results with other hospitals. However, their data was amalgamated with that of the Royal Sussex County Hospital and so it was not possible to be specific about the effectiveness of treatment at the Princess Royal Hospital emergency department.

**RCEM Audit: Moderate and acute severe asthma 2016/17 – Royal Alexandra Children’s Hospital**

Children attending the Princess Royal hospital were not included in this audit and so it was not possible to compare their treatment with best practice.

Comparing this hospital to other hospitals on the 2016/17 Moderate and Acute Severe Asthma Audit (Adult and Paediatrics), performance was better in two metrics, worse in two metrics and similar in three metrics. In this context, 'similar' means that the hospital's performance fell within the middle 50% of results. The RCEM standard of 100% was met in none of the metrics.

Trust performed worse in the following:
- Standard 1a: O2 should be given on arrival to maintain sats 94-98%
- Standard 2a: Vital signs should be measured and recorded on arrival at the ED

**RCEM Audit: Moderate and acute severe asthma 2016/17 – Royal Sussex County Hospital**

Comparing this hospital to other hospitals on the 2016/17 Moderate and Acute Severe Asthma Audit (Adult and Paediatrics), performance was better in two metrics, worse in three metrics and similar in two metrics. In this context, 'similar' means that the hospital's performance fell within the middle 50% of results. The RCEM standard of 100% was met in none of the metrics.

Trust performed worse in the following:
- Standard 4: Add nebulised Ipratropium to nebulised β2 agonist bronchodilator therapy
- Standard 5a: If not already given before arrival to the ED, steroids should be given as soon as possible: within one hour of arrival (acute severe)
- Standard 5b: If not already given before arrival to the ED, steroids should be given as soon as possible: within four hours of arrival (moderate)
RCEM Audit: Consultant sign-off 2016/17 – Royal Alexandra Children’s Hospital

Comparing this hospital to other hospitals on the 2016/17 Consultant Sign-off Audit, performance was similar in the one reported metric (fever in children under one year of age) where ‘similar’ means that the hospital's performance fell within the middle 50% of results. The RCEM standard of 100% was not met for this metric.

Of the patient records we reviewed three out of four children under one year of age with fever had been reviewed by a consultant.

RCEM Audit: Consultant sign-off 2016/17 – Royal Sussex County Hospital

Comparing this hospital to other hospitals on the 2016/17 Consultant Sign-off Audit, performance was similar in the two reported metrics (atraumatic chest pain in patients aged 30 and over, and abdominal pain in patients aged 70 and over). In this context, ‘similar’ means that the hospital's performance fell within the middle 50% of results. The RCEM standard of 100% was not met for these metrics.

Of the patient records we reviewed three out of four patients with these conditions had been reviewed by a consultant. The fourth patient had been seen be several doctors but it was not clear whether any of them were consultants.

RCEM Audit: Severe sepsis and septic shock 2016/17 – Royal Sussex County Hospital

Comparing this provider to other trusts on the 2016/17 Severe Sepsis and Septic Shock Audit, performance was better in two metrics, worse in two metrics and similar in four metrics. In this context, ‘similar’ means that the trust's performance fell within the middle 50% of results. The national standard was met in none of the relevant metrics.

Trust performed worse in the following:
- Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to):Within one hour of arrival
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival

(Source: Royal College of Emergency Medicine)

Following the results of this audit an action plan had been put in place to improve oxygen and fluid therapy. An internal follow-up audit had demonstrated that these had improved.

Staff had completed a quality audit using the Quality Standards for Liaison Psychiatry 5th edition. It assessed whether they met, had partially met or had not met each criterion. Staff had recognised areas for improvement and had actions in place to rectify criterion partially or not met.

Unplanned re-attendance rate within seven days

From July 2017 and June 2018, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and worse than the England average. The trust did not supply us with figures which were specific for the Princess Royal Hospital.

Unplanned re-attendance rate within seven days - Brighton and Sussex University Hospitals NHS Trust
Competent staff

The service made sure staff were competent for their roles.

Nurses new to the department received a three or four-day induction programme, depending on their previous experience. They then worked on a super-numery basis for four weeks and worked closely with the department’s practice educator. During this time essential skills such as wound closure and moving patients with spinal injuries were taught in a safe environment.

Newly qualified nurses were placed on a preceptor programme. Preceptorship is a period of structured transition for newly qualified healthcare professionals lasting up to one year, during which support is given by a preceptor who provides supervision, mentoring and support to develop confidence and refine skills.

There was an extensive programme of tuition and assessment of the competencies required for nurses working in emergency departments. These reflected the Royal College of Nursing’s National Curriculum and Competency Framework for Emergency Nursing published in July 2017. The competency framework was used by nurses and their managers to help identify when they were ready for increased levels of responsibility. Small badges of different colours were given to nurses when they had achieved significant milestones in the competency framework. Band 7 sisters and charge nurses undertook the advanced life support course and senior staff of all disciplines took part in the trust’s leadership courses.

One of the consultants led the training of junior doctors and the professional development of senior doctors. All the consultants took part in the training programme and one of them told us that frequent opportunities for learning were a part of everyday practice. We spoke with junior doctors who were complimentary about their training programme. They told us that they received regular supervision from the emergency department consultants, as well as twice weekly teaching sessions.

If the need for improvements in clinical practice had been identified, a consultant would lead a simulation of the practice with the involvement of all types of staff from the department. A discussion about the learning points from the simulation took place at the end of each session.
Appraisal rates

From May 2017 to May 2018, 61.3% of staff within this core service at the trust received an appraisal compared to a trust target of 78%. The trust target is correct at March 2018 as they have commented that the target will increase incrementally to 90% by June 2018. Below is a split of appraisal completion rate by staff group.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Appraisals completed</th>
<th>Appraisals required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>9.0</td>
<td>9.0</td>
<td>100.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>49.0</td>
<td>73.0</td>
<td>67.1%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>75.0</td>
<td>131.0</td>
<td>57.3%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>8.0</td>
<td>16.0</td>
<td>50.0%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>0.0</td>
<td>1.0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>141.0</strong></td>
<td><strong>230.0</strong></td>
<td><strong>61.3%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Appraisal tab)

Staff told us that appraisal rates were better than this in the emergency department at the Princess Royal Hospital. Data supplied by the trust showed that all nurses had received an appraisal in the year ending September 2018.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Staff spoke of good working arrangements with other departments including children’s services, diagnostic services and critical care. There was an imaging service adjacent to the department, and we saw effective working arrangements that benefitted patients.

The department had recently recruited two GPs. They had been given honorary trust contracts so that they could take part in trust governance processes. Staff told us that they had good working relationships with the GPs and they were able to provide care to patients who presented with minor illnesses or primary care conditions. Nurses undertook a two-month rotation with the children’s emergency department in Brighton in order to share best practice and maintain good working relationships. We observed good day-to-day working relationships with mental health staff.

There were care pathways to follow if patients needed admission to the hospital, for example, following a stroke or a fractured neck of femur (broken hip). Staff were familiar with these and made appropriate referrals.

We observed emergency department staff working seamlessly with ambulance staff and the hospital rapid discharge team. There were well established links with the hospital stroke team, the trauma team and the acute cardiology team.

Seven-day services

Patients could access diagnostic imaging services at all times, in line with the NHS Services Seven Days a Week Priority Clinical Standards. The department had access to radiology support 24 hours each day, with rapid access to computerised tomography (CT) scanning when indicated. There was always a senior radiology doctor available to interpret x-rays and scans.
The rapid discharge team were available seven days a week in order to ensure that it was safe to discharge patients who were frail or had mobility problems.

There was an on-call pharmacy service outside of normal working hours.

**Health promotion**

Staff took the opportunity, if it arose and was appropriate, to discuss smoking cessation, weight reduction, and drug and alcohol misuse with patients. We observed a doctor advising a patient about techniques for stopping smoking in order to improve a lung condition.

The parents of children who had attended with a mild asthma attack were given a personalised written care plan before going home. This gave information about preventing further asthma attacks and early interventions which could prevent a worsening of the illness.

There were leaflets and contact details of relevant organisations that may be able to offer support and advice to patients. There were a wide variety of “self-help” leaflets in the waiting room. These contained information about simple measures that people could use to treat minor illnesses.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

They understood how and when to assess whether a patient had the capacity to make decisions about their care. Mental health specialists were available if patients wanted to leave the department but had been assessed as lacking the capacity to make that decision. Where other patients lacked the capacity to make decisions for themselves, such as those who were unconscious, we observed staff making decisions which were considered to be in the best interest of the patient. We found that any decisions made were appropriately recorded within the medical records.

We observed that consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent. Consent forms were available for people with parental responsibility to consent on behalf of children. The staff that we spoke with had a good working knowledge of the guidance for gaining valid informed consent from a child. They were aware of the legal guidelines which meant children under the age of 16 could give their own consent if they demonstrated sufficient maturity and intelligence to do so (Gillick competency). Otherwise, consent would be sought from the child’s parent or guardian. If a child attended without a person who was able to provide consent, staff would attempt to contact an appropriate adult.

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

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data at core service level.

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

Data later supplied to us by the hospital showed that 75% doctors and 86% of nurses and healthcare assistants had been trained in the requirements of the Mental Capacity Acts. Although this was below the trust target it did ensure that there was always a doctor and nurse on duty with the required knowledge.
Is the service caring?

Compassionate care
We saw several examples of patients treated with compassion, dignity and respect. Staff spoke in a respectful but friendly manner and maintained patient’s confidentiality. We observed a nurse placing a call bell into a patient’s hand and explaining how it worked. They encouraged the patient to use it as soon as they needed anything. Staff displayed a gentle and patient manner towards patients who were confused.

Reception staff greeted people reassuringly and with courtesy. However, it was difficult to maintain confidentiality because of the limited amount of space in the reception area.

We spoke with two patients and three family members. They reported a positive experience. One said “Everything has been fine. The nurses have explained everything.”

We frequently observed staff approaching visitors who looked lost to ask how they could help. We heard staff updating relatives about patients’ progress whilst maintaining confidentiality

Staff showed understanding and a non-judgmental attitude when talking about patients with mental health needs, learning disabilities or dementia. Staff told us that if someone with a learning disability was distressed and needed a low-stimulus environment they would use the children’s waiting room (if not in use), where they had some sensory equipment then could use to help the patient to relax.

Friends and Family test performance
The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was about the same as the England average from July 2017 to June 2018.

A&E Friends and Family Test performance - Brighton and Sussex University Hospitals NHS Trust

![Graph showing A&E Friends and Family Test performance for This Trust and England Avg. from Jul-17 to Jun-18.](image-url)
Results for this department, rather than the trust as a whole, showed 93% of patients would recommend the service to friends and family. (Year ending September 2018)

**Emotional support**

Staff provided emotional support to patients to minimise their distress.

Patients and their families told us they were kept informed of all care and treatment due to be carried out. Medical staff were praised for the quality of the communications to families so that they understood the sequence of events and the likely timings around these.

Staff understood the impact that a patient's diagnosis could have on their wellbeing and on those close to them, both emotionally and socially. We observed two members of staff discussing the best way to break bad news to a patient and their family.

Communication with children was well thought out and effective. Staff took time to distract and comfort them during injections and blood tests. We observed a consultant kneeling down when talking to a distressed child in order to explain what was happening. Parents were involved in the assessment and treatment of their children and clear explanations were given.

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

Staff involved patients and those close to them in decisions about their care.

We observed clinical staff introducing themselves and explaining what was about to happen before examining patients. All staff wore name badges which clearly stated their name and role. New yellow badges were being introduced which helped people who were visually impaired. This helped to ensure that patients were aware of the professionals involved in their care. Staff talked to them in a way that patients could understand and described what they were going to do. They checked that patients had understood what they’d been told and what needed to happen next.

One patient, who had arrived by ambulance, had to wait in the corridor for 30 minutes until a cubicle became free. We observed staff talking to the patient on numerous occasions to give updates, apologies and reassurance.

The patients that we spoke with told us they were satisfied with the care they received and the staff who provided it. They had been involved in how and where their ongoing treatment took place.

During the day, staff had access to speech and language therapy services for aid communication with people who had learning disabilities or dementia. This helped patients become partners in their care and treatment.

**Emergency Department Survey 2017**

The trust scored about the same as other trusts for all of the 24 Emergency Department Survey questions relevant to the caring domain.

*(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017))*
Service delivery to meet the needs of local people

The trust planned and provided services in a way that mostly met the needs of local people.

The department took part in the trust-wide Patient First Improvement System which enabled all staff to take part in improving the service given to patients. We observed staff discussing improvements to the referral process for mental health patients and ensuring that all patient details were handed over from one member of staff to another.

Modernisation of the department in the last year had made the department safer and had improved the patient experience. A previous computer system, which had not met the needs of patients or staff, had been replaced. All staff, but particularly those working in reception, reported that it was much more effective than the previous system.

The trust had centralised the stroke service in Brighton. Therefore, patients who had suffered a stroke had to be transferred to Brighton for treatment. Senior staff told us that the ambulance service was not always able to arrive quickly, and treatment could be delayed for several hours. However, there was only one reported incident of this happening in the last year.

The service had arrangements, known to all staff on duty, to meet patients’ urgent or emergency mental health care needs at all times, including outside office hours and in an emergency. There was a positive working relationship between the A&E and mental health liaison staff, and staff often dropped into the liaison office to ask for advice on mental health issues that people presented with.

Last year’s plan to deal with winter pressures in the emergency department had been evaluated. Some alterations had been made ahead of this winter in order to make it more effective.

Meeting people’s individual needs

The service took account of patients’ individual needs but was not always successful in meeting them.

Although there was wheelchair access to all clinical areas there was no lowered reception desk to allow patients in wheelchairs to register without difficulty. There was also a glass screen in front of the receptionist which meant that some people with disabilities had difficulty communicating with the receptionists. The emergency department matron was aware of these problems and was trying to identify funding to improve the reception facilities. However, there was adequate seating and space in the reception and waiting areas.

Waiting times to see a nurse or doctor were continuously displayed in the waiting room. There was also a display screen showing health information advice in different languages as well as a television showing a news channel.

Staff that we spoke with had received training in responding to the needs of people living with dementia. They described the care needed in a knowledgeable and sympathetic fashion. They knew, for example, that patients with dementia should be cared for in a quiet part of the department in a low stimulus environment. However, it was difficult to achieve that while making sure that patients could be observed at all times. Senior staff were working with the trust dementia team to find a solution.

Although there was a hospital frailty team there was no agreed pathway so that they could rapidly assess emergency department patients. Frail patients were seen by emergency department
doctors who arranged investigations and diagnosed any new medical problems. If it was thought that the patient needed admitting they were referred to the geriatric doctors. If it was thought that the patient could return home they were referred to the hospital rapid discharge team. This is a multidisciplinary team who work alongside the emergency department team to assess patients’ ability to be safely discharged home. They work closely with community teams to arrange additional support services that may be needed.

There was a trust-wide learning disabilities team that had improved awareness and staff felt able to contact them for advice. Nursing staff told us that they encouraged the involvement of families and carers so that they could understand patient’s specific needs. We observed this in practice during the inspection.

The department complied with NHS England’s Accessible Information Standard by identifying, recording, flagging, sharing and meeting the information and communication needs of patients with a disability or sensory loss.

Translators could be accessed via the telephone translation system provided by the hospital.

The department had appropriate discharge arrangements for people with complex health and social care needs. In the care records of mental health patients, we viewed, each person was discharged with a package of support in place. These varied from a follow up appointment with their local mental health team, to daily input from the mental health crisis team and medicine.

Emergency Department Survey 2017

The trust scored about the same as other trusts for all three of the Emergency Department Survey questions relevant to the responsive domain.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Access and flow

People could, on the whole, access the service when they needed it.

There was a steady flow of patients through the department with no lengthy delays in investigations, treatment or specialist opinions. Late afternoon was often a busy time and ambulance patients occasionally had to wait in a corridor for a few minutes while space was made available for them. One ambulance patient had to wait for thirty minutes. The ambulance crew stayed with the patient and we observed a doctor and nurse speaking to the patient on several occasions to provide reassurance and updates on the delay. Ambulance crews that we spoke with said that it was unusual to wait more than 30 minutes. Data from the trust showed that delays of more than an hour happened, on average, nine times a month. This was better than the emergency department in Brighton. If a patient was causing immediate concern space would be made available immediately. This was usually by identifying a patient whose condition was stable and moving them into the corridor temporarily.

Some patients, for example, those waiting for the results of investigations, were assessed to see if they were “fit to sit”. If there was no reason for them to be lying on a trolley, they would be moved to a row of comfortable seats near to the staff base. They were constantly observed by clinical staff and could easily ask for help if they needed it. This practice allowed examination cubicles to be freed so that patients could be transferred from the ambulance assessment area.
Median time from arrival to treatment (all patients)

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust met the standard for 11 months over the 12-month period from July 2017 to June 2018.

From July 2017 to June 2018 performance against this standard was better than the England average for 10 of the 12 months within this period.

Median time from arrival to treatment from July 2017 to June 2018 at Brighton and Sussex University Hospitals NHS Trust

![Graph showing median time from arrival to treatment from July 2017 to June 2018.](Source: NHS Digital - A&E quality indicators)

Senior doctors were consulted at an early stage for all patients with a serious illness who were likely to need admission. Specialist doctors from other departments came to the department as soon as possible once a patient had been referred to them. We observed no delays during our inspection.

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From August 2017 to July 2018 the trust were consistently worse than the standard and performed worse than the England average.

Four hour target performance - Brighton and Sussex University Hospitals NHS Trust

![Graph showing four hour target performance.](Source: NHS Digital - A&E quality indicators)
Patients at the Princess Royal Hospital were treated and discharged or admitted more quickly than average time for the trust as a whole. In the year ending September 2018, the percentage of patients meeting the four-hour target ranged from 87% to 96%. This was better than most other hospitals in England.

As a result of this it was unusual for the department to become crowded. We saw regular visits from members of the bed management team who had come to liaise with the nurse in charge of the department. They discussed the numbers of patients in the department, the number of ambulance on the way to the hospital and the number of patients waiting for admission to a ward. Senior staff told us that, if delays for admission were prolonged, or there was a sudden influx of very ill patients, they would contact the divisional director of operations or the hospital site manager out-of-hours. This was in line with the hospital’s full capacity protocol.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted**

From August 2017 to July 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average.

From August 2017 to July 2018 performance against this metric showed a peak of approximately 40% in January 2018 before ending with an improved figure at the end of the reporting period at approximately 24%.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted - Brighton and Sussex University Hospitals NHS Trust**

![Graph showing percentage of patients waiting more than four hours from the decision to admit until being admitted](Source: NHS England - A&E Waiting times).

There were fewer delays for admission at the Princess Royal than the rest of the trust. Delays of four hours after the decision to admit varied from 1.3% in September 2017 to 12.6% in January 2018. This was better than the England average.

During our inspection only one patient waited more than four hours after the decision to admit
was made. This was a patient who needed to be detained under a section of the mental health act. There was a delay of approximately nine hours before an approved mental health professional could attend the department to complete the required assessment. ED staff told us that this was not unusual and the issue was one of the highest risks on the departmental risk register.

Children who needed to be admitted were transferred to the Royal Alexandra Hospital for Children in Brighton. There could sometimes be delays if they needed to be transferred by ambulance. There were 20 reported incidents of ambulance delays in the year ending August 2018 although it was not clear how many of them were children.

**Number of patients waiting more than 12 hours from the decision to admit until being admitted**

Over the 12 months from August 2017 to July 2018, 153 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in December 2017, (51), March 2018 (35) and January 2018 (27).

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2017</td>
<td>637</td>
<td>7</td>
</tr>
<tr>
<td>September 2017</td>
<td>731</td>
<td>6</td>
</tr>
<tr>
<td>October 2017</td>
<td>925</td>
<td>0</td>
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<tr>
<td>November 2017</td>
<td>884</td>
<td>1</td>
</tr>
<tr>
<td>December 2017</td>
<td>1,112</td>
<td>51</td>
</tr>
<tr>
<td>January 2018</td>
<td>1,333</td>
<td>27</td>
</tr>
<tr>
<td>February 2018</td>
<td>1,183</td>
<td>18</td>
</tr>
<tr>
<td>March 2018</td>
<td>1,091</td>
<td>35</td>
</tr>
<tr>
<td>April 2018</td>
<td>980</td>
<td>5</td>
</tr>
<tr>
<td>May 2018</td>
<td>843</td>
<td>0</td>
</tr>
<tr>
<td>June 2018</td>
<td>595</td>
<td>0</td>
</tr>
<tr>
<td>July 2018</td>
<td>797</td>
<td>3</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E Waiting times)

No patients at the Princess Royal Hospital waited more than 12 hours to be admitted.

**Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment**

From July 2017 to June 2018 the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was similar to the England average.

From July 2017 to June 2018 performance against this metric showed a sign of improvement.
Percentage of patient that left the trust’s urgent and emergency care services without being seen - Brighton and Sussex University Hospitals NHS Trust

(Source: NHS Digital - A&E quality indicators)

Median total time in A&E per patient (all patients)

From August 2017 to July 2018 the trust’s monthly median total time in A&E for all patients was higher than the England average.

From August 2017 to July 2018 performance against this metric showed a stable trend.

Median total time in A&E per patient - Brighton and Sussex University Hospitals NHS Trust

(Source: NHS Digital - A&E quality indicators)

We asked the trust to send us information for the Princess Royal Hospital but they were unable to do so. During our inspection all but one patient spent less than seven hours in the department. The exception was a patient with a severe mental illness who spent approximately 15 hours in the department.
Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Summary of complaints

From March 2017 to April 2018 there were 74 complaints about urgent and emergency care services. The trust took an average of 45 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed within 40 days.

The four most common subjects of complaints are shown in the table below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to treatment or drugs</td>
<td>41</td>
</tr>
<tr>
<td>Values and Behaviours (staff)</td>
<td>9</td>
</tr>
<tr>
<td>Admission and Discharges (not including delay due to no care package)</td>
<td>8</td>
</tr>
<tr>
<td>Communication</td>
<td>7</td>
</tr>
</tbody>
</table>

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of complaints</th>
<th>Days taken to close</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Sussex County Hospital</td>
<td>51</td>
<td>47</td>
</tr>
<tr>
<td>Princess Royal Hospital</td>
<td>18</td>
<td>43</td>
</tr>
<tr>
<td>Other sites</td>
<td>5</td>
<td>37</td>
</tr>
</tbody>
</table>

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

There were leaflets and posters in the waiting area with contact details for the trust’s Patient Advisory Liaison Service (PALS) for patients and relatives to raise concerns or make a complaint. Staff told us that if a patient made a verbal complaint to them they would try and resolve the concern at the time and record the details on the electronic system if there were opportunities for learning.

We reviewed three formal complaints that had taken place in the emergency department in the last year. We saw that complaints were investigated thoroughly and in a timely manner, opportunities for learning identified and action taken when required. For example, improvements had been made to the information given to patients when they were prescribed medicines to take home with them.

Replies to the complaint were courteous and displayed understanding of how the complainant felt.
Number of compliments made to the trust

From March 2017 to April 2018 there were 229 compliments in urgent and emergency care.

The breakdown by site is below:

2. Royal Sussex County Hospital: 140 compliments  
3. Princess Royal Hospital: 76 compliments  
4. Other sites: 13 compliments  

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

Is the service well-led?

Leadership

Managers at all levels had the right skills and abilities to run a service providing high-quality sustainable care.

The emergency department was part of the hospital’s medicine division. The divisional structure had changed since our last inspection and so emergency department staff were working with new senior managers. We were told that the divisional management team worked at the Princess Royal Hospital for one day a week. We observed two members of the divisional team in the department during our inspection. They were obviously familiar with the department and staff who worked there.

The leadership of the emergency department was shared by the matron and a senior consultant (clinical lead). They had been in post for over a year and so there was increased leadership stability compared to our last inspection. The matron and clinical lead were highly visible in the department. They supported junior staff, lead the treatment of the sickest patients and dealt with the more complex situations that arose. They demonstrated the skills, knowledge, integrity and experience needed for their roles. Staff told us that they trusted the leadership team and knew that they would be listened to if they raised concerns.

On a day-to-day basis we observed constant communication between the nurse and consultant in charge. They both looked at the case notes of patients being treated as well as those who were waiting to be seen in order to prioritise treatment. Both frequently consulted patient information on the emergency department computer system to maintain an overview of all the patients in the department. During handover, the condition and number of patients in the waiting room was discussed. These practices helped to improve patient safety and flow within the department. The role of each member of staff was displayed clearly on the back of their uniform tunics. This made it easier for new members of staff and staff from outside the department to identify who was in charge.

Vision and strategy

There continued to be confusion about the strategy for the emergency department.

Senior staff that we spoke with said that they wanted the department to deliver the best, evidence-based care and treatment to the local population. The trust’s most recent clinical strategy document (March 2018) states “PRH [Princess Royal Hospital] will continue as a Local Emergency Hospital, offering access to emergency medical care and A&E services 24 hours a day, 7 days a week. In a separate statement sent to us by the trust we were told “Princess Royal Hospital is and
will continue to be a Local Emergency Hospital, which sees acutely unwell medical patients and patients with minor injuries and ailments.” However, we observed a steady stream of patients with significant injuries and ailments such as neck fractures, internal haemorrhage, broken hips and chest wall fractures. The needs of these patients did not appear to have been considered when developing the strategy.

**Culture**

The leadership team promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

We observed interactions between staff that were cooperative, supportive and appreciative. They worked collaboratively and shared responsibility where necessary.

There had been improvements in morale since our last inspection. Staff that we spoke with felt that the department was more “dynamic” and they no longer felt like a “poor relation” of the Royal Sussex County Hospital. There was a hospital-wide project to encourage staff to suggest improvements in working practices and to be involved in implementing them. This was called the Patient First Improvement System. We observed a 15 minute “improvement huddle” which was attended by all levels of staff, both clinical and non-clinical. Improvements that had been achieved, or were in progress, included grab bags for resuscitation equipment and swipe card access for medicines storage areas.

Staff considered patients’ mental health and emotional wellbeing in day to day activity. We observed these issues being discussed during handover sessions.

There were appropriate security arrangements to keep staff and others safe and protected from violence. We observed rapid and effective responses from security officers. We were told that all security staff were trained annually in conflict management and physical intervention.

**Governance**

The department used a systematic approach to continually improve the quality of its services and safeguarding high standards of care.

There was a robust governance system in place with the production of detailed information about the department’s performance. This was discussed at quarterly governance meetings and was used to demonstrate effectiveness and progress. Governance meetings were usually cross-site so that learning could be shared. They were chaired by the emergency department governance lead and were well attended by all levels of clinical staff. Issues discussed included new clinical guidelines, the results of incident investigations, complaints and updates to the risk register. Mortality and morbidity reviews were well-established and were also discussed. A briefing document was distributed afterwards so that all staff were aware of learning and the actions that needed to be taken.

There were short, weekly governance meetings which looked at recent incidents and complaints. A difficult case history from the previous week was discussed in detail. Options were considered that could avoid the problems that had been encountered.

Staff told us they were clear about their roles and felt supported by their clinical leads and senior managers. The lead children’s nurse had recently undertaken an audit of the new Intercollegiate Standards for children in emergency settings. (Published in June 2018). Recent improvements in the department meant that many of the standards were met. Where they were not, further work was being undertaken to improve practice.
Management of risk, issues and performance

The department had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The department maintained a risk register, which defined the severity and likelihood of risks in the department causing harm to patients or staff. It was displayed on a staff noticeboard and documented the measures to be taken to reduce the risk. We saw that the risks described accurately reflected the concerns described by staff in the department. The risk register was reviewed at least quarterly by the leadership team and severe risks were escalated to the board when necessary.

The senior staff we spoke with were clear about the challenges the department faced and they were all committed to improving the patients’ journey and experience. Where national audits had demonstrated a weakness in clinical practice the senior clinical team ensured that action plans were developed. Further audits then took place to check that practice had changed.

There was a major incident plan (MIP), which was up-to-date and detailed. The major incident plan provided clinical guidance and support to staff on treating patients of all age groups and included information on the triaging and management of patients suffering a range of injuries. These included injuries caused by burns, blasts or chemical contamination.

Staff in the department were well-briefed and prepared for a major incident and could describe the processes and triggers for escalation. Similarly, they described the arrangements to deal with casualties contaminated with chemical, biological or radiological material. Major incident training had taken place in the last year. Learning from a joint exercise with the ambulance service was being incorporated into a new version of the major incident plan.

Information management

The department collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Staff received helpful data on a daily basis, which supported them to adjust and improve performance as necessary. There was a computer link to the local ambulance services which informed staff of the number of ambulances en-route to the department. It gave details of the patient’s condition and an estimated time of arrival. This allowed staff to make space in an appropriate treatment area.

The departmental computer system displayed useful patient information such as the risk of their condition deteriorating and whether they were vulnerable, either physically or psychologically. The system was refreshed every 15 minutes and allowed senior staff to have an up-to-date overview of all patients in the department. Information from the system provided information for performance monitoring and management.

Engagement

The department engaged with patients, staff, the public and local organisations to plan and manage appropriate services.

Monthly nursing staff meetings were held and were well attended. Topics, such as training, infection control and learning from complaints were discussed. Minutes of the meetings were sent to staff via e-mail and were posted on the staff noticeboard. Letters of thanks and praise for staff were also displayed on the staff noticeboard.
There continued to be consultation with nursing staff regarding rotation to the Royal County Hospital at Brighton and different shift patterns. Staff were encouraged to suggest and implement improvements to working practice via the Patient First Improvement System.

There had been an extensive public awareness campaign so that people living in the local area knew that there were no children’s in-patient facilities at the hospital. There had also been communication with the 111 service, local GPs and schools and the ambulance service.

Emergency department staff and the hospital rapid discharge team worked with local volunteers from Age UK. The volunteers provided transport for vulnerable adults when they were discharged home. They assessed the home environment to make sure that it was safe. They also collected shopping to make sure that patients had sufficient food and drink when they first went home.

**Learning, continuous improvement and innovation**

The department was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation. There had been several improvements since our last inspection in 2017.

Extensive modernisation and re-building of the department had improved the environment for patients and staff. This included a piped oxygen supply to major treatment cubicles and the resuscitation room. As a result, staff no longer had to manipulate very large and heavy oxygen cylinders. The arrangements for safe storage and availability of patient’s own medicines showed initiative and clear thinking.

A lead nurse for children had been appointed. Following this, a comprehensive training programme had been implemented for nurses and healthcare assistants so that they had improved skills and knowledge to treat sick children.

There was increased stability in the leadership team and improved morale amongst all staff. The doctor’s self-rostering system had been highly commended for innovation by the British Medical Journal in May 2018.

The percentage of patients who were treated and discharged (or transferred) within four hours had improved and was better than the national average.
Brighton and Sussex University Hospitals NHS Trust (BSUH) provides a range of medical care services from the Royal Sussex County Hospital (RSCH) site, Brighton and from the Princess Royal Hospital, (PRH) Haywards Heath. These services include the management of respiratory diseases, diabetes and endocrinology, HIV and sexual health, stroke, and elderly medicine. The hospital provides a specialised service for older patients including managing frailty, cognitive problems and older people with multiple medical problems.

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

(Source: Routine Provider Information Request AC1 - Acute context)

There are 371 medical inpatient beds located across 24 wards at the trust

A site breakdown can be found below:

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

(Source: Routine Provider Information Request – Sites tab)

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

Admissions for the top three medical specialties were:

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

(Source: Hospital Episode Statistics)

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

At this inspection, we were assured that staff were sufficiently trained to meet the needs of patients. At our previous inspection, we noted that the trust “Must ensure that all staff within the medical directorate have attended mandatory training and that there are sufficient numbers of staff with the right competencies, knowledge and qualifications to meet the needs of patients.” We saw the trust’s mandatory training record included fire training, health and safety, infection control and information governance. All staff groups at the hospital met the trust’s completion target.

Mandatory training was recorded on an electronic staff record. All ward managers kept up-to-date spread sheets showing the compliance of each individual staff member. To help improve compliance, the trust had employed practice educators. The unit practice educator we spoke with told us that she monitored the electronic record regularly. She promptly contacted any non-complaint staff to ensure that alternative attendance dates were scheduled. Since then compliance of statutory and mandatory training had improved from 72% to 89%. In particular adult basic life support training had improved from 44% to 80% compliance.

Mandatory training was primarily carried out face to face with some modules available as e-learning. Staff commented that they were given sufficient time to complete their training. Staff told
us that mandatory training included reference to the management of patients with mental health conditions, people with learning disabilities and people living with dementia.

Staff we spoke with told us the e-learning modules were available to access from their home computers and that they appreciated the opportunity of completing updates remotely.

The ward manager on Plumpton ward had designed a number of self-adhesive large icons that resembled living flames to adhere to a range of surfaces to help with fire drill training. Staff advised us that real life fire drills had been conducted which involved staff participating in evacuation scenarios using the external fire escapes.

**Safeguarding**

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

Hospital compliance figures for Safeguarding training were; Safeguarding Adults 86% for medical staff and 96% for nursing staff; Safeguarding Children Level 1 was 100% for nursing staff, medical staff were not required to complete this; Safeguarding Children Level 2 was 95% for nursing staff and 77% for medical staff; Safeguarding Children Level 3 was 100% for nursing staff, again medical staff were not required to complete this training. Level 3 child safeguarding is mandatory only for clinical staff working with children and young people.

Band six nurses were allocated three or four staff members to help ensure the high uptake of safeguarding training. They monitored these staff for safeguarding training compliance.

All of the staff we spoke with were fully aware of their responsibilities regarding safeguarding, including the reporting of female genital mutilation and those at risk of self-harm. They also knew who to contact if they needed to escalate safeguarding concerns.

Safeguarding information, including contact numbers and details of the safeguarding lead were highly visible throughout clinical areas. Staff had confidence to access safeguarding advice. There was a trust wide team of nurses established to support staff with safeguarding issues upon request, who were available 24 hours a day, seven days a week.

The trust had introduced safety huddles throughout the medical division. During these staff routinely discussed safeguarding concerns. Wards had introduced an additional multidisciplinary safety huddle. We attended several huddles and saw that safeguarding was always included on the agenda.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

Clinical areas in all medical wards were visibly clean. Nursing staff had carried out daily and weekly checklists to ensure effective cleaning. We checked ward daily cleaning records and saw that these were complete and up-to-date for each day over the previous week.

We saw hand sanitisers were available at the entrance to each ward. There were also red handwashing and sanitisation notices on the doors to each of the clinical bays and side wards. Additionally, hand sanitisers were located at the foot of each bed. There was prominent signs to
inform visitors to use hand sanitisers and all staff were vigilant in asking or reminding visitors including other staff to wash their hands.

We saw all staff were bare below the elbow at all times in accordance with ‘National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England’. Senior ward nurses showed us the results of monthly handwashing audits as well as evidence to show whenever a ward scored below standard, action was taken at the following safety huddles to improve compliance.

There was easy access to personal protective equipment (PPE) such as aprons and gloves throughout the medical unit and we witnessed staff using PPE effectively. We saw that staff adhered to infection control procedures, such as hand washing and using hand sanitisers when entering and exiting the unit and clinical areas. Staff told us they felt confident to challenge staff to ensure they were ‘bare below the elbows’ and used PPE such as gloves and aprons.

Infection, prevention and control (IPC) was part of mandatory training. The medical unit had appointed a dedicated link nurse who liaised with the infection control team and gave regular updates on any infection control issues during ward safety huddles. The clinical staff we spoke with knew who their link nurse was and reported effective communication regarding infection control issues.

The hospital infection prevention and control standard operating procedures and policies were all up-to-date. Staff had access to these via the hospital intranet.

Ward-based domestic staff carried out domestic duties with dedication and enthusiasm. We observed domestic staff worked in teams of three and followed cleaning schedules. They showed us the standardised cleaning schedules they adhered to, which detailed the types of cleaning tasks that needed to be completed. We saw that domestic staff were very much part of the ward teams.

Staff displayed cleaning audit scores on all wards. All scores met the standards in accordance with the risk category they were in with regards to the National Specification of Cleanliness (NSC) in the NHS. All wards inspected were of a standard of cleanliness that reflected the score displayed, except Ardingly ward, which in September 2018 scored 94.3% where the standard required was 95%. Although the shortfall did not present a significant risk, we saw completed corrective action sheets detailing the actions taken where cleaning has not attained the standard and these were completed within appropriate timescales.

Housekeeping staff we spoke with were fully aware of the Control of Substances Hazardous to Health as sanctioned by the Control of Substances Hazardous to Health Regulations (COSHH). They showed us the steps they had taken to adhere to these regulations. We saw cleaning cupboards were all locked and ward staff had no access to the cupboards. There was a heightened awareness of COSHH throughout the medical division. During our inspection, we saw no breaches in COSHH regulations and all the staff we spoke with were fully aware of the regulations and their own obligations to patient safety.

We inspected various items of equipment such as commodes, electronic thermometers, blood pressure machines and infusion pumps, and found a good level of visible cleanliness and up-to-date use of ‘I am clean’ stickers.

We saw staff complied with ‘Health and Safety (Sharp Instruments in Healthcare) Regulations 2013’. In all ward areas we visited staff had dated, signed and securely closed the sharps containers.
All staff followed ‘Health Technical Memorandum HTOM 01-06: Decontamination of flexible endoscopes’ and Health and Safety Executive (HSE) Standards.

Environment and equipment

Patients were protected from the risk of fire. At our previous inspection we noted the trust must ensure fire plans and risk assessments ensure patients, staff and visitors could evacuate safely. Staff advised us, since that inspection, fire safety had been high on the agenda throughout the medical wards. Each ward had identified several fire wardens and had ensured there was always a fire warden on duty at every clinical shift. We inspected the fire procedures and found that all fire doors were clearly marked, kept shut and free from obstacles. Each ward participated in regular fire drills and kept a stock of red fire warden tabards in a range of sizes for the fire wardens to wear as required.

We saw that all the medical wards had undergone fire risk assessments. These were detailed, up-to-date and included the person’s name who had accountability for a task. We also saw a daily safety risk checklist that included a full examination of fire ski sheets, which facilitate the safe and prompt evacuation of immobile patients.

We saw that the corridors throughout the service areas were free of clutter. Emergency trolleys were available on every ward and were secured with plastic snap locks. Trolleys were checked daily and weekly with staff signing a log to confirm the checks had been made. Consumables and equipment were appropriately stored and labelled. We checked various consumables, such as fluids and found that they were sealed and in date.

Staff on each of the wards told us they were confident they had access to sufficient equipment and that the equipment was in good working order. We saw documents showing equipment was regularly serviced and calibrated in accordance with manufacturer’s guidance.

We checked various items of equipment such as pumps and found they had been safety tested.

Waste management and removal, including contaminated and hazardous waste was in line with national standards.

We saw that access to clinical areas across the service where vulnerable adult patients were cared for but especially those with Deprivation of Liberty Safeguard measures applied were controlled by electronic access doors with full CCTV coverage.

Staff kept the environment safe for those experiencing poor mental health. Staff showed us that appropriate ligature checks had been performed and that curtain rails, shower rails and blind cords were all safety checked.

Assessing and responding to patient risk

There were systems to aid staff in recognising deteriorating patients, especially those at risk of sepsis. We saw that staff had been trained to use a sepsis screening tool, which had been developed and rolled out by the trust. The medical unit had put considerable effort into helping staff recognise the early warning signs of emerging sepsis and all staff could access the clinical nurse specialist lead for sepsis. The trigger for sepsis recognition was partly facilitated through the use of NEWS2. Staff routinely used NEWS2 to enhance clinical assessments of patients but especially those in danger of clinical deterioration attributed to sepsis. Staff we spoke with told us that the trust had put great emphasis in introducing NEWS2 to ensure staff had the skills and
competencies to effectively use the algorithm in monitoring patients at risk of deterioration. The National Early Warning Score (NEWS2) uses a scoring technique based on physiological measurements.

The sepsis bundle and NEWS2 scoring sheets were important additions to the patient safety risk assessment and care bundles used throughout the trust. All the frontline staff we spoke with highly praised the patient safety bundle, which had comprehensive sections on a full range of patient safety areas including pressure area monitoring and falls assessment.

Patient safety huddles had been introduced to reduce potential patient harm. The huddles aided the sharing of patient information to ensure holistic, multidisciplinary care was provided. We saw that huddles were also an opportunity to focus on a topic of the week. The topic of the week during our inspection was sepsis, thus giving an opportunity to remind staff about the use of the sepsis bundle.

The patient safety risk assessment and care bundle used throughout the division was well designed and covered all aspects of patient safety. In particular, the bundle focused on the SAFER framework developed within the trust. A range of factors was considered in the framework, such as status, acuity, falls (history), environment/equipment and risks. The safety care bundle also had a detailed section on pressure area assessment on admission, a daily pressure area care plan and a daily falls care plan. Staff were highly complementary of the safety care bundle and told us that its use had facilitated greater vigilance around areas such as falls in the frail elderly. We saw from our inspection of a sample of records that “the patient first improvement system” which had been implemented within the division of medicine in September 2018 had been fully embraced by staff. The records we inspected also showed that the patient safety, risk assessment and care bundles had been fully completed for all domains including falls and pressure area assessments. Adherence to national early warning scores for patients (NEWS) was good and when we inspected the nursing record we saw that any concerns had been appropriately escalated. Additionally the SAFETY shift handover form used by the clinical areas always considered the acuity of sick patient causing concern.

Staff completed a safety handover form every 12 hours for each shift. They followed a pattern of ‘SAFETY’; Staffing, Acuity, Falls, Environment and Equipment, Trust and Ward issues, and Yourselves (how was your shift). We observed staff used this in the safety huddles we attended during inspection.

Nurse staffing

Although the division did not utilise a patient acuity tool to determine levels of staffing, staff we spoke with told us that staffing was always included in the daily handover meetings and concerns about staffing could be escalated without delay.

Staff told us they relied on bank staff to ensure safe levels of staffing but that bank staff were regular and very familiar with the wards on which they worked. Staff told us bank and agency staff were most frequently used for night duty.
Planned vs actual

The trust reported the following qualified nursing staff numbers in medical care for two snapshots in time; 31 March 2017 and 30 April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>As at 31/03/2017</th>
<th>As at 30/04/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>All sites</td>
<td>411.3</td>
<td>465.9</td>
</tr>
</tbody>
</table>

The trust fill rate for qualified nursing staff in medicine at 30 April 2018 is lower than the trust fill rate at 31 March 2017 (81.7% compared to 88.3%). At 30 April 2018, the trust had 87.9 fewer members of qualified nursing staff in medicine (WTE) than they had planned.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From May 2017 to April 2018, the trust reported an overall vacancy rate of 13.7% for qualified nursing staff in medicine. The trust has set a vacancy target of 10.5% as at March 2018 reducing incrementally to 9% by March 2019. A site breakdown can be seen below;

- Princess Royal Hospital medical department: a vacancy rate of 24.7%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From May 2017 to April 2018, the trust reported a turnover rate of 8.9% for qualified nursing staff in medicine, which is better than the trust target. The trust has set a turnover target of 10.5% as at March 2018 reducing incrementally to 9% by March 2019. A site breakdown can be seen below;

- Princess Royal Hospital medical department: a turnover rate of 0.0%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From May 2017 to April 2018, the trust reported a sickness rate of 4.0% for qualified nursing staff in medicine. The trust has set a sickness target of 4.2% as at March 2018 reducing incrementally to 3.5% by March 2019. A breakdown of sickness rates by site is found below:

- Princess Royal Hospital: a sickness rate of 4.1%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

Please note that the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff in all cases. Therefore, we were unable to analyse bank and agency usage as a proportion of the total shifts needing to be filled.
The table below shows the numbers of shifts in medicine at a trust wide level from April 2017 to March 2018 that were covered by qualified nursing and nursing assistant bank and agency staff or left unfilled.

For qualified nurses, 12,623 shifts were filled by bank staff and 4,587 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses. In addition, 7,000 shifts were not filled by either bank or agency staff.

For nursing assistants, 19,240 shifts were filled by bank staff and 14 shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants. In the same period, 7,007 shifts were not filled by either bank or agency staff.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Qualified nurses</th>
<th>Healthcare assistants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>12,623</td>
<td>19,240</td>
<td>31,863</td>
</tr>
<tr>
<td>Agency</td>
<td>4,587</td>
<td>14</td>
<td>4,601</td>
</tr>
<tr>
<td>Not filled</td>
<td>7,000</td>
<td>7,007</td>
<td>14,007</td>
</tr>
</tbody>
</table>

Unfortunately, we could not provide a site-specific breakdown of nursing bank and agency usage in the medical care core service, due to the format of the data provided by the trust.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

**Medical staffing**

Staff advised us there were sometimes shortages of middle grade doctors. The division had created a lead specialist registrar to support middle grade trainees in raising issues regarding training directly to the senior leadership team. Additionally the division had improved middle grade rotas and improved the quality of the training. We also saw plans to expand the medical consultant workforce beginning in September 2018. Patients were seen by members of the medical team on a daily basis and we saw the medical team on Plumpton ward for example conducting their daily ward round. Staff told us that out of hours cover was satisfactory. Junior doctor training had been enhanced by the appointment of two people to the Royal College of Physicians Chief Registrar Scheme in October 2018. This was a new role that provides protected time for senior trainees to practice leadership and quality improvement while remaining in clinical practice and provide a vital bridge between senior clinical leaders, managers and the wider medical trainee workforce.

Doctors participated in the daily multidisciplinary huddles where wider patient discharge concerns were discussed.

**Planned vs actual**

The trust reported the following medical staffing numbers in medical care for two snapshots in time; 31 March 2017 and 30 April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>As at 31/03/2017</th>
<th>As at 30/04/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>All sites</td>
<td>249.0</td>
<td>235.2</td>
</tr>
</tbody>
</table>

The trust fill rate for medical staff in medicine at 30 April 2018 is lower than the trust fill rate at 31 March 2017 (102.1% compared to 105.9%), although at both snapshots in time the trust reported a fill rate of over a 100%. At 30 April 2018, the trust had 5.2 extra members of medical staff in medicine (WTE) than they had planned.
Vacancy rates

From May 2017 to April 2018, the trust reported an overall vacancy rate of 1.1% for medical and dental staff in medicine. The trust has set a vacancy target of 10.5% as at March 2018 reducing incrementally to 9% by March 2019. A site breakdown can be seen below:

- Princess Royal Hospital medical department: an over-establishment of 509.1%.

The trust confirmed that there was not an over establishment of 509.1% junior doctors in medicine at PRH. As of 17 October 2018, the hospital had one foundation junior doctor vacancy in medicine at PRH.

This inaccurate figure was as a result of differences between how the payroll/HR system is set up compared to the finance system for this group of staff as they rotate between the medicine specialities. Junior doctors were set up on one cost-code, however the budget was devolved to the relevant speciality and Finance made a manual adjustment of costs each month.

Turnover rates

From May 2017 to April 2018, the trust reported a turnover rate of 5.6% for medical and dental staff in medicine. This is better than the trust turnover target of 14% that was set for March 2018 (the trust has said that they are aiming to reduce this target incrementally to 11.0% by March 2019). The trust was unable to provide turnover rates for medical staff by site.

Sickness rates

From May 2017 to April 2018, the trust reported a sickness rate of 0.9% for medical and dental staff in medicine. The trust has set a sickness target of 4.2% as at March 2018 reducing incrementally to 3.5% by March 2019. A breakdown of sickness rates by site is found below:

- Princess Royal Hospital: 0.3%

Bank and locum staff usage
Trust wide

From April 2017 to March 2018, the trust reported that 1,122 shifts within medical care trust-wide were filled by bank staff and 864 shifts were filled by locum staff. There were 483 shifts which were not filled by either bank or locum staff. A breakdown of bank and locum usage by staff type at the trust is shown below.

Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff. Due to the format of the data provided, no site breakdown is available.

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
<th>Unfilled shifts</th>
<th>Total shifts (bank + locum + unfilled)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>141</td>
<td>698</td>
<td>163</td>
<td>1,002</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>836</td>
<td>166</td>
<td>283</td>
<td>1,285</td>
</tr>
<tr>
<td>Junior</td>
<td>145</td>
<td>0</td>
<td>37</td>
<td>182</td>
</tr>
<tr>
<td>Total</td>
<td>1,122</td>
<td>864</td>
<td>483</td>
<td>2,469</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix

In March 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was slightly higher.

Staffing skill mix for the 396 whole time equivalent staff working in medicine at Brighton and Sussex University Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>35%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>2%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>40%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>23%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

Source: NHS Digital - Workforce Statistics - Medical (01/03/2018 - 31/03/2018)
**Records**

Staff kept appropriate records of patients’ care and treatment and stored them securely. We inspected 10 sets of medical records and saw none had omissions and all were legible, dated and signed. Of the records we reviewed, all included a complete record of the patient’s journey through the hospital. For example we saw that a falls assessment had been completed on a patient on Plumpton ward and that a comprehensive care plan had been constructed.

We observed staff securely stored patients’ records in locked trolleys.

The patient safety care bundle was well designed. The records we reviewed included person centred care plans that detailed preferences of patients and their families, and included clear instructions for staff to follow. Review dates were clearly identified and we saw staff had regularly reviewed care plans and managed individual care records in a way that kept people safe.

We viewed the hospital’s own records audit data and saw that compliance to record standards were met and where there was room for improvement, there was an action plan with a completion date and an accountable person cited.

**Medicines**

The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.

We saw thermometers were situated in all drug storage rooms to record ambient room temperature and refrigerators used to store medicines were closely monitored on a daily basis for temperature variation. At our previous inspection, we noted wards were not monitoring the ambient temperature of medicine storage rooms. There was therefore no guarantee of the effectiveness of the medicine. We inspected drug refrigerator temperature monitoring charts and saw staff had completed these and knew what to do if the temperature fell out of range.

Balcombe ward had introduced new bedside patient lockers which had fob operated patient drug dispensing compartments. This facilitated safe and effective personal drug dispensation. We did not see any breaches of drug dispensation protocols, for example, no drugs were left unattended on patient lockers.

We inspected 25 medication prescription records, all of which complied with recognised Nursing and Midwifery Council standards for medicine management.

There were systems that ensured the supply, administration and disposal of medicines in accordance with ‘NICE NG5 Medicines optimisation: the safe and effective use of medicines’. The documentation of medicine administration met agreed standards including the annotation of allergies.

We saw that controlled drugs were appropriately stored in locked controlled drugs cabinets. These were secured to the treatment room walls and the records showed that all controlled drugs had been checked by two qualified members of staff. For general medicines the wards had a locked box that unwanted medicines were posted into. This could only be opened by a member of the pharmacy team. The medicines policy stated that Controlled drugs for disposal were signed out of the controlled drug record by a member of the pharmacy team and a nurse, which we saw on the wards.

The pharmacy service was available Monday to Friday and Saturday mornings. Out of hours and at weekends there was an on-call service and staff could access advice from the RSCH pharmacy.
department. There was a clinical and dispensing service for the in-patient areas and a dispensing service out-patient for medicines. The clinical service included reconciliation of medicines on admission, review of prescribing and medicines advice for staff. The service worked in line with the Royal Pharmaceutical Society Standards for Hospital Pharmacy. There was a medicines information helpline that patients could contact with any queries following discharge.

However, a clinical pharmacist did not visit all wards daily; for example, Plumpton ward did not receive a regular pharmacy visit. The prescription charts for these patients were not reviewed on the wards by the pharmacy team, they would only be seen if the chart was sent to the pharmacy if a medicine was needed.

We could not find evidence that during planning for opening new beds, for example for winter pressures, the impact on the pharmacy had been considered and no extra pharmacy resources had been provided. The patients on any new services would not receive a clinical pharmacy service. Their medicines would not be reviewed unless a prescription chart was sent to pharmacy and there was a risk of increased medicine interactions and adverse reactions to medicines.

The trust had up-to-date policies and procedures for the management of medicines, and staff we spoke with knew how to access them. However, there was no policy/procedure for self-administration of medicines, although we did see evidence of auditing of self-administration of insulin. Out of hours services were provided by on-call pharmacist service. The wards could phone the Royal Sussex County pharmacy during their weekend opening hours.

**Incidents**

The service managed patient safety incidents well. There was a very good culture of incident reporting across the medical division.

Staff recognised incidents and reported them appropriately. The trust used an electronic incident reporting system to report incidents. Staff were aware of how to report incidents and could show us how to access the online system. Staff told us they were encouraged to report incidents and were able to identify types of situations that should trigger incident reporting completion, including ‘near miss’ situations. Staff told us they received feedback when they reported incidents. Staff we spoke with were able to recall the most recent serious incident and the learning and recommendations that came from the subsequent investigation.

Managers investigated incidents and shared lessons learned with the whole team and the wider service. We viewed an action plan following an incident and noted the hospital had taken appropriate action in ensuring staff were aware of the incident to prevent something similar happening in the future. Staff had amended policies to include the national standards and performance was audited. We reviewed three recent investigation reports and saw evidence of learning from that was shared across the trust through email alerts and announcements on the trust intranet. We saw staff discussed them at local level during safety huddles, team and divisional meetings.

All incidents were reviewed and staff told us that they received helpful feedback after incident reporting.

Staff understood the arrangements in place for managing major incidents and all were familiar with the major incident plan and the plans for a pandemic. We accessed both plans and both were fully up-to-date.
When things went wrong, staff apologised and gave patients honest information and suitable support. We saw that the duty of candour was firmly embedded throughout the medical division and staff we spoke with were familiar with the duty and were able to give examples of when it had been enacted. Staff showed us examples of where duty of candour had been applied on the online incident reporting system.

**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 2017 to May 2018, the trust reported one incident classified as a never event for medicine. The one recorded never event occurred at Princess Royal Hospital and related to the misplacement of a nasogastric tube into the right main bronchus contributing to the death of a patient from respiratory failure. Since the incident, we saw the trust had updated its policies and procedures to ensure they were up to date followed national guidelines. We also saw that staff competencies were in the process of being reassessed and the hospital was conducting audits of the procedure to ensure compliance.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported nine serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from June 2017 to May 2018.

Of these, the most common types of incident reported were:

- Slips/trips/falls meeting SI criteria with six (67% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with one (11% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (11% of total incidents).
- Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria with one (11% of total incidents).

Site specific information can be found below:

- Princess Royal Hospital: five incidents
Safety thermometer

The Staff collected safety information and shared it with staff, patients and visitors. The service used this information to improve the service. We saw staff had completed the safety thermometer data in line with national standards and that the online data entries were up-to-date. Data on safety initiatives were shared with staff and service users in a variety of ways including visually displayed dashboards and widely promoted innovations such as the Jowers blanket project which had reduced the number of falls in certain patient groups such as those suffering dementia. Here the use of personal coloured blankets had helped patients find their way back to their beds more easily, leading to fewer falls.

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 10 new pressure ulcers, 19 falls with harm and 31 new urinary tract infections in patients with a catheter from June 2017 to June 2018 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls with harm and new urinary tract infections at Brighton and Sussex University Hospitals NHS Trust

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only
**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance. Staff were able to access a full range of evidence-based care policies via the trust intranet. We randomly reviewed a sample of 10, and all were fully up-to-date.

Sepsis screening was fully in line with national guidance and the sepsis screening tool was professionally produced and easy to apply in all clinical environments. All staff had access to the lead nurse for sepsis management.

The Cuckfield Endoscopy unit carried out procedures according to professional guidance and we saw the unit had produced numerous helpful patient information leaflets and pathways for each procedure carried out on the unit. E.g. “About your colonoscopy examination” and “About your flexible sigmoidoscopy examination.” The endoscopy unit participated in supplying data to the Joint Advisory Group (JAG) on gastrointestinal endoscopy.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health.

Patients were screened for nutrition and hydration issues using the Malnutrition Universal Screening Tool (MUST), which is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition, or obese. It also includes management guidelines that can be used to develop a care plan. We saw 10 MUST care plans and found they were fully completed including fluid/food input and output, weekly weights and swallow assessments. Staff knew how to escalate concerns when a patient’s input was low.

Staff had full access to dietetic services throughout the medical division and vulnerable patients’ dietetic needs were discussed at the safety huddles.

Dietitians were available from 9am to 5pm Monday to Friday and there was an out of hour’s telephone service for advice. However, there was no hospital or trust wide dietetic service commissioned or provided for bariatric patients and staff advised us they did not receive any specific bariatric nutritional training. However, staff did not perceive this to be problematic.

Dietitians contributed to patient care plans and recorded instructions for other members of the multi-disciplinary team. Staff advised us that dietitians and speech and language therapists supported them to look after patients’ nutritional needs. We observed a speech and language therapist conducted a training session with a senior nurse on thickened fluids and showed the number of scoops of thickener required.

We observed a lunch service at the hospital and noted that there were enough staff to support patients who required help with feeding. Staff interacted with patients during mealtimes, asked them what part of the meal they wanted next and ensured patients received fluids. The atmosphere during lunchtime was calm and pleasant.

We saw staff offered snack boxes to patients who had missed mealtimes on their return from a therapy session. Staff had access to ward kitchen pantries, which stored biscuits, bread, butter, preserves, cereals and hot and cold drinks.
We saw a variety of menus in use to support the clinical nutritional needs of patients including, a bulk menu for patients needing to build strength and put on weight, fork mashable for patients on a soft diet and a specialist menu for renal patients. All menus had detailed allergens in order that patients could make informed decisions regarding their meal choices.

At the time of inspection, there were no patients requiring feeding through a percutaneous endoscopic gastrostomy tube directly into the stomach.

**Pain relief**

Staff managed patients pain and by assessing pain levels and taking action.

At our previous inspection we noted, “The medicine directorate should review the provision of the pain service in order to provide a seven day service including the provision of the management of chronic pain services.” we saw that staff had access to a trust wide pain management service and the trust had a dedicated pain page on their public website for patients with chronic pain. Additionally the dying patient care algorithm had detailed information on pain management for the terminally ill and additional pain management advice was available via the palliative care intranet page. We also saw that improving pain management was part of the trust wide Patient First Improvement System with an aspiration of assessing and offering analgesia within 30 minutes of the patients arrival on the ward. The medical division had improved compliance to this target from 15% to 50% since commencing the initiative.

We saw staff assessed pain levels routinely and there was a section of the patient safety bundle specifically about pain management. Pain was assessed prior to each medication round and prescribed analgesia administered as required.

Staff routinely used a one to ten pain scale when asking patients about their level of pain and we saw staff return to patients later to ensure the pain relief had been effective.

Staff used facial expressions and levels of agitation to assess the pain of patients who were unable to verbally communicate. However, staff did not use specialised pain scales such as the Abbey Pain Scale, which assesses pain in patients who cannot verbalise such as dementia or communication difficulties. Staff were confident that they could manage all types of pain using the available pain assessment tools.

The medical division were currently participating in a pain relief audit where five sets of records were audited every day to measure compliance to the division’s mandate that all patients should be offered pain relief where required within 30 minutes of arrival on the ward. Although recently implemented and ongoing the pain relief audit was showing good compliance to the standard.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them.

The endoscopy unit participated in supplying data to the Joint Advisory Group (JAG) on gastrointestinal endoscopy. JAG is principally a quality improvement and service accreditation programme for gastrointestinal endoscopy which supports and assesses endoscopy units to meet and maintain the JAG standards, offering patients and commissioners a badge of quality. JAG accreditation provides an independent validation that an endoscopy service has demonstrated competence measured against national standards and is considered to be fit for purpose.
Clayton ward, which is a neurology unit, participated in sending data for the National Audit of Seizure Management that aims to raise the profile of epilepsy within the NHS. Additionally, a range of other audits were carried out including an audit of patients with multiple sclerosis and Parkinson’s disease.

Relative risk of readmission

**Trust level**

From March 2017 to February 2018, patients at the trust had a higher than expected risk of readmission for both elective and non-elective admissions when compared to the England averages.

**Elective Admissions – Trust Level**

- Patients in gastroenterology had a similar risk of readmission for elective admissions
- Patients in clinical haematology had a lower than expected risk of readmission for elective admissions
- Patients in cardiology had a higher than expected risk of readmission for elective admissions

**Non-Elective Admissions – Trust Level**

- Patients in geriatric medicine had a similar risk of readmission for non-elective admissions
- Patients in general medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in respiratory medicine had a higher than expected risk of readmission for non-elective admissions.
From March 2017 to February 2018, patients at Princess Royal Hospital had a higher than expected risk of readmission for both elective and non-elective admissions when compared to the England averages.

**Elective Admissions - Princess Royal Hospital**

![Graph showing elective admissions risk by specialty]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

- Patients in geriatric medicine had a higher than expected risk of readmission for elective admissions
- Patients in neurology had a similar risk of readmission for elective admissions
- Patients in respiratory medicine had a higher than expected risk of readmission for elective admissions

**Non-Elective Admissions - Princess Royal Hospital**

![Graph showing non-elective admissions risk by specialty]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

- Patients in geriatric medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in respiratory medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in diabetic medicine had a similar risk of readmission for non-elective admissions

(Source: Hospital Episode Statistics - HES - Readmissions (01/03/2017 - 28/02/2018))

**Lung Cancer Audit**

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 64.6%, which did not meet the audit minimum standard of 90%. The 2016 figure was 60.0%. The service told us that they had streamlined rapid access pathway for new referrals compliant with National Optimal Lung Pathway which NHS Improvement had approved for rollout in late 2018/early 2019.
The proportion of patients with Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 18.1%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 53.1%. This is within the expected range. The 2016 figure was significantly better than the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 62.7%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The one year relative survival rate for the trust in 2017 was 38.7%. This is within the expected range. The 2016 figure was not significantly different to the national level.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

Princess Royal Hospital

The crude proportion of patients who had a vision assessment (if applicable) was 20%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 5%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 43%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 73%. This did not meet the national aspirational standard of 100%.

Although the results of this audit were poor, staff on Hurstpierpoint ward advised us they had focused staff training regarding the completion of comfort rounds. These were completed every 30 minutes and staff asked patients if they required anything that was out of reach or whether the patient needed the bathroom. This had reduced the number of falls as it meant patients were less likely to walk on their own.

(Source: Royal College of Physicians)

Competent staff

The service made sure staff were competent for their roles and managers appraised staff’s work performance. At our previous inspection, we noted, “The trust must ensure all staff within the medicine directorate have an annual appraisal.” At this inspection, we saw that appraisal rates had improved from 78% to 92%. Staff we spoke with advised us that appraisals were detailed, that they were given adequate time and covered a range of topics including continuous professional development.

There was an induction process for all new starters and nurses we spoke with described the induction as helpful. I covered use of equipment, a tour of the ward, fire evacuation procedures, safeguarding and emergency contact telephone numbers. The induction period was also used for new staff to complete specific training relevant to their ward.
There were trust wide induction processes for both permanent and temporary (agency and locum) staff. Staff who were new to the hospital told us they felt the induction process supported them in their new role. Staff we spoke with who had been recruited from overseas told us that the trust had been extremely helpful to them in adjusting to working in a different environment.

Nursing students we spoke with told us that they were allocated a primary and buddy mentor and that they worked at least 40% of their time with their mentors. They told us they were given good support from their mentors that conformed to national standards and there was supported learning and assessment.

The trust had developed a series of one-day study days to enhance staffs’ clinical skills. Additionally, courses for specific professional development were available through Brighton University. This ranged from individual stand-alone modules such as the mentor preparation module through to longer courses at post graduate level such as the Advanced Practice (Health) MSc/PG Dip which was designed to enable healthcare professionals to develop their career at masters level, and to practice at an advanced level, providing key clinical expertise and leadership. Access to such courses was adjudicated through the practice educators and nurses we spoke with told us that funding was available for such courses.

**Appraisal rates**

From May 2017 to May 2018, 73.8% of staff within medicine at the trust received an appraisal compared to a trust target of 78.0%. The trust target is correct at March 2018; however, they have commented that the target will increase incrementally to 90.0% by June 2018. Below is a split of appraisal completion rates by staff group in medicine.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals completed</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>29</td>
<td>28</td>
<td>96.6%</td>
<td>78.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>16</td>
<td>15</td>
<td>93.8%</td>
<td>78.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>65</td>
<td>56</td>
<td>86.2%</td>
<td>78.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>551</td>
<td>417</td>
<td>75.7%</td>
<td>78.0%</td>
<td>No</td>
</tr>
<tr>
<td>Medical &amp; dental</td>
<td>139</td>
<td>101</td>
<td>72.7%</td>
<td>78.0%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>395</td>
<td>276</td>
<td>69.9%</td>
<td>78.0%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>26</td>
<td>8</td>
<td>30.8%</td>
<td>78.0%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>1,221</td>
<td>901</td>
<td>73.8%</td>
<td>78.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

**Multidisciplinary working**
Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

All staff we spoke with advised us that multidisciplinary working throughout the division was very good and that the trust wide Patient First Improvement System had enhanced teamwork among differing grades of staff.

We saw wards used ‘True North Dashboards’ which showed efforts within the division to produce a culture of continuous improvement.

We observed ward rounds and a safety huddle and noted that all participants including healthcare assistants were encouraged to participate in patient centred discussions. Any member of the team was able to lead a huddle and at one of the huddles we attended, a health care assistant led the discussions.

The trust provided a wide range of allied health care professionals such as physiotherapists, occupational therapists, dieticians and speech and language therapists that provided professional support for patients with both acute and long-term conditions. Patients we spoke with told us that their care was exemplary and that all staff delivered care which was responsive to their needs. We saw that there was good liaison with the community care teams and during the multidisciplinary huddle we attended we noted that the occupational therapist was assessing patient independence and planning to share information with about this with her peers in primary care prior to discharge of individual patients.

**Seven-day services**

Not all services were available seven days a week. However, the trust had plans to provide full seven-day services to comply with National Health Service Improvements (NHSI), Seven-day services in the NHS. We saw plans stating that the trust was working towards a seven-day service by 2020.

Dietitians and speech and language therapists did not provide a seven-day service and were available Monday to Friday, 9am to 5pm. Although there was an out of hours telephone advice line to support staff, this meant patients with swallowing difficulties admitted to a ward on Friday evenings, were not fully assessed until the following Monday.

Agency and locum staff supported out of hours cover. There was on-call medical cover.

Physiotherapy and diagnostic services were available seven days a week.

**Health promotion**

We saw patients, their families and carers had access to a comprehensive range of information and support. We saw there was a wide range of good quality patient literature with informative content available via patient literature stands. There were also leaflets on managing different health conditions and for example within the endoscopy unit there was a large range of patient information leaflets a full range of procedures.

We saw the trust webpages hosted a full range of patient information leaflets and that they were available in different languages.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**
Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Staff we spoke with confirmed they had recently completed Mental Capacity training and fully understood their responsibilities regarding the Mental Capacity Act. Staff understood that Deprivation of Liberty Safeguards could only be used if the patient lacked capacity and that patients were allowed to make what staff thought were unwise decisions, and staff ensured patients were aware of any associated risks in order that they could make an informed decision.

We inspected 4 patient records where the patient had a Deprivation of Liberty Safeguard in place. All paperwork was signed, dated and within date. Staff we spoke with knew the process for gaining an urgent referral and how to follow up with a standard referral if an extension was required. All staff we spoke with knew to pass the details of a referral to the trust’s Deprivation of Liberty Safeguards team and they could go to the team if they had any queries or questions.

Of the 10 patient records we checked, all consent forms were completed, signed and dated. During the inspection we heard a consultant give a full and detailed description of the structure of a heart, how it worked, what the patient’s heart was doing and the planned procedures to operate. The consultant checked the patient understood everything before asking them to sign a consent form.

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

Trust data showed training completion rates at Princess Royal Hospital for Mental Capacity training was 91% for medical staff and 94% for nursing staff, which was better than the trust target.

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**Is the service caring?**

**Compassionate care**

NICE QS15 Statement 1 states “Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.” We found staff at all levels in all wards we visited adhered to these principles during their interactions with patients, families and visitors.

During our inspection we saw and were provided with numerous examples of staff going above and beyond. For example;

On Balcombe ward, a patient with anorexia was staying on the ward while waiting for a specialist bed. During their time on the ward, staff voluntarily attended eating disorder training in order to support the patient.

Staff on Hurstpierpoint ward were proud of the annual carol service they held at Christmas. They advised us that the relatives of patients who had died on the ward years ago still asked if they could attend the service, as it reminded them of the time they spent with their family member before they passed. Staff also arranged for an end of life patient to read out the service lessons as the patient knew it would be their last Christmas.

A patient on Hurstpierpoint ward was due to attend his wife’s funeral while he was an inpatient. However, on the day of the funeral felt he could not attend. Therefore, a staff member escorted him to the hospital’s chapel where they held their own service and lit a candle. Afterwards, the patient said how happy they were to be able to mark the occasion in their own way.
A patient on Ardingly ward enjoyed painting and had made a portrait of each of the ward staff. When the patient was due to be discharged, the ward staff purchased a large art set for them to take home.

Staff on Ardingly ward showed us a poignant thank you card from the daughter of a patient who they had trained in order that she could provide at home care for her dying mother.

On Pycombe ward, we spoke with a staff member who commented that the hospital razors were poor quality and some staff had never shaved someone’s face and were weary of hurting male patients. Therefore, they started an initiative to train ward staff and contacted several well-known razor brands asking for support. All companies they contacted supplied razors and shaving foam, with one sending a free training video showing how to shave a man’s face. Several staff commented that since then they had received compliments regarding how clean-shaven all the patients on the ward were.

Staff on several wards advised us that they came in on their days’ off to do patients’ hair and nails. A member of staff advised us that friends and family of patients who were previously on the ward had come up to them in the street to thank them for the care they gave and that “Things like that make the job worthwhile”.

Staff on several wards advised us they had arranged for patients’ pets to come onto the ward in order that patients could visit with them, especially if the patient was receiving end of life care.

All patients we spoke with were overwhelmingly positive in their praise of staff. For example, on Pyecombe ward, one patient said, “The manager is so caring and the team work so well together that this place runs like a well-oiled machine”. Another patient on the ward said they were rethinking whether to keep their private healthcare insurance when the care they had received on the ward was so “Exemplary”. On Hurstpierpoint ward, a patient advised us the “Ward is wonderful, like a home from home”. And on Lindfield ward, we were advised the “Nurses are lovely, they are so attentive and help in any way they can”.

In all areas we visited, staff closed curtains before examination and spoke quietly enough so the patients in adjacent beds could not hear conversations.

We saw staff knocked patients’ doors and waited for a response before entering. Staff we spoke with understood the importance of ensuring patients’ dignity and respect during their stay at hospital, especially where patients were in a heightened emotional state due to being away from home and their families.

At our previous inspection, we noted that staff on Balcombe ward conducted the multidisciplinary team meetings in an open area. Therefore, patient privacy was not always respected as other patients and visitors could overhear private information. However, at this inspection we saw that staff conducted all meetings in a side room where clinical conversations could not be overheard.

Friends and Family test performance

The Friends and Family Test response rate for medicine at the trust was 14% which was worse
than the England average of 25% from June 2017 to May 2018. A breakdown by site and ward can be found below.

**Princess Royal Hospital**

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<tbody>
<tr>
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<td>Princesse Ward</td>
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</table>

**Key**

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Note: The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any National standard.

Wards with fewer than 100 responses have been excluded.

(Source: NHS England Friends and Family Test)

**Emotional support**

The hospital provided a 24-hour chaplaincy service. As well as the main chapel that provided Christian services, there was also a Muslim prayer room. Religious literature was available for family and patients to take away if they did not wish to stay in the chapel. The literature included prayer books from six different religions as well as leaflets and guides on spirituality. There was a prayer sheet where people could write the names of their loved ones. These would be read out during services in order that the congregation could pray for a specific individual. Patients and visitors were also able to write in a book of remembrance for those who had lost babies and children.

We spoke with the chaplain who showed us a hospital initiative where the chaplain had their own notes within the patient's records. They advised this enabled staff to provide a more holistic approach to care, as all staff were aware of any spiritual guidance the patient had received as well as any further recommendations made by the chaplain. Prior to this, there had been no record of whether a patient had spoken with the chaplain.

The chaplain described the staff at the hospital as “emotional athletes” regarding how they supported patients, families and each other.

In the first instance, patients received support from staff on the wards. Staff knew how and when to refer patients to specialist nurses for emotional support when required.

All wards we visited had a side room that could be used for private or difficult conversations with patients and families. All side rooms were not in open, busy areas, therefore noise within the rooms was kept to a minimum. Also, they did not have a dual purpose whereby the room may be required when families and patients needed to use the room for an extended time.
We saw posters advertising that patients and families could have access to a chaperone if they wished to. Staff advised us there was always someone available to do this.

**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. Patients and their families were active partners in their care. Staff were fully committed to working in partnership with patients and always took personal preferences into consideration during decision-making and discussing next steps in care.

The trust website provided a welcome booklet for inpatients staying at the hospital. It included information regarding life of the ward, what patients could expect from their medical team, as well as the discharge process.

We saw patient notes included details of discharge discussions with patients and their families. The needs of patients were reviewed and discussed with all parties.

We saw staff explained procedures to patients using every day English rather than medical terminology. Staff also ensured patients understood what they had been told and gave them and their families the opportunity to ask questions.

On Hurstpierpoint ward, we saw a member of staff taking patients observations. She explained the type of measurements she was taking and why. She explained that the blood pressure cuff would tighten, that this was normal but to let her know if it hurt. She reassured the patient that the machine would bleep and this was normal. After all observations had been taken the member of staff explained them to the patient and checked they understood.

On all wards we visited, the nurses in charge wore red shoulder straps on their uniform and were therefore easily identifiable. All patients and family we spoke with knew who the nurse in charge of their ward was, as well as the nurse and consultant who were looking after them. Patients advised us that all nurses introduced themselves at the start of their shift.

However, we noted patient name boards did not include the details of the patient’s consultant and the nurse looking after them.

**Is the service responsive?**

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

The trust planned services in a way that met the needs of local people although there were still instances of mixed sex accommodation. At our last inspection, we saw there were mixed sex breaches regarding ward planning of bays where male and female patients had to cross an area used by the opposite sex to access bathroom facilities. ‘The Department of Health, Health Building Note 00-09: Infection control in the built environment 3.11’ states “Patients should not have to pass through areas used by the opposite sex to reach their own facilities.” We noted that during this inspection while there were no mixed sex breaches when we were on site. However, between April and July 2018, NHS England reported 219 breaches of mixed sex accommodation across the trust.

At our last inspection we saw signage at Princess Royal was confusing, especially regarding the discharge lounge, which at the time had just been moved, however, the signage had not been
updated. At this inspection, we found signage had still not improved. However, we saw an environmental audit from April 2017 to March 2018 that showed signage was recognised as an issue across the trust and that there were plans to make improvements although there was no a planned date for when this would happen.

Staff had access to specialist nurses to meet the needs of patients with complex problems and co-morbidities. We noted several patients had co-morbidities, which is the presence of one or more additional diseases or disorders co-occurring with a primary disease or disorder, including learning disabilities, mental health problems or dementia. Staff we spoke with had significant insight on how to manage this group of patients. They had access to advice from the onsite learning disability nursing team, the mental health care team based in the emergency department and specialist dementia advice from the lead occupational therapist for dementia and the lead nurse for dementia.

**Average length of stay**

**Trust Level**

From April 2017 to March 2018 the average length of stay for medical elective patients at Brighton and Sussex University Hospitals NHS Trust was 3.2 days, which is lower than the England average of 6.0 days. For medical non-elective patients, the average length of stay was 6.8 days, which is similar to the England average of 6.4 days.

**Elective Average Length of Stay – Trust Level**

![Average length of stay for elective specialties graph]

*Note: Top three specialties for specific trust based on count of activity.*

Average length of stay for elective specialties:

- Average length of stay for elective patients in respiratory physiology is similar to the England average.
- Average length of stay for elective patients in cardiology is similar to the England average.
- Average length of stay for elective patients in gynaecological oncology is lower than the England average.

**Non-Elective Average Length of Stay – Trust Level**
Average length of stay for non-elective specialties:

- Average length of stay for elective patients in geriatric medicine is lower than the England average.
- Average length of stay for elective patients in general medicine is similar to the England average.
- Average length of stay for elective patients in respiratory medicine is lower than the England average.

**Princess Royal Hospital**

From April 2017 to March 2018 the average length of stay for medical elective patients at Princess Royal Hospital was 5.1 days, which is lower than the England average of 6.0 days. For medical non-elective patients, the average length of stay was 6.1 days, which is similar to the England average of 6.4 days.

**Elective Average Length of Stay - Princess Royal Hospital**

Average length of stay for elective specialties:

- Average length of stay for elective patients in neurology is lower than the England average.
- Average length of stay for elective patients in geriatric medicine is lower than the England average.
- Average length of stay for elective patients in gastroenterology is lower than the England average.
Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in geriatric medicine is lower than the England average.
- Average length of stay for non-elective patients in respiratory medicine is lower than the England average.
- Average length of stay for non-elective patients in diabetic medicine is lower than the England average.

(Source: Hospital Episode Statistics)

Meeting people’s individual needs

The service took account of patients’ individual needs and there were arrangements to ensure these were met.

We viewed the trust dementia strategic plan, which included: change the reach out to me and butterfly scheme to the forget-me-not scheme and launch on dementia awareness week in May 2018. The purpose of the plan was to develop relationships and network with acute and community lead dementia nurses in Sussex. At the time of this inspection, the trust had contacted dementia leads at neighbouring trusts to support learning and ensure continuity of care.

Hurstpierpoint ward specialised in the care of patients with Dementia. There was a lounge where there were daily activities as well as a piano. The quiet room had an interactive TV and life-sized interactive dogs that could sit and lie down on command. There was also a reminiscence room that was set up to look like a 1950’s living room with an old fashioned TV. This room was used during therapy as staff found patients participated more when they were outside of a clinical environment. The ward corridor was made to look like a street with trees and butterflies painted on the walls as well as a bus stop that was used as a focal point for patients. We saw patients enjoy sitting at the bus stop where they could see what was happening on the ward and provided them with somewhere safe to rest. One patient advised us it helped him remember which bay he was staying in, therefore he did not wander into another patient’s private space.

Patients living with dementia often have restless hands. Staff provided patients with single-use twiddle blankets that had buttons and ribbons attached for patients to play with. Staff gave patients with cannulas twiddle mittens and they advised us this had reduced the number of patients pulling out their cannula. However, staff had not audited the results as cannulas were removed after a 48-hour period.

We checked four records of patients living with dementia and saw that they all had completed ‘This is me’ paperwork. Staff used this document to support the patient, for example, finding the best way to communicate with them.
On Balcombe and Hurstpierpoint ward, we found bays were painted different colours to support patients with cognitive issues find their way around.

We saw staff had access to a variety of toolkits to help them support vulnerable groups. For example, the Public Health England and Royal College of Nursing toolkit to support gay, lesbian and bisexual young people, a resource guide designed to help staff respond to the needs of patients and clients who identify as ‘transgender’ and a communication guide for patients who were Deafblind, had acquired communication impairment, visual impairment or a learning disability. Staff we spoke with knew how to access these guides and where to get assistance when required.

We saw a variety of menus in use to support the cultural nutritional needs of patients including, Halal, vegetarian and gluten-free.

The trust website used a computer programme to support users with visual impairment. The programme enabled users to highlight information within the website, which the system then read back to them. This programme was also available in numerous other languages.

Rehabilitation facilities on Lindfield ward such as the occupational therapy kitchen were widely used and patients described they really appreciated having the kitchen on the ward. We spoke with several patients who advised us that using the kitchen enabled them to feel “Normal again” and meant that they could combine their therapy session with preparing a meal they could share with family and friends.

Bariatric care was discussed at multidisciplinary team meetings and all staff we spoke with advised us there was quick access to equipment, which was provided and maintained by the manual handling team.

**Access and flow**

Patients could not always access care when they need it as waiting list times exceeded national standards. Although the hospital was not meeting referral to treatment times, there were initiatives in place to minimise the impact this had on patients, for example. The hospital also had a Rapid Access Medical Unit where GPs could directly refer patients to the hospital. This was used to reduce referral to treatment times.

There were arrangements to ensure patients were discharged in line with good practice and in a timely way. We saw that transfers and discharges were discussed at the huddles and that occupational therapists played a significant role in ensuring that other agencies and teams within the community were fully involved in ensuring that strategies were in place prior to the patients’ discharge. We attended a multidisciplinary huddle where we saw the occupational therapist in dialogue with the duty consultant and the ward manager making robust plans to discharge medically fit older people who had complex discharge issues.

Staff in the cardiology ward at Princess Royal Hospital showed us their use of the Hospital Rapid Discharge Team (HRDT) who reviewed short stay patients. These patients stayed under the care of the HRDT in order that ward staff were freed up to focus on longer term patients and to expedite the discharge of patients only needing a few days’ hospital care.

Staff in all wards described initiatives used to expedite discharge and support patient flow through the hospital. For example, discharge planning was discussed with night staff that assisted in getting patients ready the morning of discharge. Patient transport services were arranged two
days in advance in order to ensure transport teams had the capacity to include the patient. Where possible discharges took place at 10am to allow beds to become available sooner in the day.

At the last inspection, we noted that hospital policy stated that staff had to order to take home medicines from pharmacy before staff could transfer patients to the discharge lounge. However, to free beds, some ward staff sent patients down to the discharge lounge before medication was ready. This resulted in patients sometimes going home without their to-take-home medication. At this inspection, we saw to-take-home medication was ordered the day before discharge to prevent delay in being transferred to the lounge or patients not receiving medication.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From June 2017 to June 2018 the trust’s referral to treatment performance was consistently worse than the England average.

![Chart showing referral to treatment performance](image)

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**

Six medical specialties at the trust were above the England average for admitted RTT pathways (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
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</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>100.0%</td>
<td>97.0%</td>
</tr>
<tr>
<td>Neurology</td>
<td>96.5%</td>
<td>91.3%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>100.0%</td>
<td>94.4%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>97.8%</td>
<td>92.8%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>90.8%</td>
<td>82.2%</td>
</tr>
<tr>
<td>General medicine</td>
<td>100.0%</td>
<td>96.4%</td>
</tr>
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</table>

There were also two medical specialties at the trust that were below the England average for admitted RTT pathways (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
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</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>51.5%</td>
<td>82.1%</td>
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<tr>
<td>Gastroenterology</td>
<td>90.5%</td>
<td>93.7%</td>
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(Source: NHS England)

**Patient moving wards per admission**
The trust has reported the number of ward moves for non-clinical reasons for the period May 2017 to April 2018. They have provided details of ward moves for the five wards with the highest number of non-clinical ward moves. However, none of these were medical care wards.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

**Patient moving wards at night**

From May 2017 to April 2018, there were 2,364 patient moving wards at night within medicine. At site level, there were 617 ward moves at night at Princess Royal Hospital.

(Source: Routine Provider Information Request (RPIR) – Moves at night)

**Learning from complaints and concerns**

The trust website provided clear information on how to make a complaint and also had links on how to join the trust’s patient experience panel.

Throughout the medical wards, we saw complaint leaflets and posters prominently advertised. All included details of the Patient Advise and Liaison Service (PALS).

Staff provided us with numerous examples of where a complaint had resulted in change. For example, on Balcombe ward, staff had introduced soft close bins after patients had complained about the noise at night. Staff on Ardingly ward showed learning after a recent incident and we saw that emergencies were discussed at safety huddles. In addition, the Resuscitation Team included real life scenarios as part of their training programme.

**Summary of complaints**

From April 2017 to March 2018 there were 44 complaints relating to medical care. The trust took an average of 49 days to investigate and close complaints.

Of the 44 complaints received for medical care, 43.2% were concerning access to treatment or drugs, 20.5% related to admission and discharges and 11.4% of the complaints related to patient care.

- Princess Royal Hospital: There were 12 complaints relating to medical care. Of these, four complaints related to admission and discharges (33.3%) and three complaints related to access to treatment or drugs (25.0%).

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

**Number of compliments made to the trust**

From April 2017 to March 2018 there were 80 compliments within medicine.

The breakdown by site is shown below;

- Princess Royal Hospital: 32 compliments

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

The service had managers at all levels with the right skills and abilities to run the service.

Since our last inspection, the trust had reduced the number of medical divisions to five, at our previous inspection it was 10. The trust had also moved to triumvirate leadership.

The triumvirate management team for each directorate included an operational manager, a clinical director and a lead nurse who had clearly defined roles and responsibilities in order to support their directorate.

The medical division was divided into three clinical groups; acute, speciality and specialised, which included cardiology, renal and neurology.

In the 2017 NHS Staff Survey, we saw there were 11 questions regarding how supportive managers were, their communication skills and quality of feedback. Results in 10 of the 11 questions showed improvement since the 2016 survey.

All staff we spoke with gave positive reviews of their ward managers, stating they felt supported and valued. There was also overwhelmingly positive praise for the chief nurse.

At our last inspection, staff advised us the medical directorate had three different matrons in one year, which resulted in limited stability and support. At this inspection, staff advised us the current matron was settled in their post and they appreciated the stability this provided.

Vision and strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff and patients. We saw posters advertising the trust’s new set of values and vision for the future, which was also available on the intranet. Most staff we spoke with were positive about the values and said it gave the hospital a focus. However, some staff we spoke with did not know the trust values. For example, within the last year, Ardingly ward had moved directorate from Neurology to Specialist Medicine and had had a large turnover of staff. Balcombe ward’s focus had moved from cardiovascular to heart failure and diabetes. Due to the speed of change on these wards, staff felt they wanted to adhere as a staff group before focusing on the wider trust values.

The trusts strategy was called ‘Patient First’ and was introduced last year. The trust presented details of the strategy to the inspection team, which showed patients at the top of a triangle with all the elements of how to improve the patient experience underneath.

All staff we spoke with were aware of the ‘Patient First’ initiative.

We viewed the medical directorates strategy for the next five years which was called its ‘True North’. It included plans regarding how to improve patient experiences by offering services where previously patients would have to travel to London, sustainability plans including virtual clinics to improve capacity issues, as well as details regarding refurbishment across the trust. Ward managers we spoke with were aware of the strategy and its content.
Culture

Managers were developing a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

At our previous inspection, we noted there was a negative culture at the hospital. At this inspection, all staff we spoke with described a positive improvement regarding the culture at the trust. Comments included “The culture feels so much better”, “The bullying culture has changed beyond recognition”, “Now it’s much less toxic”, “It just feels like a happier place to be.”

Staff also knew who their speak up guardian was, and felt that any issues or concerns they had would be taken seriously and acted on.

In the 2017 NHS Staff Survey, the trust had an overall engagement score of 3.62. This was in the worst 20% when compared with trusts of a similar type and the same figure as 2016. The overall indicator of staff engagement is calculated using the results of three key findings; KF1: Staff recommendation of the trust as a place to work or receive treatment, KF4: Staff motivation and engagement at work, and KF7: Staff ability to contribute towards improvements at work. The trust scored in the worst 20% for KF7, KF1 and KF4. It had improved its score for KF1 since 2016 but had deterioration in score for KF4.

Despite the above results, the 2017 survey generally showed improvement in all areas when compared to the 2016 survey.

Staff relations measured by numbers of informal grievances had improved showing management understanding of issues and concerns of staff had also improved. At our previous inspection, we noted the number of grievances within medicine was worse when compared nationally to trusts of a similar size. However, in the last 12 months there were only two grievances (one at each site) which was better than the national average. This showed.

At previous inspections, we noted there were inconsistencies regarding the use of and support from the human resources department. At this inspection, all ward managers we spoke with advised us they had seen a dramatic improvement in support from their human resource colleagues and that everyone was following protocol in accordance with the trusts policies and procedures.

Governance

The trust had governance systems for identifying risks, and which provided a systematic approach to improving quality and safety of care.

At our last two inspections, we noted there was silo working within the trust. The trust had since reviewed its governance structure to ensure the sharing of information. The three clinical leads for seven areas of medicine including; accident and emergency, acute, are of the elderly, dermatology, diabetes, HIV/GUM and respiratory now led the quarterly specialty governance meetings. These fed into monthly governance lead meetings where patient safety, clinical outcomes and effectiveness, patient experience, risk and compliance and implementing, sharing and disseminating best practice were discussed. There were also Quarterly Divisional Governance away days. All three of these reported to the Quality Governance Steering Group.

While ward staff provided examples of cross-hospital learning between their equivalent wards at the Royal County Hospital site, we were advised there was little learning or sharing of information
between different directorates within the medical care team. Therefore, although we saw evidence of shared learning at trust level, it had not always reached ward staff.

The trust provided us with governance meeting minutes for all medical directorates. The minutes showed the directorate leads reviewed incidents as well as possible learning and how that could be cascaded. There were managerial updates as well as a focal topic related to the ‘issue of the week’ which during our inspection was sepsis. An accountable person was allocated to all actions and had to work towards a review date and completion.

There were monthly morbidity and mortality meetings, which were part of the monthly clinical governance meetings. Senior nurse attended these meetings and minuted in the governance reports. Any lessons learned were cascaded to staff at the huddle meetings and individual ward key incidents were also discussed at the huddle meetings.

Management of risk, issues and performance

We saw up-to-date risk registers divided by directorate. The risk registers provided a description of each risk, a named person who had responsibility for managing the risk, as well as up to date actions against the risk. Ward managers were aware of the registers, knew their content and that the current biggest risks were capacity, patient flow and staffing, the plans for improvement as well as the planned timescale for improvements. Therefore, there were assurances that management had identified risks, reviewed them and implemented control measures.

We saw action plans to improve performance where audits had fallen below national standards. These included a timetable for re-auditing to ensure an improvement in audit results. Senior management were aware of performance issues at the hospital, and were actively trying to reduce their impact. Senior management and board level staff met three times a day in order to review and manage issues relating to staffing levels, patient flow and bed vacancies.

Engagement

The service engaged well with patients and carers. Several wards organised regular carers groups, where family and friends could meet and support each other. Family members we spoke with advised us they appreciated having other people to talk to who were going through a similar situation to themselves.

The ward manager on Hurstpierpoint ward advised us she attended Dementia Cafés within the community every few months. These gave her an opportunity to promote the ward and hospital, but also act as a source of knowledge for members of the public attending the café. The manager advised us she had been asked to attend every week, as she was able to provide valuable insight.

The service engaged well with staff. All staff we spoke with during inspection advised us there were regular staff meetings and that management arranged these for different times and days in order to ensure all staff were able to regularly attend.

Since our last inspection the trust had introduced short monthly surveys in order that they could regularly monitor staff culture rather than waiting for the annual national staff survey. The trusts survey showed improvement in all areas.
Staff excellence was acknowledged and celebrated. We saw posters around the hospital promoting employees who had won the Patient First Star Awards. These were staff members who had gone above and beyond on a regular basis and were nominated by their colleagues.

Learning, continuous improvement and innovation

All staff we spoke with felt the culture at the trust was now one of learning and improvement rather than blame.

Staff were able to make suggestions for improvement, for example the introduction of the Broset Tool, to support staff in dealing with aggressive patients. The Broset Tool is a checklist that helps to predict violent behaviour and therefore protected staff from patients who may suddenly become violent.

The inspection team felt the ‘Patient First’ initiative and the various huddles improved multi-disciplinary working and ensured all teams within the hospital were “working from the same page”.

The trust had shown improvement regarding the discharge of patients and flow through the hospital through the improved use of the discharge lounge, the organisation of to take home medication, the use of the Rapid Access Medical Unit and the Hospital Rapid Discharge Team.

Surgery

Facts and data about this service

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

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

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

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

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

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

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

(Source: Hospital Episode Statistics)

During our inspection, we visited all areas of the surgical services, including theatres, wards, pre-operative assessment unit, Sussex Orthopaedic Treatment Centre (SOTC), and day surgery.
We spoke with 32 staff of all grades, including, nurses, doctors, healthcare assistants, therapists, and housekeeping, other healthcare professionals as well as the management team for the division.

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

**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**

Statutory and mandatory training for all staff groups was comprehensive. The training was a mixture of face-to-face and on-line learning system. Mandatory training modules included fire safety training, infection prevention, information governance and manual handling. Other training was role specific for example, consent, medicines management and advance life support.

There was a trust wide electronic staff record where all training attended was documented. Compliance was monitored centrally and wards had access to compliance information so that staff could be reminded to attend, or complete on-line training.

The overall statutory and mandatory training rates for nursing staff was 95% and medical staff was 100%, which was better than the trust target of 90%. We saw all statutory and mandatory training modules were above 90%, with the exception of manual handling – patients for nursing staff which was 86%.

Staff we spoke with told us they felt their training was good. For nursing staff there was a dedicated practice education facilitator who oversaw statutory and mandatory training within the surgical division. Staff had individual logins and could access the system remotely. Statutory and mandatory training modules were colour coded; green for complete or red for incomplete. Staff received email alerts when training was due for completion and could view available mandatory training dates. This meant individual staff had oversight of their mandatory training status.

Staff received training in recognising and managing deteriorating patients including those with confirmed or suspected sepsis. This was monitored and where compliance was low, or additional training needs identified, the sepsis team provided focused training. This was in line with National Institute for Health and Care Excellence, guidance (NG) 51, recommendation 1.12, training and education.

Staff received training on patients with complex needs such as mental health needs and dementia. The training strategy for the whole trust had been reviewed and is being implemented. Across the trust there is 88% compliance for dementia training.

**Mandatory training completion rates**

The trust set a target of 90% for completion of mandatory training.
Mandatory Training Completion by module – Nursing and Midwifery Staff

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible staff</th>
<th>Compliance rate</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Safety Training</td>
<td>168</td>
<td>172</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety Training</td>
<td>166</td>
<td>172</td>
<td>97%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention – Clinical</td>
<td>165</td>
<td>172</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>168</td>
<td>172</td>
<td>98%</td>
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</tr>
<tr>
<td>Manual Handling - patients</td>
<td>148</td>
<td>172</td>
<td>86%</td>
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</tr>
<tr>
<td>Safeguarding Adults at Risk</td>
<td>169</td>
<td>172</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children and Young People – level 2</td>
<td>165</td>
<td>172</td>
<td>96%</td>
<td>Yes</td>
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</tbody>
</table>

Mandatory Training Completion by module – Medical and Dental Staff

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<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible staff</th>
<th>Compliance rate</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Safety Training</td>
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<td>5</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention – Clinical</td>
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<td>5</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
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<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling – inanimate loads</td>
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<td>5</td>
<td>100%</td>
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<tr>
<td>Safeguarding Adults at Risk</td>
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<tr>
<td>Safeguarding Children and Young People – level 2</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Additional Data Request (ADR) – 74)

Safeguarding

At the last inspection the trust failed to meet the safeguarding training completion target for all staff working across the surgery service. Senior staff told us there had been a focus on improving compliance. Both nursing and medical staff had achieved the trust target for adult safeguarding and safeguarding children and young people level two.

There were systems and processes to protect people from abuse and harm. Staff understood their responsibilities and the steps to take in the event of any safeguarding concerns.

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. There were also specific policies on female genital mutilation, domestic abuse, and ‘Prevent’ (identifying when vulnerable people may be exploited and drawn into terrorism).

Staff could identify the safeguarding leads for the trust, and could 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 team was available to give support and advice to staff Monday to Friday between 9am and 5pm.
Staff understood and could give examples of what constituted a safeguarding concern. For example, we were told of a safeguarding concern, where a patient was worried about leaving their child with their other parent, while they had their operation. Staff explained what actions they had taken to help resolve the concern, where it was documented and who they went to for advice.

Data indicated that 100% of medical staff and 98% of nursing staff had completed their safeguarding adults at risk training, which was better than the trust target of 90%. This meant the trust could be confident staff had the necessary training to keep adult patients safe and protect people from abuse and harm.

The surgical wards at the Princess Royal Hospital did not routinely treat children and young people. Data indicated that 100% of medical staff and 96% of nursing staff had completed safeguarding children and young people level two training, which was better than the trust target of 90%. We spoke to the ward manager on one of the surgical wards we visited, who told us a young person was due to be admitted for a procedure. The ward manager told us they had liaised with the safeguarding team and the paediatric services within the trust to make sure the correct safeguards had been put in place.

Cleanliness, infection control and hygiene

The service controlled infection risk well. 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. All areas on the wards, department and theatres we visited were found to be uncluttered and visibly clean. Equipment was visibly clean and staff had a good understanding of responsibilities in relation to cleaning.

There was evidence that regular clean audits were taking place in line with National Specification of Cleanliness. This had improved from our previous audit where we found the hospital did not have cleaning schedules and audits in place in line with the National Specification of Cleanliness, including a deep cleaning schedule for theatres. In addition, there was a regular deep cleaning process which was now undertaken on a three-monthly basis. Deep cleans were scheduled in advance to allow operations and theatre usage to be planned.

All the wards and departments had their cleaning audit score displayed within the area and all scores met the standards in accordance with the risk category they were in with regards to the National Specification of Cleanliness (NSC) in the NHS. All wards we visited were of a standard of cleanliness that reflected the score displayed.

We looked at July, August and September audit results. All wards and departments inspected reached the standard required in their risk category according to the National Specification of Cleanliness in the NHS with one exception, Antsy in July 2018 scored 94.4% the standard required was 95% and the shortfall would not present a significant risk. Corrective action sheets were available to the housekeeping staff to complete the actions where the cleaning has not attained the standard and these were completed within timescale.

We randomly checked five sharps containers and found them correctly assembled, dated and not overfull. This had improved from our previous inspection where we found the theatre department was not complying with ‘The Health and Safety (Sharp instruments in Healthcare) Regulations’ 2013 which states that healthcare providers must use safer sharps. In addition, we saw safety cannulas had been introduced. Safety cannula, protect staff from the risk of an accidental needlestick injury.
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.

The trust had policies in place to manage effective infection control and hygiene processes, in line with the recommendations of the Code of Practice on the prevention and control of infections and related guidance (the code) criterion 9; Staff demonstrated how they could access the policies on the trust’s electronic system. We observed that policies had been reviewed and were up to date.

All areas on the wards, department and theatres we visited were found to be visibly clean. This was an improvement on our previous inspection where we found the theatre corridor to be dusty. However, some areas such as on Ansty ward, and Twineham ward, we found some of the walls, fixtures, and fittings were not intact. For example, we saw sink surrounds, which were damaged with exposed wood, this is not in line with the Department of Health’s Health Building Note (HBN) 00-09: infection control in the built environment. Non-intact surfaces, flooring and walls can harbour dirt and dust and make the cleaning difficult.

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 across the surgical division at Princess Royal Hospital the hand hygiene compliance for all wards and departments for weeks commencing, 20 and 27 August 2018, 3 and 10 September 2018, except for Twineham ward, were above 95%. Twineham ward ranged between 70% and 80%, this meant the ward could not be confident all staff were cleaning their hands as per trust policy. Where there were episodes of non-compliance we were told that members of staff were spoken to immediately.

Personal protective equipment (PPE), such as gloves and aprons were generally used appropriately and were available in sufficient quantities, both on the ward and in theatres. However, during our inspection we saw mixed compliance to the practice with some staff using gloves and aprons inappropriately. There was potential for cross infection because gloves can transfer bacteria in the same way hands can. We saw multiple members of staff come out from behind a curtain or leave a patient’s bed space with gloves and apron on, to collect clean linen, as staff did not remove their gloves after coming out from behind the curtain, or leaving a patient and have contact with a clean linen, there was potential for cross infection. We saw that no staff challenged other staff who were wearing personal protective equipment incorrectly. We fed this back to the ward manager, who told us they would remind their staff of the importance of wearing personal protective equipment correctly. We visited the ward the next day, and saw staff wearing and removing gloves and aprons correctly.

Single use items of sterile equipment were readily available and stored appropriately in all areas checked. Instruments used for patient treatment that required decontamination and sterilisation were processed via the on–site sterile supplies department, to ensure compliance with regulatory requirements for cleaning (decontamination), Health Technical Memorandum (HTM) 01-01: management and decontamination of surgical instruments (medical devices) used in acute care.

We found equipment was visibly clean on the ward and in theatre, and staff had a good understanding of responsibilities in relation to cleaning and infection control. Disinfectant/detergent
wipes were available on the wards and in theatres to clean equipment between patient contacts. Good supplies were seen across both the wards and theatres we visited.

We reviewed four sets of medical records of patients who had a peripheral intravenous line in place. A peripheral intravenous line is a tube that is inserted into a vein and used to administer fluids and medication. Visual infusion phlebitis scores were completed correctly. Visual infusion phlebitis score, is an assessment tool to look for the early signs of inflammation of a vein.

The documentation included information about the site of the peripheral intravenous line, skin cleaning product, hand hygiene and how often to review the device, in line with National Institute for Health and Care Excellence, quality standard (QS) 61 statement five, vascular access devices.

We reviewed the records of two patients who had a urinary catheter in place. A urinary catheter is a thin flexible tube used to drain urine from the bladder. We saw the patient was placed on an integrated care pathway, which included information about hand hygiene, catheter insertion, and maintenance in line with National Institute for Health and Care Excellence, quality standard (QS) 61 statement four, urinary catheters.

In theatres, we observed all staff wore the appropriate theatre attire, such as theatre scrubs, hats and masks, all staff were bare below the elbow in line with national guidelines. We saw good scrub practice and there was correct use of alcohol-based hand sanitising.

There was good differentiation of clean and dirty areas in theatres and we saw staff leaving and entering theatres change out of scrubs or cover them in accordance with trust policy.

Between September 2017 and August 2018 there have been no Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infections, assigned to the trust, against an NHS objective of no ‘avoidable’ bloodstream infections.

The trust could not be confident it identified all patients with Methicillin-resistant Staphylococcus aureus (MRSA) to make sure appropriate infection prevention precautions were in place. Screening of patients pre-operatively for carriage of Methicillin-resistant Staphylococcus aureus (MRSA) has been a Department of Health recommendation since 2007. Patients would be screened for Methicillin-resistant Staphylococcus aureus (MRSA), either prior to admission as an elective patient, or on admission as an emergency patient. Patients could also be screened regularly during their admission. We asked the trust for their compliance rates for screening of patients for Methicillin-resistant Staphylococcus aureus (MRSA). The trust informed us they do not monitor screening rates.

There were clear guidelines for staff to follow to screen patients for the presence of infections. For example, carbapenemase-producing enterobacteriaceae (CPE), on admission and Creutzfeldt–Jakob disease (CJD), prior to surgery. We saw that these had been followed in the records we reviewed. CPE are bacteria that are resistant to the carbapenem class of antibiotics, considered the drugs of last resort for such infections.

The trust’s total knee replacement surgical site infection report for January to March 2018 showed 0.9% of patients developed a surgical site infection following knee replacements during this period.
This was worse than the average infection rate of 0.4% for other hospitals that sent patient questionnaires during the same period.

Between September 2017 and August 2018, there were seven cases of Clostridium difficile (C. diff) in the surgical directorate, three of which were at the Princess Royal Hospital site. Clostridium difficile is a type of bacteria, which can infect the bowel and cause diarrhoea.

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. We saw from the three cases, all three had an identified ‘lapse of care’. One was due to a delay in isolation, the second was antibiotics not prescribed in line with policy, the third was due to a delay in sending a specimen. We saw each case of Clostridium difficile had been investigated through a process of root cause analysis (RCA), with outcomes and lessons learned shared with staff. We looked at one of the root cause analysis investigation reports, which had been completed, with recommendations and action plans, which confirmed the process.

Data supplied to us showed between September 2018 and August 2018, there were seven cases of Meticillin-sensitive Staphylococcus aureus (MSSA) blood streams infection (BSI) in the surgical directorate. Three of these were at the Princess Royal Site. There is currently no NHS Improvement objective for MSSA BSI.

Data supplied to us showed that between September 2017 and August 2018, there had been 17 Escherichia coli (E. coli) blood streams infection (BSI). Two of these were at the Princess Royal Hospital Site. NHS Improvement requires all trusts to reduce gram-negative bacteria (such as Escherichia coli), by 50% by 2021.

**Environment and equipment**

The service had suitable premises and equipment but did not always look after them well. For example, sink surrounds, which were damaged with exposed wood, were not suitable as outlined in the cleanliness, infection and hygiene section of this report.

Theatre changing room was very clean and tidy. Scrubs were stored neatly. It was unclear how often shoes were cleaned in theatres. Most staff had their own shoes so were responsible for the cleaning. We observed staff correctly dressed for theatres in line with the trust's uniform policy. All staff wore scrubs, hair was secured above the shoulders and hats were worn in clinical areas.

Theatre scrub areas had been appropriately cleaned with approved cleaning agents. We saw control of substances hazardous to health (COSHH) risk assessments in place to support staff’s exposure to hazardous substances. The cleaning cupboards inspected on the wards and theatres were locked at the time of inspection. We also saw the cleaning trolleys with lockable compartments and of the ones inspected all were locked at the time of inspection.

We saw spill kits and emergency eye wash kits available in main theatres and staff we spoke with were aware of their location. This meant theatres had suitable equipment to deal with spillage of biological material such as bodily fluids and any incidents of foreign bodies entering a staff member’s eye.

We saw that the Association of Anaesthetists of Great Britain and Ireland safety guidelines 'Safe Management of Anaesthetic Related Equipment' (2009) was adhered to. This guideline stated that records must be kept of each safety check of all anaesthetic machines in a logbook, which was
kept with the machine. This meant there were assurances that vital safety checks had been undertaken and the equipment was safe to use.

Theatres had a difficult intubation (placing a breathing tube in the windpipe) trolley, which met the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and Difficult Airway Society standard. The difficult intubation trolley had completed records to show it was checked on a regular basis and safe to use.

We asked for evidence that theatres were safe to operate from a ventilation / air change perspective. We were shown the theatre verification programme which ran from May 2018 to February 2019. There are 13 theatres at Princess Royal Hospital site. All theatres appeared on the verification programme. The theatres are shut down for eight days with a further two or three days built in to the plan as contingency. We were told, following any work, if the theatre was not to the required standard it would remain closed until further work was completed.

The test criteria used when verifying the theatre ventilation was the one recommended in Health Technical Memorandum (HTM) 03-01 and this gave the recommended supply and extract supplied to and from theatre suites. We saw evidence of theatre verification reports that were undertaken by a specialist company, and each theatre was verified annually which was in line with Health Technical Memorandum 03-01.

We saw the verification report from theatre four, dated 6 September 2018. The theatre supply, anaesthetic room supply, anaesthetic extract and preparation room supply were checked for air change frequency. The theatre supply, anaesthetic room supply and preparation room supply met the required standard and were reported as satisfactory within the report. The anaesthetic extract did not meet the required standard of 15 air changes per hour and achieved 7.1 changes per hour.

The report stated that it recommended to increase the airflow to this area, although the anaesthetic extract is low it is was not considered detrimental to the running of the suite. The recommendations also stated that the pressure differentials created the correct cascade through the suite to maintain the hierarchy of cleanliness.

Systems were in place to make sure access to theatres and other areas were limited to specific staff. Access to theatres and wards was restricted with a call bell system, which granted access to only those who were allowed.

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

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.

The trust’s electronics and medical engineering (EME) department serviced equipment. Maintenance was generally undertaken using two methods: planned preventative maintenance (PPM) or reactive maintenance. PPM was undertaken on a regular programme (weekly, monthly, quarterly, yearly) to meet statutory requirements, legislation, manufacturer’s guidance, and industry good practice. Reactive maintenance was undertaken on an as required basis to address damage, breakdowns, or failure.

The service maintained equipment so that it was safe and fit for purpose. During our inspection, we saw 22 pieces of equipment. All equipment was labelled with dates showing they had been serviced in the past year.
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.

There was sufficient equipment to maintain safe and effective care such as anaesthetic equipment, theatre instruments, blood pressure, and temperature monitors, commodes and bedpans. During our inspection, we did not see any patients that needed bariatric equipment.

Piped oxygen and suction equipment was available at most bed spaces, as well as call buttons for emergency use. Call bells were tested regularly. Where piped oxygen was not available portable oxygen and suction equipment was being used to reduce the risk to patients.

**Assessing and responding to patient risk**

The service made sure that patients having elective surgery had risk-based pre-operative assessments. Elective patients attended a nurse-led pre-assessment appointment to make sure they were medically fit for their surgery. Risk assessments for falls, malnutrition, venous thromboembolism and pressure ulcers were undertaken. Nurses referred patients that presented with co-morbidities for an anaesthetic assessment prior to surgery. During the appointment all required tests would be undertaken, such as blood tests or a swab taken to test for Meticillin-resistant *Staphylococcus aureus*. This was in line with National Institute for Health and Care Excellence (NICE), guideline (NG) 45, routine preoperative tests for elective patients, and national guidance from the Modernisation Agency.

The trust used the five steps to safer surgery, World Health Organisation (WHO) surgical safety checklist, in line with National Patient Safety Agency (NPSA) guidelines. The National Patient Safety Agency version of the checklist had been revised and incorporated into the trust’s format. The checklist is a national core set of safety checks for use in any operating theatre environment. The checklist consists of five steps to safer surgery. These are team briefing, sign in (before anaesthesia), time out (before surgery starts), sign out (before any staff members left the theatre) and debrief.

We observed good ‘team briefs (step one), during out inspection. This included a full introduction of the team and requirements. We saw the process was fully interactive and all team members participated. We saw all elements of the brief checklist were read aloud, including the procedure, equipment, position of the patient, allergies, and any anaesthetic requirements.

We saw staff were introduced to the patient and the anaesthetist was present during the patient’s details check. This included checking the patient identification, consent, allergies, check of the site marking and the last time the patient had anything to eat or drink, this complied with best practice. We saw all elements of the ‘sign in’ stage were read aloud and confirmed before marking on the checklist as completed.

We saw the ‘time out’, was a fully interactive process. ‘Silent focus’ was observed in line with guidance. We saw all elements of the ‘time out’ stage were read aloud and confirmed before marking on the checklist as completed.

Weekly audits showed an overall compliancy score for completion of the checklist was 100% for surgery. We looked at the audits for weeks commencing, 13, 20 and 27 August 2018, and 3 and 10 September 2018.
In theatres, we observed staff checked all surgical instruments and gauze swabs before, during and at the end of patients’ operations. This ensured no items were left in patient’s bodies following surgery and was in accordance with the Association for Perioperative Practice (AfPP) guidelines.

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. This allowed staff to identify patients who were becoming unwell, before they became critical, and provide them with increased support. We looked at 10 sets of national early warning system charts, and saw they were completed fully, and scored correctly. Staff on the wards told us that in the case of a deteriorating patient there was never any difficulty in accessing medical support. The service used a communication tool called Situation Background Assessment Recommendations (SBAR) for both medical staff and nursing staff to use when escalating concerns about a patient’s condition to their seniors.

Patients were assessed for their risk of falls on admission and regularly throughout their admission. We looked at 10 risk assessments and found they were fully completed. Patients identified as being at high risk of falls following assessment had individual falls management plans. In addition, we saw some patients were placed on sensor mats, which alerted staff when a patient left their bed or chair, so that staff could assist them if necessary. This is in line with National Institute for Health and Care Excellence (NICE), quality standard (QS) 86, falls in older people. Falls formed part of the metrics dashboard for each ward, so they could see how they were performing in each area, compare themselves to the trust average for the month, monitor trends and improve and make changes to practice.

The trust had a paper based screening tool and all surgical wards had information about screening and managing sepsis. The trust had reviewed its data and identified the wards that had a greater risk such as Ansty Ward. The staff on Ansty ward showed us their sepsis trolley which allowed staff to locate all required equipment and protocol for the screening and treatment of sepsis. All checks of the trolley were fully complete. The outreach service working from the intensive care unit was available twenty-four hours; seven days a week to support staff on the surgical wards, therefore there was access to clinical advice and support if a patient’s condition was deteriorating. This is in line with National Institute for Health and Care Excellence (NICE), guideline (NG), 51, sepsis: recognition, diagnosis and management.

The trust supplied a strategy document setting out its current state on managing sepsis and the vision to 100% adherence to the pathway. Sepsis champions were appointed and weekly meetings were proposed to discuss any patient that did not receive treatment appropriately.

Staff could contact the mental health team to give support to distressed patients, when necessary and one to one care was available for these patients.

National Safety Standards for Invasive Procedures (NatSSIPs) were available in the theatre department. The trust was in the process of implementing a local safety standard for all invasive procedures (LocSSIPs). However, not all staff were aware of local safety standards for invasive procedures or their availability.
Nurse staffing

The trust has reported their staffing numbers below for two different times; March 2017 and April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>As at 31 March 2017</th>
<th>As at 30 April 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>All sites</td>
<td>829.6</td>
<td>947.3</td>
</tr>
</tbody>
</table>

In March 2017 the trust reported they had filled 87.6% of their planned staffing. This decreased to 86.0% in April 2018.

No site breakdown is available as the trust did not report the data at site level.

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

There were systems and processes in place to assess, plan and review staffing levels on the ward, including staff skill mix. Each ward determined its nurses and healthcare assistants for each shift staff to ensure safe patient care. This is in line with National Institute for Health and Care Excellence (NICE) safe staffing guideline one. Required and actual staffing levels were displayed on each ward.

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. Shortfall in the staffing levels were covered by either hospital bank staff or agency staff. During our inspection, required staffing levels did not always meet the actual levels, however, the nurse in charge structured the ward to make sure staffing levels met the needs of the patients.

Staff told us they had enough staff to provide good nursing care. Patients told us they felt safe, on the ward, and there were adequate numbers of staff on the wards to meet their needs.

We found theatres complied with recommendations of the Association of Perioperative Practice (AfPP) for the number of staff on duty during a standard operating list. This consisted of two registered nurses, an operating department practitioner, a healthcare assistant, a consultant and an anaesthetist.

The leadership team told us the trust recruitment of staff particularly for the Princess Royal Hospital site remained a challenge, data as of April 2018, showed the site had a 24.1% vacancy rate. Data supplied to us by the trust showed as of July 2018, the vacancy rate for the surgical division was 9.9%. This had improved from the previous year’s vacancy rate which was 15%, and was on track to meet the March 2019 target. They told us this was mainly due to the cost of living, and lack of a ‘weighting’ allowance. Recruitment campaigns are being planned to encourage nursing staff to work for the trust.
Vacancy rates

From May 2017 to April 2018, the trust reported a vacancy rate of 15.0% in surgery. This was higher than the trust target of 10.5% in March 2018, reducing incrementally to 9.0% by March 2019.

The breakdown by site was as follows:

- Princess Royal Hospital: 24.1%
- Royal Sussex County Hospital: 11.0%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From May 2017 to April 2018, the trust reported a turnover rate of 13.4% in surgery. This was better than the trust’s overall target turnover rate of 14% in March 2018 reducing incrementally to 11% by March 2019.

- Princess Royal Hospital: 6.3%
- Royal Sussex County Hospital: 24.7%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From May 2017 to April 2018, the trust reported a sickness rate of 3.0% in surgery. This was better than the trust overall target sickness rate of 4.20% in March 2018 reducing incrementally to 3.50% by March 2019.

A site level breakdown is shown below:

- Princess Royal Hospital: 3.1%
- Royal Sussex County Hospital: 3.2%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

Please note that the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff in all cases. Therefore, we have been unable to analyse bank and agency usage as a proportion of the total shifts needing to be filled.

The table below shows the numbers of shifts in this core service from April 2017 to March 2018 that were covered by qualified nursing and nursing assistant bank and agency staff or left unfilled.

For qualified nurses, 5,282 shifts were filled by bank staff and 2,858 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses. In addition, 2,803 shifts were not filled by either bank or agency staff.

For nursing assistants, 5,221 shifts were filled by bank staff and 3 shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants. In the same period, 1,815 shifts were not filled by either bank or agency staff.
<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Qualified nurses</th>
<th>Healthcare assistants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>5,282</td>
<td>5,221</td>
<td>10,503</td>
</tr>
<tr>
<td>Agency</td>
<td>2,858</td>
<td>3</td>
<td>2,861</td>
</tr>
<tr>
<td>Not filled</td>
<td>2,803</td>
<td>1,815</td>
<td>4,618</td>
</tr>
</tbody>
</table>

Unfortunately, we are unable to provide a site-specific breakdown of nursing bank and agency usage in this core service, due to the format of the data provided by the trust.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

**Medical staffing**

The trust has reported their staffing numbers below for two different times: March 2017 and April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>As at 31 March 2017</th>
<th>As at 30 April 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>All sites</td>
<td>461.9</td>
<td>492.8</td>
</tr>
</tbody>
</table>

In March 2017 the trust reported they had filled 93.7% of their planned staffing. This decreased to 89.0% in April 2018.

No site breakdown is available as the trust did not report the data at site level.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Surgery was consultant delivered and led. We looked at the rotas for medical staff and saw there was an identifiable consultant of the day or week, who had overall responsibility, seven days a week, 24-hours a day. Consultants led ward rounds seven days a week.

We reviewed the medical staffing arrangement by grade with those of the England average and there were 49% at consultant level which was equal to the England average. Registrars (a doctor who is receiving advanced training in a specialist field of medicine to become a consultant) made up 39% of the workforce, which was better than the England average of 29%. Middle career (doctors with years at foundation year level two) made up 5% which was lower than the England average of 11%. Junior Foundation year level one and two accounted to 7% of the workforce which was lower than the England average of 11%.

Medical staff told us locum staff were used to cover shortfall in vacancies and shifts. We saw where possible the same locum staff were used, which meant they were aware of the roles and responsibilities required of them.

The leadership team, told us they had challenges for recruiting across junior and middle grade staff. The Tier 2 visa cap (a visa offered to fill a skilled job vacancy), for international recruitment and new terms and conditions for doctors in training, impacted on the trust’s ability to recruit staff. Recruitment campaigns were being planned to encourage medical staff to work for the trust.

Junior doctors we spoke with confirmed they felt supported and encouraged by consultants, and felt included in decision making. We saw medical staff were involved in patient first huddles that took place on the wards we visited.
Vacancy rates

From May 2017 to April 2018, the trust reported a vacancy rate of 15% in surgery. This was higher than the trust target of 10.5% in March 2018, reducing incrementally to 9.0% by March 2019.

The breakdown by site was as follows:

- Princess Royal Hospital: 24.1%
- Royal Sussex County Hospital: 11%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From May 2017 to April 2018, the trust reported a turnover rate of 4.2% in surgery. This was better than the trust’s overall target turnover rate of 14% in March 2018 reducing incrementally to 11% by March 2019.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From May 2017 to April 2018, the trust reported a sickness rate of 0.8% in surgery. This was better than the trust overall target sickness rate of 4.20% in March 2018 reducing incrementally to 3.50% by March 2019;

A site level breakdown is shown below:

- Princess Royal Hospital: 0.0%
- Royal Sussex County Hospital: 0.4%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

From April 2017 to March 2018, the trust reported that 4,119 shifts within this core service trust-wide were filled by bank staff and 1,025 shifts were filled by locum staff. There were 675 shifts which were not filled by either bank or locum staff. A breakdown of bank and locum usage by staff type at the trust is shown below.

Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
<th>Unfilled shifts</th>
<th>Total shifts (bank + locum + unfilled)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>658</td>
<td>525</td>
<td>42</td>
<td>1,225</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>2,842</td>
<td>492</td>
<td>559</td>
<td>3,893</td>
</tr>
<tr>
<td>Junior</td>
<td>619</td>
<td>8</td>
<td>74</td>
<td>701</td>
</tr>
<tr>
<td>Total</td>
<td>4,119</td>
<td>1,025</td>
<td>675</td>
<td>5,819</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)
Staffing skill mix

In March 2018, the proportion of consultant staff reported to be working at the trust was the same as the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the whole time equivalent staff working at Brighton and Sussex University Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>49%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career</td>
<td>5%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>39%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>7%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff kept appropriate records of patient care and treatment. Records were available to all staff providing care, however, we did find some inconsistencies. We looked at 18 patient records and found they contained patient reviews, referrals to and from other clinicians and clear treatment plans. All entries of patient’s recent admissions were signed, dated and timed by staff. There was clear recording from physiotherapists and occupational therapists. We found up to date and completed risk assessments and saw they were reviewed regularly.

We reviewed 18 patient records during inspection. The records we looked at were generally found to be accurate, fit for purpose. However, we did find some inconsistency with filing of documents across the wards, which meant patient records were not straightforward to read.

Patient medical records were paper-based. At the time of inspection, we saw patient personal information and medical records were managed safely and securely, in line with the Data Protection Act 1988. Records contained information relating to current and past admissions.

Medical notes were kept in locked trolleys outside of bays, and contained all admission assessment documentation and contemporaneous medical notes. Both medical and nursing staff wrote in patients’ medical notes. This is in line with National Institute for Health and Care Excellence (NICE), quality standard (QS) 15, statement 12, patient experience in adult services, which says health and social care professionals should ensure they support coordinated care through clear and accurate information exchange.
Operating registers were checked and were fully completed and legible with information about the patient, procedure carried out and time in and out of theatre.

Nursing risk assessments and care records, such as observations charts, and fluid balance charts, were placed in a folder at the end of the patient’s bed, along with the patient’s medication chart.

Patient medical records showed where staff had completed patient risk assessment. These included risk assessments for falls, malnutrition, pressure ulcers, and risk of developing a blood clot. All risk assessments were completed and reviewed regularly. For example, all patients were risk assessed on admission for their risk of developing a type of blood clot called, venous thromboembolism (VTE). This was in line with the National Institute for Health and Care Excellence (NICE), quality standard three, statement one.

Staff told us discharge information was communicated electronically to a patient’s General Practitioner (GP) as soon as the patient was discharged. We looked at three patient discharge forms and saw they were clear and informative. This meant patients could receive continuity of care after discharge within the community.

**Medicines**

We saw medicines were stored securely and handled safely. On the wards we visited we saw the medicines were stored in locked rooms. Only authorised staff had access via a key pad entry system, which was changed regularly. Regular code changes will make sure that the locks remain an effective tool for restricting access. In the rooms, medicines were stored in locked cupboards. Where medicine trolleys were unused we found them locked and secured to the wall, when not in use.

There were systems in place to check for out of date medicines. Staff told us every week a member of staff checked the medicines to make sure they were all in date. During our inspection we looked at a random selection of medicines across the wards and theatres we visited and found all medicines were within their expiry date.

Controlled drugs, such as morphine, are a group of medicines liable for misuse that require special management. All controlled drugs were kept securely in suitable double locked cupboards, which were bolted to the wall, access to them was restricted. The keys to the controlled drug cupboard were kept with a registered nurse at all times.

We looked at the controlled drug register on the wards and in theatres and saw they were fully completed, had the correct balance recorded and dated with two staff signatures.

Appropriate medicines were stored in dedicated medicine fridges, records showed daily temperature checks were undertaken. This provided assurance the ward or department stored refrigerated medicines within the recommended temperature range to maintain their function and safety. We also saw recommended actions to be taken if the fridge temperatures were not in the correct range. We also checked the records for the ambient temperatures of the treatment room, where medicines were stored, which showed these had been completed correctly.

A copy of the national formulary was accessible to staff within the surgery division to support prescribers. The national formulary provides guidance on prescribing, monitoring, dispensing, and administering medicines, as well as uses, cautions and side effects.

Processes were in place to ensure the safe issue of medicines at the point of a patient’s discharge. We saw staff checking medicines before giving them to patients. Staff told us they would go through the medication with patients and relatives, if appropriate, to make sure they were aware how they were to be taken.
We checked intravenous fluids and found them to be in date and intact. This was in line with National Institute for Health and Care Excellence (NICE), clinical guidance (CG) 174, intravenous therapy in adults in hospital.

We reviewed six prescription charts during our inspection and found all six were legible. All prescriptions were signed and dated, and allergies were recorded. In addition, we saw before medication was administered to patients nursing staff would check the patient’s name, date of birth and if they had any allergies. We saw they waited with the patient while they took the medication before signing as given. This is in line with Nursing and Midwifery Council (NMC) Standards for medicines management, which says ‘you must be certain of the identity of the patient to whom the medicine is to be administered’ and ‘you must check that the patient is not allergic to the medicine before administering it’.

There were processes in place for the stewardship of antimicrobials (drugs used to treat infections due to bacteria, viruses or fungi). We looked at six drug charts of patients who had been prescribed antimicrobial treatment. All prescriptions were signed and dated, and allergies were recorded. In addition, 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. However, in only three of the six reviewed was a microbiological sample taken to identify the cause of the infection. This meant that the incorrect antimicrobial may be used and increase the risk of antimicrobial resistance, which is when antimicrobial medicines lose their effectiveness. This was not in line with National Institute for Health and Care Excellence (NICE) quality standard (QS), 121, statement 4, microbiological samples.

**Incidents**

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 September 2017 and August 2018, there were 1,784 incidents reported by the surgical division at Brighton and Sussex University Hospital NHS Trust. Of these, 716 were reported at the Princess Royal Hospital (including the Sussex Orthopaedic Treatment Centre) site. The biggest category was low harm, minimal impact, which accounted for 498 incidents, followed by low harm, (139). No harm, impact prevent accounted for 70 incidents and moderate nine. The top three themes were staffing, facilities and environment (102), treatment and procedure (95) and patient accident (88).

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 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 were told of actions that had been put in place following a recent never event that had happened.
Staff described the principle and application of duty of candour, Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which 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. Patients and their families were told when they were affected by an event where something unexpected or unintentional had happened.

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. For example, the urology and trauma and orthopaedic directorates discussed their mortality and morbidity issues in their monthly clinical governance meetings. The perioperative directorate used its perioperative quality, safety and patient experience meetings to discuss their cases. 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 July 2017 to June 2018, the trust reported one incident classified as a never event for surgery. This was a surgical/invasive procedure incident meeting SI criterion.

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

The never event occurred in the urology directorate at the Princess Royal Hospital site on 15 December 2017. We looked at the investigation of the incident, and saw evidence that the duty of candour regulation had been applied. We saw the consultant had met with the patient the next day and explained what had happened and apologised for the error. We saw an in-depth investigation had been undertaken, which had identified the root causes, and recommendations that should be put in place to prevent the same thing from happening again on another patient, and arrangements for sharing the learning with staff. We saw an action plan had been developed, with a lead for each action and had been completed within the required timescales.
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 13 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from July 2017 to June 2018.

Of these, the most common types of incident reported were

- Slips/trips/falls meeting SI criteria with eight (62% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with 2 (15% of total incidents).
- Treatment delay meeting SI criteria with one (8% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (8% of total incidents).
- HCAI/Infection control incident meeting SI criteria with one (8% of total incidents).
- All other categories with zero (0% of total incidents).

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Brighton and Sussex University Hospitals NHS Trust
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 ten days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported eight new pressure ulcers, ten falls with harm and 15 new catheter urinary tract infections from July 2017 to July 2018 for surgery.

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

During the inspection we saw that safety thermometer information was displayed on noticeboards for staff, patients and visitors to see. The information was kept up to date to keep patients and visitors informed about the 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.

Safety thermometer data also formed part of the metrics dashboard for each ward, so they could see how they were performing in each area, where they were in comparison to the trust average for the month, monitor trends, improve and make changes to practice. For example, the ward manager on Twineham ward explained they had not had a fall since 21 August 2018 (five weeks), they had worked together with staff, and physiotherapists to put in place simple actions to prevent a patient from falling. These included, making sure all patients wore anti-slip socks when mobilising and a ‘this is how we mobilise’ introduced at the bedside, so if a member of staff was unfamiliar with the patient they could see easily how they mobilised.
Is the service effective?

Evidence-based care and treatment

The use of guidelines ensured patients received treatment that was in line with the latest evidence-based guidance. Guidelines were available on the intranet for staff to review at the point of care.

Care and treatment on the ‘enhanced recovery programme’ encouraged patients to participate actively in their preparation and recovery by promoting early mobilisation, healthy eating, and reducing drinking of alcohol. For example, hip and knee replacements. This helped to ensure a shorter recovery time. We saw the discharge process started during the pre-assessment appointment. This meant any support a patient may require was organised in advance.

Staff assessed patients for the risk of venous thromboembolism (VTE) and took steps to minimise the risk where appropriate, in line with the venous thromboembolism in adults: reducing the risk for patient in hospital National Institute for Health and Care Excellence (NICE), quality standard (QS) 3, statement 5.

National Institute for Health and Care Excellence (NICE), clinical guidance (CG) 65, for hypothermia: prevention and management in adults having surgery was followed, the patient’s temperature was monitored within an hour of going to theatre, in the anaesthetic room and then every 30 mins if the operation took longer than 30 mins. This is important as keeping patients warm lowers the risk of complications following surgery.

We saw patients’ observations, including patients’ temperatures and pulse rates, were recorded appropriately in patient’s records. This was in accordance with National Institute for Health and Care Excellence (NICE), clinical guidance (CG) 50, ‘Acutely ill patients in hospital - recognising and responding to deterioration’.

Staff in pre-assessment, reviewed patients’ physical, mental health and social needs holistically, this started at the pre-assessment stage. For example, staff obtained information about patient’s social care needs and abilities with activities of daily living (ADL) to facilitate discharge planning.

The surgical directorate carried out sepsis screening which was managed in line with national guidance. The sepsis screening was part of the care bundles and had been updated to reference ‘sepsis six’. Sepsis six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. Sepsis six consists of three diagnostic and three therapeutic steps, all to be delivered within one hour of the initial diagnosis of sepsis.

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 unit e on the trust’s intranet, and staff we spoke to were aware of it and knew how to find the policy. Staff we spoke with had received annual training on sepsis, including the use of sepsis screening tools and use of the care bundle.

We observed staff handovers during our inspection. The handovers were structured and referred to the psychological and emotional needs of patients, as well as their relatives / carers.

Doctors provided consistency in care for their patients and reviewed patient conditions regularly. Consultants covered patient intakes for a week at a time in some surgical care division services. Patients in acute areas were reviewed by consultant led ward rounds daily seven days a week.

The surgical division contributed to national audits and used the information to identify and act on areas for improvement.
Nutrition and hydration

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 10 nutrition screening tools and saw all 10 were fully completed.

Ward managers undertook malnutrition universal screening tool audits monthly. For example, on Newick ward the screening tool was completed 100% of the time in line with National Institute for Health and Care Excellence guidance, for May, June, July and August 2018. In September 2018, this had dropped to 86.6%, but was still above the trust average for this month.

Staff assessed patient’s vomiting and nausea after their surgery. Medication could be given to relieve symptoms if necessary. We saw this was recorded in the notes and in the medication charts. Patients were given anti sickness medicine intravenously in the recovery area if they complained of feeling nauseous post operatively.

Staff had access to an up to date Nutrition and Hydration policy. This included, assessment tools, food record charts and guidance on diets and supporting patients with dietary choices. Across the trust food and drink was available twenty-four hours a day.

Protected mealtimes were in place across the hospital. Protected mealtimes encouraged the hospital to stop all ‘non-urgent’ clinical activity on ward during mealtimes. This meant patients could eat their meals without being interrupted, and allowed staff to assist those who needed it. During our inspection, we saw staff assisting patients with their meals, or helping to position them in chair, to make them more comfortable to be able to eat.

On the wards we saw that patients always had access to water or other drinks and these were within their reach. Patients told us the food was ‘adequate’, but if they were in for more than a week, the choice became repetitive. Two patients told us they would have liked information on protected meal times, to have been given to them at pre-operative assessment, so they knew when to expect their meals and could inform their visitors.

Dietitians were available to support patients with nutritional advice, if needed. Speech and language therapists (SALT), were available if a patient needed help with eating and drinking. The trust used special feeding and hydration techniques when necessary. The service adjusted for special dietary requirements, such as diabetics, lactose intolerance or soft/pureed diet.

There were systems in place to make sure patients were nil by mouth prior to undergoing a general anaesthetic. Pre-assessment staff gave patients information about fasting both verbally and in writing. For example, patients were told not to eat for six to eight hours before a general anaesthetic. However, the amount of time a patient was kept nil by mouth was not always kept to a minimum. We spoke with one patient at 2pm, who had not had anything to eat or drink since 6 am. This is not in line with, Royal College of Anaesthetists’ guidance on fasting before surgery, which states that food can be eaten up to six hours and clear fluids consumed up to two hours before surgery. However, the patient did have an intravenous (IV) infusion of fluids, to prevent them from becoming dehydrated.

The service did not undertake fasting audits to monitor compliance with the fasting guidance to make sure patients are not routinely starved longer than necessary.

Patients undergoing day surgery were offered light refreshments and drinks prior to discharge.
Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. Pain was risk assessed and recorded using the National Early Warning Score (NEWS) scale and we saw these were completed. We observed staff asking patients if they were in any pain.

Patients said they were asked if they were in any pain usually during most interactions with staff, and offered patient relief quickly when they reported pain. We observed staff discussing pain during handovers and concerns were referred to the consultant.

There were different methods of managing patient’s pain. Pain relief was given by mouth (oral), injection, suppositories, epidural and patient controlled analgesia (PCA).

Some surgical patients received intravenous patient-controlled pain relief post-operatively. This was in line with national best practice guidance from the British pain society.

The service undertook a Patient Controlled Analgesia (PCA) Pump Audit in May 2018. The audit showed improvements had been made in all areas from the previous audit, including the recording of observations, recording of the rate of breathing and reasons for when observations had not been recorded. Actions have been put in place for any areas that fell below the required level, and a re-audit planned for 2019.

The service undertook an epidural (an injection into the back, which produces a loss of sensation below the waist) re-audit in December 2017, which demonstrated poor compliance with the trust’s epidural policy. For example, half-hourly observation for the first five hours were completed for 16% of the time, hourly observation for the first five hours were completed for 50% of the time, vital signs observations following a rate change was completed in 48% of the cases. Actions have been put in place for any area that fell below the required level, and a re-audit planned.

During our inspection, we found one patient who had, had an epidural as pain relief. We saw the records were mainly complete and in line with trust policy. Apart from observation recorded after the epidural had been removed. The patient had been reviewed by the trust pain team.

Patient outcomes

The service took part in national audits, such as the elective surgery Patient Reported Outcome Measures (PROMs) programme and the National Emergency Laparotomy Audit. Patient Reported Outcome Measures (PROMs) were reviewed by the clinical lead for the relevant speciality. The hospital benchmarked patient outcomes with other trusts to improve patient care. Action plans were in place to improve areas in the audit that were not at the required level.

Staff we spoke with told us that significant work had been undertaken to address sepsis performance including additional training and internal auditing. The trust also participated in the Commissioning for Quality and Innovation (CQUIN) framework. The Commissioning for Quality and Innovation (CQUIN) framework encourages care providers to share and continually improve care, how it is delivered and to achieve transparency and overall improvement in healthcare. This made sure of a better experience, involvement, and outcomes to patients.

We saw the service participated in the reducing the impact of serious infection Commissioning for Quality and Innovation (CQUIN) and that the trust had an action plan in place to make sure patient care was delivered in line with evidence-based guidance, standards and best practice.

We saw the trust had an incrementally rising target, over the four quarters of 2018 to 2019, to achieve 100% compliance with the CQUIN. The latest data indicated that they achieved senior review of antibiotics prescribed (element one) 97% of the time. A review of the antibiotics between
24-72 hours of prescribing (element two) in 78% of the cases. For element three, a reason for continuing intravenous administration was documented in 87% of the time. This meant the trust had a CQUIN compliance of 75%, this was against a trust target of 25%, for the first quarter.

There were nursing audits undertaken by the department that fed into monitoring patient outcomes such as recording of pain, pressure ulcers, hand hygiene, and falls.

**Trust level**

From April 2017 to March 2018,

- All patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
- Colorectal surgery patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
- Urology patients at the trust had a similar expected risk of readmission for elective admissions when compared to the England average.
- Trauma and orthopaedics patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

**Elective Admissions – Trust Level**

![Elective Admissions Chart]

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity*

- All patients at the trust had a similar expected risk of readmission for non-elective admissions when compared to the England average.
- Colorectal surgery patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at the trust had a similar expected risk of readmission for non-elective admissions when compared to the England average.
- Neurosurgery patients at the trust had a higher expected risk of readmission for non-elective admissions when compared to the England average.
Non-Elective Admissions – Trust Level

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

(Source: Hospital Episode Statistics - HES - Readmissions (01/04/2017 - 31/03/2018))

Princess Royal Hospital

From April 2017 to March 2018,

- All patients at Princess Royal Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.
- Urology patients at Princess Royal Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.
- Colorectal surgery patients at Princess Royal Hospital had a similar expected risk of readmission for elective admissions when compared to the England average.
- Trauma and orthopaedics patients at Princess Royal Hospital had a similar expected risk of readmission for elective admissions when compared to the England average.

Elective Admissions - Princess Royal Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity

- All patients at Princess Royal Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at Princess Royal Hospital had a similar expected risk of readmission for non-elective admissions when compared to the England average.
- Urology patients at Princess Royal Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Colorectal surgery patients at Princess Royal Hospital had a higher expected risk of readmission for non-elective admissions when compared to the England average.
Non-Elective Admissions - *Princess Royal Hospital*

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

**Sussex Orthopaedic Treatment Centre**

From April 2017 to March 2018,

- All patients at Sussex Orthopaedic Treatment Centre had a lower expected risk of readmission for elective admissions when compared to the England average.
- Trauma and orthopaedics patients at Sussex Orthopaedic Treatment Centre had a lower expected risk of readmission for elective admissions when compared to the England average.

**Elective Admissions - Sussex Orthopaedic Treatment Centre**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

- All patients at Sussex Orthopaedic Treatment Centre had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at Sussex Orthopaedic Treatment Centre had a lower expected risk of readmission for non-elective admissions when compared to the England average.
Non-Elective Admissions - Sussex Orthopaedic Treatment Centre

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

National Hip Fracture Database

In the 2017 National Hip Fracture Database, the risk-adjusted 30-day mortality rate was 4.2% which was better than expected. The 2016 figure was 4.4%.

The proportion of patients having surgery on the day of or day after admission was 83.1%, which failed to meet the national standard of 85%. This was within the top 25% of trusts. The 2016 figure was 81.7%.

The perioperative medical assessment rate was 95.9%, which failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 95%.

The proportion of patients not developing pressure ulcers was 99.1%, which failed to meet the national standard of 100%. This was within the top 25% of trusts. The 2016 figure was 98.7%.

The length of stay was 16.4 days, which falls within the top 25% of trusts. The 2016 figure was 19.5 days.

(Source: National Hip Fracture Database 2017)

Bowel Cancer Audit

In the 2017 Bowel Cancer Audit, 63.9% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than expected. The 2016 figure was 66.7%.

The risk-adjusted 90-day post-operative mortality rate was 9.9% which was a negative outlier. The 2016 figure was 5.0%.

The risk-adjusted 2-year post-operative mortality rate was 33.7% which was worse than expected. The 2016 figure was 28.0%.

The risk-adjusted 30-day unplanned readmission rate was 12.0% which was within the expected range. The 2016 figure was 9.0%.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 66.7% which was worse than expected. The 2016 figure was 66.9%.

(Source: National Bowel Cancer Audit)
**National Vascular Registry**

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 1.1% for Abdominal Aortic Aneurysms. The 2016 figure was 1.0%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 12 days, better than the audit aspirational standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was 0%, this was within the expected range.

(Source: National Vascular Registry)

**National Oesophago-Gastric Cancer Audit**

In the 2016 National Oesophago-Gastric Cancer Audit, the age and sex adjusted proportion of patients diagnosed after an emergency admission was 3.7%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2015 figure was 2.2%.

The 90-day post-operative mortality rate was 4.6%. The 2015 rate was 4.8%.

The proportion of patients treated with curative intent in the **Strategic Clinical Network** was 40%. This was similar to the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

**National Emergency Laparotomy Audit**

The national Emergency Laparotomy audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80% and red ratings indicate performance under 50%.

In the 2016 National Emergency Laparotomy Audit (NELA), Royal Sussex County Hospital achieved a green rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 219 cases.

The site achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 172 cases.

The site achieved an amber rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 120 cases.

The site achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 87 cases.

The risk-adjusted 30-day mortality for the site was within the expected range based on 219 cases.

(Source: National Emergency Laparotomy Audit)
Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17 performance on groin hernias was worse than the England average.

For varicose veins, performance was about the same as the England average.

For hip replacements, performance was worse than the England average.

For knee replacements performance was worse than the England average.

(Source: NHS Digital)
Competent staff

Appraisal rates

From May 2017 to May 2018, 82% of staff within this core service at the trust received an appraisal compared to a trust target of 78%. The trust target is correct at March 2018 as they have commented that the target will increase incrementally to 90% by June 2018. Below is a split of appraisal completion rate by staff group.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals complete</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>15</td>
<td>13</td>
<td>87%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>260</td>
<td>222</td>
<td>85%</td>
</tr>
<tr>
<td>Medical &amp; dental</td>
<td>361</td>
<td>305</td>
<td>84%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>607</td>
<td>492</td>
<td>81%</td>
</tr>
<tr>
<td>(Qualified nurses)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>60</td>
<td>45</td>
<td>75%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>19</td>
<td>11</td>
<td>58%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>6</td>
<td>3</td>
<td>50%</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>11</td>
<td>5</td>
<td>45%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>1339</strong></td>
<td><strong>1096</strong></td>
<td><strong>82%</strong></td>
</tr>
</tbody>
</table>

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

Staff training and professional development needs were identified through informal one to one meetings with their managers and annual appraisals. During appraisals, personal development individual goals were agreed. At our last inspection we saw improvement on the overall appraisal rate for all staff, however it is currently below the trust target of 90%.

Data supplied to us by the trust, during inspection, showed the overall compliance rate for appraisals within the surgical division as of September 2018, was 95%, which is above the trust target of 90% introduced in June 2018. Staff told us the process was useful and worthwhile.

We observed that staff were professional and competent in their interactions with colleagues, patients, and their relatives/carers on this inspection. Patients we spoke with told us they felt staff were appropriately trained and competent to provide the care they needed.

Nursing staff and health care assistants (HCA’s) could describe ways in which they managed and cared for patients living with dementia or learning disability, in line with National Institute of Health and Care Excellence (NICE) guideline (NG) 11. Nursing staff had received all relevant or required training to support their role. Healthcare assistants were completing the care certificate qualification and relevant competencies were being developed. Staff told us there were plenty of development opportunities within theatres.
Training and educational development was embedded in the surgical division. Staff we spoke with told us they completed competency assessment to make sure they had the skills and knowledge to carry out the roles they were employed to do. Regular study days were provided and staff said they were encouraged to undertake continuing professional development, to support revalidation and progress in their careers.

All ward areas had the support of a clinical practice educator and staff told us this supported them in developing their skills and knowledge. Practice educators kept a record of staff development which included courses and conferences attended. Practice educators met monthly at the practice development forum. The trust wide nurse educator, told us they were working with the local university to create some bespoke courses that could be offered at the trust, and count toward staff continuing practice development or education certificates, such as contributing toward a degree. For example, anaesthetic course, or the surgical first assistant course.

All new staff completed a trust wide and local induction programme. Trust wide included an introduction to the trust, how and where to access policies. The local induction included department tours, introduction to colleagues and completion of induction documentation. Nursing staff we spoke with confirmed they had received both a local and trust wide induction. However, we spoke with three locum doctors, who told us they had received their trust wide induction, but had not been given a local orientation or induction. This meant, not all staff had the correct information or competencies to do their role.

Link nurses received extra training in specific areas. For example, there were link nurses for falls who had extra training and spent time with the falls lead nurse, and infection prevention and control link nurses who attended an update study day every year.

Surgical staff had received training to care for and resuscitate patients in a medical emergency. Data supplied to us by the trust showed that 93% of staff had, had basic life support training, which was above the trust target of 90%. Most wards were above the trust target except for Newick ward (86%) and Theatres (89%).

Junior doctors (foundation years one and two) are required to prove they have up to date intermediate life support. This is recorded and monitored via their electronic portfolio system.

The trust measured comparative outcomes by consultant. This meant the trust would be able to identify any deterioration in consultant performance and provide additional training or support.

Multidisciplinary working

We observed staff worked well together during our inspection. Nurses, healthcare assistants and doctors spoke of teamwork and joint working and the way in which it enhanced good working relations as well as improved patient safety.

They also worked well with multidisciplinary teams within the hospital and with other outside services to provide the best care. The pre-assessment ward manager told us one of the things they were most proud of was their team’s ability to work collaboratively with other teams and services, to make the patient’s admission safe.

For example, we saw a daily multidisciplinary meeting, was well attended by consultant, ward manager, physiotherapists, occupational therapist and discharge coordinator. The meeting reviewed each patient holistically, considering any medical or nursing concerns, mobilisation issues, and palliative care or end of life care. Discharge planning was embraced through early
planning, and took account of patient’s social and cultural needs when deciding on how to progress their treatment to ensure continuity of care.

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. Staff worked hard as a team to ensure patient care was safe. All staff told us consultants were approachable and they felt comfortable asking them questions and raising concerns with them.

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.

There were daily ward rounds on all the surgical wards involving nursing and medical staff together with the physiotherapist and other therapist as required.

Our review of 18 patient records, talking with 32 members of staff and 12 patients, 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.

The preoperative assessment nurses liaised with anaesthetists, surgeons and ward staff to coordinate pre-operative investigations, including confirming what assessments were needed and following up the communication once results were known.

Theatre staff had a daily morning brief, which ensured all staff had up to date information about issues with scheduling or cancellations, risks or concerns.

Seven-day services

The service was working toward seven-day services in line with National Health Service Improvements (NHSI), Seven-day services in the NHS. We saw in the trust operational plan 2018-2019, that they plan to deliver the Seven Day Service standards for all admitting specialities by 2020. The seven-day services programme is designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital.

There was consultant presence seven days a week within surgery at the Princess Royal Hospital site. Registrars (a doctor who is receiving advanced training in a specialist field of medicine to become a consultant), were available 24 hours a day, to support junior doctors. Staff on the wards confirmed that surgical patients had a daily review from a clinician, seven days a week. We saw evidence of this in the notes that we looked at.

Theatres, anaesthetics and recovery staff had a rota in place to make sure an emergency theatre was available seven days a week for urgent operations.

Diagnostic services were available 24 hours a day, seven days a week. This allowed surgical 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).

Patients requiring elective surgery received a pre-operative assessment and appointment before their surgery. The pre-assessment service was available Monday to Friday at the Princess Royal site between 8.15am to 12pm and 1.30 pm to 3pm. Monday to Friday between 8.15 am to 12.45pm and 1.15 to 3.45pm at the Sussex Orthopaedic Trauma Centre. For patients requiring pre-assessment for vascular surgery, this was provided at the Royal Sussex County Hospital
Tuesday afternoons between 1.30 pm to 4.30 pm and Thursday mornings between 9.30am to 12.30pm.

Physiotherapy was provided to patients seven days a week.

Pharmacy services were available five days a week, Monday to Friday, between the hours of 9am to 5pm. The pharmacy was open on a Saturday between 9am to 12pm, for emergencies only, and was closed on a Sunday.

**Health promotion**

The service supported patients to live healthier lives. The enhanced recovery programme (ERP) provided patients with information on how they could ensure they were as fit for their procedure as possible. It reminded patients of the importance of eating a balanced diet, quitting smoking and reducing alcohol intake.

In addition, Patients having elective orthopaedic surgery attended a pre-operative “joint school”. This was an information session run by physiotherapists to help patients feel fully informed about their planned surgery and the subsequent recovery period. Physiotherapists demonstrated exercises and started patients on their exercise programmes pre-operatively with the aim of helping them recover more quickly after surgery.

Staff at pre-assessment explained that they would discuss with patients their operation, health and risks. This included information about diet, smoking and alcohol intake, this allowed staff to identify additional support or intervention for patients who may require it, and signpost patients as appropriate.

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

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

Mental Capacity Act (MCA) training was completed by 95% of staff in surgical services compared to the trust target of 90%.

A breakdown of completion rates for medical, dental, and nursing staff is shown below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate (%)</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing staff</td>
<td>155</td>
<td>175</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Additional data request (ADR) – 109)

All staff were required to follow the trust policy and procedure for consent. The policy was based on guidance issued by the Department of Health. This included information for staff on obtaining valid consent, and links to consent forms.

Data supplied to us by the trust showed the overall compliance training rate for Mental Capacity Act training for the surgical services was 95%, which was better than the trust target of 90%.

Staff demonstrated a good understanding of the legislation and best practice regarding consent, and we saw them follow this in practice. We observed multiple occasions where staff obtained
consent prior to examining or carrying out care and treatment on patients. Patients we spoke with, confirmed this.

Staff in pre-assessment told us, they took time to go through information about patient’s surgery with them. Patients we spoke with told us they had received information regarding the procedures they were undergoing verbally and in written form before surgery.

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.

We looked at nine written consent forms. We saw consultants had documented the risks and benefits of surgery, in line with the General Medical Council (GMC) guidance. However, on one of the forms, we found it contained medical terminology, which was not clear if it had been explained. Additionally, we found not all consent forms for elective surgery were signed before the day of surgery. This is not in line with guidance from the Royal College of Surgeons Good Surgical Practice 2014, which states staff should, “Obtain the patient’s consent prior to surgery and ensure that the patient has sufficient time and information to make an informed decision”.

Dementia and learning disability specialty nurses were available to offer advice and guidance on the Mental Capacity Act and Deprivation of Liberty Safeguards if required.

Staff across the wards told us they worked with family members at best interests’ meetings where patients lacked capacity, to get the best outcomes for patients.

**Is the service caring?**

**Compassionate care**

Patients were treated with dignity and respect. All staff we spoke with were very passionate about their roles and were dedicated to making sure patients received the best patient-centred care possible. Patients told us staff were caring, attentive, and professional.

Staff introduced themselves, and their role, and asked patients 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.

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

Staff respected patients’ privacy and dignity both on the wards and in theatres. We saw curtains were closed to hold private conversations or undertake procedures.

We saw how staff spoke to patients with respect and gave time for them to respond. This was particularly evident during meal times when patients, who needed help to eat and drink, were supported to maintain their dignity.

Patients with additional needs were supported by staff. We were told of how patients with conditions such as learning disabilities were treated with understanding. Patients with these conditions benefitted from being cared for in familiar surroundings and staff tried their best to ensure they were admitted to the same ward for their care if possible. For example, we were told about a patient, with learning disabilities, who found people in uniforms “scary”, they had nursed the patient in a side room and wore their own clothes to reduce the patient’s anxiety.
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.

In pre-assessment we were told of a patient who was extremely worried about their procedure, the ward manager described how they managed their concerns. This included, extending the appointment slots to make sure they had time, and the patient did not feel rushed. A dedicated member of nursing team was allocated to the patient so they always had the same point of contact if they were contacting or attending the pre-assessment unit.

Where possible staff made hospital feel as normal as possible, for example, we saw patients were encouraged to sit in a chair to eat their meals. On Twineham ward, the ward manager explained they encouraged patient’s relatives to bring in clothes to allow the patients to get dressed and not sit in a hospital gown, or night clothes. Patients confirmed this when we spoke with them.

Patients we spoke with said that staff answered buzzers quickly and during the inspection we did not hear buzzers ringing for long periods of time.

We spoke to 12 patients, relatives, or carers during our inspection. Patients we spoke with were positive about the way staff treated them. Patients told us staff were “brilliant”, “lovely”, “helpful” “caring”, and “can’t fault it”. In addition, surgical wards visited displayed many thank you cards, which they had received from patients and relatives.

**Friends and Family test performance**

The Friends and Family Test response rate for surgery at Brighton and Sussex University Hospitals NHS Trust was 24% which was worse than the England average of 26% in June 2018. A breakdown of response rate by site can be viewed below.

**Friends and family test response rate at Brighton and Sussex University Hospitals NHS Trust, by site.**
A breakdown by ward for wards with over 100 responses can be found below:

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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Newick Ward</td>
<td>1,127</td>
<td>38%</td>
<td>99%</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
<td>97%</td>
<td>100%</td>
<td>100%</td>
<td>98%</td>
<td>96%</td>
<td>95%</td>
<td>99%</td>
<td>98%</td>
<td></td>
</tr>
<tr>
<td>Pickford Ward (First Floor)</td>
<td>1,010</td>
<td>21%</td>
<td>89%</td>
<td>100%</td>
<td>100%</td>
<td>86%</td>
<td>97%</td>
<td>93%</td>
<td>93%</td>
<td>100%</td>
<td>99%</td>
<td>95%</td>
<td>93%</td>
<td>98%</td>
<td>95%</td>
</tr>
<tr>
<td>Ansty Ward</td>
<td>903</td>
<td>19%</td>
<td>97%</td>
<td>100%</td>
<td>98%</td>
<td>100%</td>
<td>97%</td>
<td>88%</td>
<td>100%</td>
<td>88%</td>
<td>98%</td>
<td>95%</td>
<td>93%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>L9A Level 9 Millennium Wing</td>
<td>680</td>
<td>25%</td>
<td>87%</td>
<td>86%</td>
<td>100%</td>
<td>84%</td>
<td>76%</td>
<td>95%</td>
<td>100%</td>
<td>94%</td>
<td>84%</td>
<td>86%</td>
<td>96%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Day Surgery Unit</td>
<td>584</td>
<td>38%</td>
<td>98%</td>
<td>98%</td>
<td>88%</td>
<td>100%</td>
<td>97%</td>
<td>95%</td>
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<td>97%</td>
<td>100%</td>
<td>99%</td>
<td>96%</td>
<td>97%</td>
<td></td>
</tr>
<tr>
<td>Albourne Ward</td>
<td>583</td>
<td>48%</td>
<td>100%</td>
<td>96%</td>
<td>95%</td>
<td>92%</td>
<td>93%</td>
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<td>100%</td>
<td>98%</td>
<td>81%</td>
<td>93%</td>
<td>90%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>L8A West Ward - Level 8 Millennium Wing</td>
<td>491</td>
<td>24%</td>
<td>91%</td>
<td>82%</td>
<td>98%</td>
<td>87%</td>
<td>100%</td>
<td>96%</td>
<td>100%</td>
<td>92%</td>
<td>87%</td>
<td>92%</td>
<td>75%</td>
<td>91%</td>
<td></td>
</tr>
<tr>
<td>SOTC Post-Anaesthesia Care Unit</td>
<td>327</td>
<td>53%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>HWP Surgical Unit - Day Case Ward</td>
<td>316</td>
<td>43%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>L7A Cardiac Surgery - Level 7 Millennium Wing</td>
<td>277</td>
<td>51%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>L8 Surgical Ward - Level 8 Thomas Kemp Tower</td>
<td>265</td>
<td>18%</td>
<td>90%</td>
<td>88%</td>
<td>85%</td>
<td>93%</td>
<td>100%</td>
<td>93%</td>
<td>92%</td>
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<td>94%</td>
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<tr>
<td>L8A East Ward - Level 8 Millennium Wing</td>
<td>214</td>
<td>27%</td>
<td>100%</td>
<td>78%</td>
<td>89%</td>
<td>100%</td>
<td>96%</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
<td>96%</td>
<td>100%</td>
<td>94%</td>
<td>100%</td>
<td>96%</td>
</tr>
<tr>
<td>Twineham Ward (1st Floor)</td>
<td>209</td>
<td>30%</td>
<td>88%</td>
<td>82%</td>
<td>100%</td>
<td>93%</td>
<td>90%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>83%</td>
<td>92%</td>
<td>94%</td>
<td>91%</td>
<td></td>
</tr>
<tr>
<td>Surgical Unit - Day Case Ward</td>
<td>190</td>
<td>24%</td>
<td>90%</td>
<td>89%</td>
<td>100%</td>
<td>97%</td>
<td>94%</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RSCH Theatre Admissions</td>
<td>129</td>
<td>43%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endoscopy Suite -</td>
<td>125</td>
<td>35%</td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

Note: The table shows the total number of responses and the percentage recommended for each month from July 2017 to June 2018, with an annual performance percentage at the bottom.
### Emotional support

Staff provided emotional support to patients, relatives, and carers to minimise their distress.

Patients we spoke with said they felt they could ask the staff anything and they always received answers and explanations about treatments. Patients were encouraged to ask questions and staff spent time with the patient answering them.

Staff told us they helped patients, who became distressed in an open environment. They maintained their privacy and dignity by taking them to a private room where they could voice their concerns and worries. Staff told us they would offer as much support as they could by listening to their patient’s worries or concerns.

Patients had access to support from clinical nurse specialists, such as the diabetes or stoma nurses, dementia specialists and Macmillan nurses. Staff understood the emotional stress of patients having surgery. For example, we observed staff in theatres being supportive and reassuring patients before their anaesthetic to reduce their anxiety.

Patients’ spiritual needs were considered irrespective of any religious affiliation or belief. Patients and staff could access the chaplaincy team who provided religious support 24 hours a day.

Debriefs were undertaken if staff had been in a difficult situation. Staff told us this provided support and a forum to talk openly, ask questions in a safe environment or express any concerns.

The service used the ‘forget-me-not’ scheme on its wards. This scheme supports patients with dementia and memory impairment. It aims to improve patient safety and wellbeing by teaching staff to offer a positive and appropriate response to people with memory impairment.
Understanding and involvement of patients and those close to them

We saw effective interactions between staff and patients. Patients told us they were kept informed and included in their care decisions and treatment.

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.

Patients we spoke with confirmed this and told us their care had been discussed with them. Patients 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.

All the patients spoken with could explain their procedure and they had received all relevant information during their pre-assessment appointment. Most were clear what was expected of them post operatively and the exercises, if applicable, they needed to do.

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. We were given an example where a ward had purchased small white boards to communicate with a patient, who was deaf.

The pre-assessment clinic, or the waiting list team (if they had previously attended the hospital), identified the communication needs of patients. This included access to language interpreters, specialist advice or teams, such as the learning disabilities team. This meant the service was compliant with the Accessible Information Standards (2015). These standards direct and define a specific and consistent approach to identifying, recording, flagging, sharing and meeting information and communication needs of patients, where those are related to a disability, impairment or sensory loss.

Carers were consulted about patient care when there was some form of dementia. They were asked to complete a ‘This is me’ booklet which was kept with patient care records for staff to review. The allowed staff to detail a person’s family background; events, people and places from their lives; dietary preferences, routines and their personality, and provided continuity of care. Use of the patient passport helped to reduce distress for the person with dementia and their carer and helped them to overcome problems with communication.

Is the service responsive?

Service delivery to meet the needs of local people

The surgery directorate provided both elective (planned) and non-elective (emergency) surgical treatment and procedures for patients. A range of elective surgical procedures were available to patients, some of which could be done as day cases.
There was a dedicated area where pre-operative assessments for elective surgery patients were undertaken. Patients who were booked for elective surgery had health checks prior to their operations to assess their fitness for surgery and screen for infections.

The service had systems and staff in place to aid the delivery of care to patients in need of additional support. For example, the trust had a learning disabilities team, that was visible and worked well with staff on the wards. The trust has various initiatives to allow patients to feel included and supported while they were in hospital. For example, on Twineham ward, we saw there were dedicated ‘dementia friendly’ bays for both male and female patients, used the ‘forget-me-not’ and ‘This is me’ passport.

An enhanced recovery programme was in place to support patients prior to, during and after their procedure. The aim of the programme was to:

- Make sure patients were as healthy as possible for their treatment or procedure
- Make sure patients received the best care during their procedure or treatment
- Encourage early mobilisation to avoid complications such as chest infections or pressure damage to their skin

The hospital has a significant redevelopment programme underway, as part of their 3T’s development. The 3T’s were teaching, trauma tertiary. The focus of development was at the Royal Sussex County Hospital site in Brighton, but we were told of development and improvements being made at the Princess Royal site. For example, the department manager in pre-operative assessment, told us they were redesigning the department to improve the flow and capacity. They added this made them feel valued and had improved staff morale as a result.

The hospital was well sign-posted from the main road, and was on a bus route. Patients and staff told us there were issues with parking, and sometimes it was difficult to find a space. Signposting around the hospital was poor, and made it difficult for people who were unfamiliar with the hospital to find their way around. We saw multiple visitors, and patients lost or unable to locate the ward or department they needed to find. This was an issue that we identified on our previous inspection.

**Average length of stay**

**Trust Level – elective patients**

From May 2017 to April 2018, the average length of stay for all elective patients at the trust was 4.6 days, which is higher compared to the England average of 3.9 days.

- For trauma and orthopaedics elective patients at the trust was 4.9 days, which is higher compared to the England average of 3.8 days.
- For colorectal surgery elective patients at the trust was 5.5 days, which is lower compared to the England average of 7.1 days.
- For urology elective patients at the trust was 2.4 days, which is as expected compared to the England average of 2.5 days.
Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

Trust Level – non-elective patients

The average length of stay for all non-elective patients at the trust was 7.5 days, which is higher expected compared to the England average of 4.9 days.

- The average length of stay for colorectal surgery non-elective patients at the trust was 6.2 days, which is higher compared to the England average of 4.4 days.
- The average length of stay for trauma and orthopaedics non-elective patients at the trust was 10.7 days, which is higher compared to the England average of 8.8 days.
- The average length of stay for neurosurgery non-elective patients at the trust was 8.5 days, which is lower compared to the England average of 13.1 days.

Non-Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

Royal Sussex County Hospital - elective patients

From May 2017 to April 2018 the average length of stay for all elective patients at Royal Sussex County Hospital was 7.4 days, which is higher compared to the England average of 3.9 days.

- The average length of stay for colorectal surgery elective patients at Royal Sussex County Hospital was 8.8 days, which is higher compared to the England average of 7.1 days.
- The average length of stay for cardiac surgery elective patients at Royal Sussex County Hospital was 9.2 days, which is as expected compared to the England average of 9.0 days.
- The average length of stay for Neurosurgery elective patients at Royal Sussex County Hospital was 5.6 days, which is higher compared to the England average of 5.0 days.
Princess Royal Hospital - elective patients

From May 2017 to April 2018 the average length of stay for all elective patients at Princess Royal Hospital was 3.2 days, which is as expected compared to the England average of 3.9 days.

- The average length of stay for Urology elective patients at Princess Royal Hospital was 2.4 days, which is as expected compared to the England average of 2.5 days.
- The average length of stay for colorectal surgery elective patients at Princess Royal Hospital was 2.1 days, which is lower compared to the England average of 7.1 days.
- The average length of stay for trauma and orthopaedics elective patients at Princess Royal Hospital was 11.1 days, which is higher compared to the England average of 3.8 days.

Elective Average Length of Stay - Princess Royal Hospital

Note: Top three specialties for specific site based on count of activity.

Princess Royal Hospital - non-elective patients

The average length of stay for all non-elective patients at Princess Royal Hospital was 9.9 days, which is higher compared to the England average of 4.9 days.

- The average length of stay for trauma and orthopaedics non-elective patients at Princess Royal Hospital was 14.9 days, which is higher compared to the England average of 8.8 days.
- The average length of stay for urology non-elective patients at Princess Royal Hospital was 3.3 days, which is lower compared to the England average of 2.9 days.
- The average length of stay for colorectal surgery non-elective patients at Princess Royal Hospital was 5.5 days, which is higher compared to the England average of 4.4 days.
Non-Elective Average Length of Stay - Princess Royal Hospital

Sussex Orthopaedic Treatment Centre - elective patients

From May 2017 to April 2018 the average length of stay for all elective patients at Sussex Orthopaedic Treatment Centre was 3.9 days, which is as expected compared to the England average of 3.9 days.

- The average length of stay for trauma and orthopaedics elective patients at Sussex Orthopaedic Treatment Centre was 3.9 days, which is as expected compared to the England average of 3.8 days.
- The average length of stay for spinal surgery service elective patients at Sussex Orthopaedic Treatment Centre was 3.0 days, which is lower compared to the England average of 4.1 days.

Elective Average Length of Stay - Sussex Orthopaedic Treatment Centre

Sussex Orthopaedic Treatment Centre - elective patients

The average length of stay for all non-elective patients at Sussex Orthopaedic Treatment Centre was 16.5 days, which is higher compared to the England average of 4.9 days.

- The average length of stay for trauma and orthopaedics non-elective patients at Sussex Orthopaedic Treatment Centre was 16.5 days, which is higher compared to the England average of 8.8 days.
Meeting people’s individual needs

Services were planned to take into account the individual needs of patients. Adjustments were made for patients living with a physical, or learning disability. The wards and departments we visited addressed the information and communication needs of patients with a disability or sensory loss.

There were arrangements in place for patients with complex health and social care needs. Patients’ individual needs were identified at pre-operative assessment. At every stage of their journey through the hospital, 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. Ortho-geriatricians provided junior doctors with support on the orthopaedic ward. Junior doctors told us, the patients they cared for tend to have complex needs.

Arrangements were in place for people living with a learning disability. All patients living with a learning disability were referred to the Disability Liaison Team, where information would be captured onto an electronic system for use when patients were admitted or treated. Staff confirmed they worked well with the disability team. Staff could give examples of adjustments they had made to make sure the patient’s admission was as stress-free as possible.

At pre-operative assessment, double appointment slots were booked for patients with additional needs. For example, patients living with dementia or mental health conditions. Staff could also request a member from these specialist nursing teams to attend appointments with patients.

The trust had a named dementia lead, staff confirmed they were readily available to discuss any concerns and to receive advice.

The ‘forget-me-not’ scheme was used to identify patients living with dementia. Twineham ward had two six bedded bays (male and female) dedicated for those patients living with dementia. Nursing staff would be allocated to these bays, which allowed more intensive care to be provided to ensure these patients were safe. ‘This is me’ documents were used which allowed staff to provide individualised care to patients. These documents included information about patients’ likes and dislikes, eating and drinking preferences, special requirements and personal information, such as information about family and pets.

Bariatric equipment was readily available for patients, who may require it. Pre-operative assessment staff liaised with ward and theatre staff, to inform them of a bariatric patient. 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.
Wards protected patient’s mealtimes to make sure they could eat their meals without interruption. Medicines were not routinely given out during meal times. We saw there was a choice of food options for patients, which took into account patient preferences, religious or cultural needs, such as vegetarian, vegan or kosher meals. This was in line with the National Institute for Health and Care Excellence (NICE), quality standard 15, statement 10.

The service was accessible by patients with a physical disability. We saw there were dedicated disabled toilets, throughout the hospital, wards and departments. There were bathrooms on wards that has easy access showers, with no steps, and had handrails and stools in place to provide extra support and stability when showering.

The trust used a wide range of communication support services for patients at the hospital including face-to-face interpreting for patients for who English was not their first language. Staff we spoke with told us they could access translation services from the trust’s intranet when necessary. This included communication support for patients with sensory loss or impairment, such braille and British sign language.

**Access and flow**

During our inspection the theatre lists ran mostly on time. The inspection did not highlight any concerns relating to the admission, transfer, or discharge of patients from the ward or theatres. The patients we spoke with did not have any concerns in relation to their admission, waiting times, or discharge arrangements.

The trust supplied us data on surgical bed occupancy rates for the months of June, July and August 2018, which showed they had an occupancy between 81.3% and 85.7%, with an average of 83.8%. The National Audit Office has suggested that hospitals with average bed occupancy levels above 85% can expect to have regular bed shortages, periodic bed crises and increased numbers of health care-acquired infections.

We saw medical outliers (medical patients on non-medical wards) on the surgical wards we visited. Staff told us that surgical beds were often used for medical patients, due to a shortage of medical beds within the hospital. Ward managers told us there were criteria for which medical patients could be admitted to the wards. They also told us that the number of beds available was predicted the day before, which allowed them time to review capacity, and request support from other wards. The theatre manager confirmed cancelations are kept to a minimum, the main delays are due to waiting for a bed in either the intensive therapy unit (ITU) or high dependency unit (HDU).

If patients are cancelled due to operations over running, theatres would inform the wards, so they could speak to the patients. Once the consultant has finished in theatre they will come to the wards, to discuss any concerns or issues as a result.

The service monitored theatre utilisations rates weekly via an electronic theatre management system. Between September 2017 and August 2018, theatre utilisation ranged between 69.9% and 77.6%. Theatre utilisation rates were monitored to make sure the theatre was used efficiently.
At the last inspection all specialities referral to treatment times (RTT) were below the England average. The trust stated that measures would be put in place to eliminate 52-week waiters. The surgical services achieved this in July 2018.

For example, in our last inspection we required the trust should continue to work on reducing the waiting list for specific colon surgery, as we identified patients awaiting of reversal of stomas (a surgical procedure in which an opening (stoma) is formed by drawing the healthy end of the large intestine or colon through an incision in the anterior abdominal wall and suturing it into place). The trust undertook an audit and there were 70 patients on the waiting list, of whom 25 were waiting longer than 52-weeks. Additionally, 54% of those patients on the waiting list developed either physical or psychological complications. As of June 2018, 72 reversals have been undertaken, with 31 patients remaining on the waiting list. The longest wait for a reversal is 45 weeks.

We found at that inspection, as of March 2017 the overall 18-week referral to treatment (RTT) had improved to 84% which was still below the trust target of 92%. Data supplied to us by the trust showed that two specialties (trauma & orthopaedics and ophthalmology) were better than England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery. The remaining six specialities were either similar to, or worse than the England average.
Referral to treatment (percentage within 18 weeks) - admitted performance

From July 2017 to June 2018 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was about the same as the England average.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Two specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and orthopaedics</td>
<td>80.5%</td>
<td>60.4%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>69.4%</td>
<td>69.0%</td>
</tr>
</tbody>
</table>

Seven specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>74.9%</td>
<td>76.8%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>65.1%</td>
<td>70.3%</td>
</tr>
<tr>
<td>ENT</td>
<td>63.0%</td>
<td>63.2%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>58.8%</td>
<td>60.5%</td>
</tr>
<tr>
<td>General surgery</td>
<td>58.6%</td>
<td>72.7%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>56.9%</td>
<td>79.8%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>0.0%</td>
<td>81.4%</td>
</tr>
</tbody>
</table>
Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Over the two years, the percentage of cancelled operations at the trust showed no correlation against England average but an improvement from Q1 2017/18.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Brighton and Sussex University Hospitals NHS Trust**

![Graph showing percentage of patients whose operation was cancelled and were not treated within 28 days.]

**Cancelled Operations as a percentage of elective admissions - Brighton and Sussex University Hospitals NHS Trust**

![Graph showing cancelled operations as a percentage of elective admissions.]

Over the two years, the percentage of cancelled operations at the trust showed better performance than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)
Learning from complaints and concerns

Summary of complaints

From April 2017 to March 2018 there were 120 complaints about Surgical Care. The trust took an average of 51 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be closed within 40 days.

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of complaints</th>
<th>Average days to close</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Sussex County Hospital</td>
<td>95</td>
<td>54</td>
</tr>
<tr>
<td>Princess Royal Hospital</td>
<td>18</td>
<td>45</td>
</tr>
<tr>
<td>All other sites</td>
<td>7</td>
<td>26</td>
</tr>
</tbody>
</table>

Most complaints (48%) were related to access to treatment or drugs.

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

Number of compliments made to the trust

From April 2017 to March 2018 there were 260 compliments within surgery.

A breakdown by site is shown below.

- Princess Royal Hospital: 52 compliments
- Royal Sussex County Hospital: 164 compliments
- Other sites: 44 compliments

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

The trust had a process for categorising and handing complaints and concerns. Patients could make a complaint in three ways, face to face, via the telephone, by either email or letter. The trust had a policy for the management of complaints. Senior staff were aware that response time for complaints was currently outside the complaints guidelines and were meeting weekly to improve this.

Staff could describe how they would deal with a complaint; staff told us they would always try to resolve any issues immediately. If issues could not be resolved, the patient, relatives or carer was directed to the complaints process. Staff were aware of any complaints made about their own ward or department and any subsequent learning. 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.

Complaints did not always go directly to the department. Complaints received via the patient advice liaison services (PALS) or directly to the complaints team, were allocated to a case manager who acknowledge the complaint within three working days, either by telephone, letter or email and remained the single point of contact for the patient, relative or carer and the department lead.
The complaint was investigated by a designated clinical lead for the department, who drafted a response, which was then reviewed by the allocated caseworker for the complaint, and sent to the chief executive for sign-off.

We looked at three complaint letters and found the concerns were addressed point by point and an apology was offered when care fell below the expected standards. We saw where complaints were not closed within the allocated time frame, a letter was sent explaining the delay. All letters were written in plain English, which meant the complainants understood the response. One complaint reviewed was closed via a telephone call, which addressed the patient’s concerns.

Each written complaint response, signposted the complainants to the Parliamentary and Health Service Ombudsmen (PHSO), this meant patients, relatives or carers knew who to contact if they were not satisfied with the trust’s response to their complaint. We did not see signposting to the ombudsman in the complaint that was closed via the telephone.

Is the service well-led?

Leadership

The leadership team for the surgical services had a clear leadership structure. The leadership team was made up of a matron, senior nurses, and consultants. We witnessed good and respectful interaction between medical and nursing leadership.

The surgery division was led by chief of service, director of operations and head of nursing. This leadership style is referred to as a triumvirate. Members of the triumvirate had clear roles and responsibilities. Some of the surgery undertaken at the trust fell into the specialist services division, this division had the same triumvirate leadership style.

Within the surgical division there are four directorates, abdominal surgery and medicine, head and neck, musculoskeletal and perioperative. Each directorate had a mirroring triumvirate style and was led by a clinical director, directorate manager and lead nurse.

Each surgical speciality had a clinical director. Each speciality and the theatre department had a matron who was supported by the ward and theatre manager. Staff described matrons and the wards and theatre managers as approachable and supportive, offered advice and training. Staff told us the matron would come to the ward if they asked and often supported them when they were busy.

Service leaders felt they had the necessary skills and knowledge required to lead the service effectively. They understood the challenges to quality and sustainability such as financial pressures and bed capacity.

We saw matrons were visible on the wards. Ward managers told us they were well supported by the matrons, and the surgical divisional leads. All staff we spoke with knew how to contact the matron and leads for their area.

We met with the ward managers and registered nurses during the inspection and found they were organised and demonstrated good and supportive leadership. They were knowledgeable about the ward’s performance against the trust priorities and the areas for improvement. When we raised issues with them, they responded to address them immediately.
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.

**Vision and strategy**

The trust vision was to be locally and nationally renowned for delivering safe, high quality and compassionate care and being the regional centre of clinical and academic excellence. The vision was underpinned by a set of values; communication, kindness and understanding, fairness and transparency; working together, and excellence.

The trust’s strategy, was a process of continuous measurable improvement through existing pathways, to put patients first. The strategy consisted of strong foundations, strategic themes, values, all creating a triangle topped by the patient.

Staff spoke about providing high quality care, which supported the trust-wide vision of ensuring patients received safe care and were treated with kindness and understanding. All ward and departments we visited displayed the trust patient first strategy, and could describe all elements of the strategy and the trust vision and what they meant to them.

**Culture**

There was a positive culture across all staffing groups that we spoke with within the surgical division.

Both theatre staff and nursing staff on the surgical wards reported a good culture, they described feeling supported by their colleagues, ward managers, matrons and leaders.

There was an open and honest culture, in all areas we visited. Staff we spoke with were candid throughout our inspection about the service, managers and leadership. Staff felt valued and respected by all members of the multidisciplinary team.

Staff talked positively about the service they provided; they enjoyed working at the trust. They told us they felt proud to work for the trust, and the care they provided. Staff told us their line managers looked after them well. One member of staff told us their manager was ‘brilliant’ and wished they could be ‘cloned’.

All staff told us they felt part of a team and felt they worked well together and supported each other. Morale appeared to be good. Throughout the inspection, staff told us they were happy with their work and their immediate team. There was a culture of collective responsibility between teams and services.

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. They described a “no blame culture”, particularly around reporting incidents. Most staff knew of the freedom to speak up guardian, who had been invited to attend Quality Safety Patient Experience (QSPE) meetings. The role of the freedom to speak up guardian is to ensure that staff have the capability to speak up effectively and are supported appropriately.
Governance

There were clear lines of accountability from the department to the board through the directorate governance structure. Managers, matrons, and leaders of the service described the systems and processes of accountability within surgery. Staff we spoke with were clear about their roles and responsibilities and who or what they were accountable to or for.

The Surgery Division Clinical Governance Meetings took place monthly. We saw copies of the minutes for June and July 2018, which showed key areas for patient safety were covered. These included, incidents, risk register, updates on national guidance, safeguarding, infection prevention and control, clinical outcomes and patient experience. We saw that where an action was required a person would be named responsible, this made sure that actions that arose during the meeting were completed, and the assigned person held accountable if not.

There were named sepsis leads within the surgery division. These leads oversaw the division’s 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.

As part of our additional data requests we requested one of the directorate’s clinical governance meeting minutes. The perioperative directorate held bi-monthly Safety and Quality Meeting. We looked at the minutes for April, June and August 2018. The minutes showed items discussed included, incidents, never events, risk register and areas of concern. The minutes were brief, but contained an adequate level of detail of the items discussed. Where actions were required, a named person was held accountable.

Each directorate held monthly Quality Safety Patient Experience (QSPE) meetings. These were half day training sessions for all staff. We looked at the minutes from the anaesthesia directorate’s meetings for May, June and July 2018, and saw they included a variety of subjects: organ donation, morbidity and mortality presentations, pre-operative checklists, patient safety issues and feedback on incidents.

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.

Management of risk, issues and performance

The department had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

There was a risk register in place to record risks within the division. Each risk was given an initial risk score and a current risk score after risk reductions strategies had been put in place. There were 66 risks recorded on the risk register for the division, which were into a minor, moderate, major or extreme risk. Out of the 66 risks three were classed as minor risks, 36 as moderate, 26 as major and one extreme.

The risk register had an explanation of the risks, and who had overall responsibility for the risk, ensuing existing risk controls and actions were completed for each identified risk. The risk register in theatre showed main risks to be theatre ventilation, inappropriate use of recovery and storage of equipment in the corridors presenting a fire hazard. Some of the risks on the register were historic, the oldest being 2007.
The senior staff we spoke with were clear about the challenges the directorate faced and they were all committed to improving the patients’ journey and experience. Where national audits had demonstrated a weakness in clinical practice the senior clinical team ensured that action plans were developed and re-audit programmes undertaken to ensure improvements to patient outcomes.

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 feedback 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 (LocSSIPs) using the National Safety Standards for Invasive Procedures (NatSSIPs). For example, we saw the local safety standards for invasive procedures for surgical and procedure site verification was available on the trust website. However, not all staff were aware of local safety standards for invasive procedures or their availability.

Information management

There were clinical and non-clinical systems in place that captured areas such as incident reporting which directly contributed to the quality of patient care. Through the identification of themes and trends, which helped in the development of safer working practices. National audits were used by the service to ensure the service improved patient care in line with national guidance, patterns of incidents and clinical data outcomes.

Staff had access to up-to-date accurate information on patients’ care and treatment. Staff were aware of how to use and store confidential information.

Information governance training was part of the trust’s statutory and mandatory training requirement for all staff. Data supplied to us showed that 98% of nursing staff and 100% of medical staff were up to date with this training, which was better than the trust target of 90%.

Surgical services had performance measures which were used to feed into the metrics dashboard, we saw these included but not limited to, falls and pressure damage, nutrition, pain, fluid balance and discharge planning. The metrics were presented in a way that the ward could see how they were performing in each area, and where they were in comparison to the trust average for the month, monitor trends and improve and make changes to practice.

Engagement

The surgical division gathered patient feedback through the friends and family test. The Friends and Family Test gives patients the opportunity to submit feedback to providers of NHS funded care or treatment, using a simple question which asks how likely, on a scale ranging from extremely unlikely to extremely likely they are to recommend the service to their friends and family.
if they needed similar care or treatment. We saw this could be done in different ways, either on the ward via a handheld mobile electronic device or via the trust’s main website.

The Friends and Family Test response rate for surgery at Brighton and Sussex University Hospitals NHS Trust was 24% which was worse than the England average of 26% in June 2018. During the inspection we saw staff encouraging patients to give feedback.

We did not see where patient’s views and experiences were gathered from those patients with illnesses relating to their mental health or emotional wellbeing.

We saw the trust used social media as a mechanism for engaging with staff and patients in the department, such as Facebook, twitter and Instagram. We also saw the trust answered complaints, concerns or compliments on the NHS choices website.

The most significant improvement was in how likely staff would be to recommend the trust to friends and family as a place to work with a positive response of 46.71% in 2017 rising to 75% in August 2018. At our previous inspection we required the trust should ensure the plan to improve staff engagement is fully implemented. A trust wide staff engagement survey demonstrated that staff working in surgery across all sites scored an improvement in overall staff engagement.

**Learning, continuous improvement and innovation**

The department made regular data submissions to the Royal Colleges and national audits, which allowed patient outcomes to be benchmarked nationally. We saw evidence of actions plans being implemented as a result of noncompliance’s found.

The service and its staff demonstrated a willingness to develop and improve the service provided. The trust’s strategy, was a process of continuous measurable improvement through existing pathways, to put patients first. The strategy promoted interdisciplinary working and staff engagement. Staff told us they could make suggestions to improve patient care, via a suggestion slip. Staff told us of improvements made to patient care via the patient first initiative, for example, making sure all patients wore anti-slip socks when mobilising and a ‘this is how we mobilise’ introduced at the bedside, so if a member of staff was unfamiliar with the patient they could see easily how they mobilised.

The trust recognised and rewarded its staff for the work they did to improve quality. Annual patient first staff achievement and recognition (STAR) award ceremony was held for staff and volunteers. Nominations are for staff, teams or volunteers who go ‘above and beyond. Fifty-four staff were nominated across the surgery division with three winners.
The trust has 80 critical care beds. A breakdown of these beds by type is below.

Breakdown of critical care beds by type, Brighton and Sussex University Hospitals NHS Trust and England.

**This trust**
- Neonatal, 25.0%
- Adult, 63.7%
- Pediatric, 11.2%

**England**
- Neonatal, 23.8%
- Adult, 68.3%
- Pediatric, 7.8%

(Source: NHS England)

The data provided above details all aspects of critical care provided at Brighton and Sussex University Hospitals NHS Trust. However, this evidence appendix did not include paediatric ICU or neo natal ICU. This report only provides detail about critical care for adults at the Princess Royal Hospital (PRH).
Is the service safe?

Mandatory training

Mandatory training completion rates

At the time of the inspection the overall mandatory training completion rate for critical care at the Princess Royal Hospital (PRH) was 93% for nursing staff and 96% for administrative and allied health professionals. This was above the trust target of 90%.

The mandatory training programme at the PRH was comprehensive and included online and face to face training. The training modules provided covered safety and safeguarding systems as well as processes and practices. Training modules included fire safety, health and safety, infection prevention, information governance, manual handling - patients, safeguarding adults at risk and safeguarding children and young people level 2. Within the training modules subjects such as incorporating defibrillator and pacing training, equality and diversity and conflict resolution were provided.

Nursing staff completion rates were 90% and above for all mandatory training modules except for manual handling – patients (86%) and safeguarding adults (86%). We were told these modules would soon be within the trust’s 90% completion rate target because training days were set for staff to complete these modules.

Administrative and allied health professionals’ completion rates were 100% for all training modules except for manual handling -patients (75%). We were told this module would soon be within the trust’s 90% completion rate because training days were set for staff to complete these modules.

Staff were supported to complete their mandatory training. There was an allocated practice educator who was responsible for monitoring individual training completion rates and supporting individual mandatory training needs as well as assessing staff skills. Staff told us they were given time to complete mandatory training.

The trust provided training for staff on sepsis management. Staff were aware of this training. Additionally, there were posters throughout the service reminding staff of how to recognise sepsis.

Staff received effective training in safety systems processes and practices when being introduced to the critical care environment. We were told that staff who were new to the service would receive an equipment and training log in addition to completing their mandatory training. They would have to complete the log as part of their appraisal. This log included training for equipment and processes and identified levels of competency. The equipment and training log also included action plans if a member of staff’s confidence level was not sufficient to support individual practice. We saw evidence of individual action plans that were completed and dated. However, we were told there was no centralised system able to identify each individuals equipment training competencies and that these were stored on an individual portfolio basis.

Safeguarding

Safeguarding training completion rates

Safeguarding training was part of the mandatory training programme at PRH and included safeguarding training for adults and children. We saw completion rates for safeguarding training for nursing staff were 86% for safeguarding adults at risk and 100% for safeguarding children and young people level 2. Administrative and allied health professionals had a completion rate of 100%
for both modules. We were told nursing staff would soon be within the trust’s 90% completion rate for safeguarding adults at risk because training days were set for staff to complete this module.

Staff told us that safeguarding training made them aware of the potential needs and vulnerability of people with mental health conditions, a learning disability and dementia. Staff were also aware of how to safeguard people at risk of suicide and self-harm. Staff were aware of how they could support families and relatives when identifying safeguarding needs. We reviewed 3 sets of patient notes and saw that there were safeguarding reviews in each of them.

The matron told us that they supported staff with safeguarding concerns. The matron was the designated Mental Capacity Act and safeguarding lead. The matron was supported by the consultant intensivist who was the medical designated safeguarding lead. We were also told that people with identified safeguarding risks could be brought to the attention of the trusts’ safeguarding team who would act as a link to support any safeguarding referrals to local authorities. We heard an example of how staff communicated concerns to the safeguarding team.

Staff told us that safety and safeguarding systems processes and practices were developed and communicated to staff through training as well as notice board reminders. Staff also told us that safeguarding issues were discussed as part of team meetings.

**Cleanliness, infection control and hygiene**

Infection prevention and control information was displayed to staff and visitors on the critical care unit. There was information for visitors about infections, for example methicillin resistant staphylococcus aureus, explaining care and treatment as well as counter measures to prevent cross infection.

We saw there was information on ‘being hands aware’. Hand cleaning facilities were available in the unit and alcohol gel was readily available. We also saw patient leaflets highlighting the importance of handwashing available at the entry of the unit and in the waiting room.

The bay area had the ability to be screened and we saw disposable curtains being used. These were dated and changed every six months in line with policy. We were told they would also be changed in between infectious patients or when they became soiled.

We observed medical and nursing staff were compliant with bare below the elbow infection control policy.

The service audited hand hygiene across the critical care unit benchmarking against the 5 moments for hand hygiene standard. They set a target of 95% compliance. Between April 2018 and August 2018 this was achieved in all but one month with a score of 98% recorded for May. This indicated that the standard was in line with Nation Institute of Health and Care Excellence (NICE) QS61 Statement 3: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. However, during our observation we saw that staff missed opportunities to comply with the hand hygiene standards. These were not actions that put patients at risk but were highlighted to the matron.

Staff used protective equipment such as disposable gloves and aprons correctly in all areas of the critical care unit. The unit had one single room which enabled staff to care for patients that required nursing in isolation. All staff caring for patients in this room used protective equipment which was disposed of correctly and using the right bins.
Equipment used in the critical care bay was visibly clean. Interchangeable equipment such as sliding boards and hoists had a “I am clean sticker” that was dated. In the bed spaces where equipment was not being used we saw that some equipment had not been cleaned recently or labelled with the date it had last been cleaned. We spoke with staff about this and they said that when admitting a patient all equipment was cleaned before use as part of their admission process. Resuscitation trolleys were clean and free from dust.

The critical care unit had sharps bins which were correctly assembled, dated and signed. Staff knew how to seal and dispose of sharps bins. Practice was in line with Health and Safety (Sharp instruments in Healthcare) Regulations 2013.

The critical care unit carried out audits on environmental cleanliness standards. They had set a target to achieve 98% compliance with the cleanliness standards. Data presented to us indicated that the unit had achieved and exceeded this target in all months from April 2018 to August 2018.

The critical care bay at PRH was visibly clean and tidy. Housekeeping staff were present throughout the inspection ensuring high footfall areas were kept clean and unobstructed. We saw that the kitchen area in the critical care unit was clean and tidy. However, on the first day of inspection we found that storage areas such as the linen cupboard, clean utility storage area, equipment storage room and dirty utility were not clean or tidy. We found the linen cupboard to be over filled and containing boxed and packaged items such as gowns stored alongside the linen. Additionally, because the cupboard contained the linen trolleys we found the floor behind the trolleys and upper shelves to be dusty. In the clean utility storage room, we found that a great proportion of storage draws were not clean and that the top shelves and floor were dusty. We also saw that under the storage units the floor was very dirty and that some storage items, such as packed syringes, had fallen to these areas and had not been picked up.

We found that there were moving and handling risks due to the storage of boxes at very high levels as well as unnecessary equipment being stored and cluttering this area. In the sluice we found areas behind the bed pan washer and cupboards that were not cleaned effectively. We also saw that one of the drawers in the sluice was not organised and contained items such as mouth gel, scissors and lost property all together. In the equipment storage cupboard, we found the same issues with dust and dirt accumulating in difficult access cleaning areas such as the top shelves and the floor behind stored equipment. We also found some equipment that was not being used by the service stored in this area. We looked for cleaning schedules to assess when the cleaning rota was last completed in these areas but there were no visible records available. There were no checklists to show that clinical staff made a daily check of their clinical area and conducted cleaning to the equipment in use. We brought these issues to the attention of the matron who apologised for the state of these rooms and said that all the issues highlighted would be dealt with immediately.

On the second day of inspection the matron and critical care service staff had responded to the concerns raised on the previous day. We saw that floors and cupboards had been cleaned and reorganised. Most of the clutter in the storage areas had been removed and there was more floor space visible. Equipment that had fallen to the floor was binned and equipment that wasn’t in use by the service had been removed. We were assured by the matron that there would be a continued focus to maintain the cleaning standards in these cupboards post-inspection.

We also highlighted our concerns regarding cleaning standards in the storage cupboards and accuracy of audit reporting with the hand hygiene audit and environmental cleanliness standards audit to the leadership team for critical care at PRH. We were assured that immediate action
would be taken to address the issues highlighted by our inspection and to strengthen the reliability and validity of the auditing process being undertaken.

**Environment and equipment**

Access to the critical care unit was managed by intercom or keypad. This insured access to the critical care unit was controlled and safe. Members of staff would identify themselves through the intercom and would ask how they could help us before allowing access.

When accessing the critical care unit, a poster board telling the patient story was available to visitors and described the different stages of being in a critical care unit. This board was very clear and written with concise information so families and people interested could understand the patient journey. There was the possibility to use an electronic QR code to access further information that would explain more about each stage of critical care. Staff told us they used this as a way of explaining to families and relatives what was expected during a patient’s critical care journey or where they were in their journey.

The critical care unit had two relatives waiting rooms. The first waiting room was used for families waiting or resting and had tea and coffee making facilities. The second waiting room was used for conferencing with family and supporting people when giving them news and information. This included supporting people that would like to ask further questions or to support people’s emotional needs.

The design, maintenance and use of facilities and premises in the critical care unit kept people safe. However, there was only one toilet for families visiting the critical care ward and it would be shared with patients who were starting to mobilise. Due to the reduced size of the toilet patients mobilising with a walking aid or needing assistance to use the toilet could not access it.

There were staffing information boards throughout the critical care service identifying staff members as well as the designations of each uniform. For the leadership team there was a board identifying key leadership team members and this was accompanied by a photograph of each person. Information boards also contained recent results of hand hygiene audits as well as reminders for safe practice and infection control.

The medicines storage room was clean, uncluttered and fitted with an air conditioning unit which kept the environment cool. The critical care team carried out frequent temperature checks on the fridges and the ambient temperatures in the room. We saw records of the temperatures were recorded consistently and actions taken appropriately to maintain this equipment functioning safely.

Resuscitation trolleys in the critical care unit were secure, checked daily and all equipment was cleaned and stock was within date. There was also emergency tracheostomy and difficult intubation equipment available on the unit. This emergency equipment had a completed checklist and was up-to-date.

The critical care unit had an appropriate waste segregation and disposal system in place with the use of different coloured bags to identify the different categories of waste. Bins clearly stated what should be disposed in them. Additionally, we saw that all substances hazardous to health were stored correctly and locked. This was in accordance with HTM07-01, Control of Substances Hazardous to Health and the Health and Safety at Work regulations.
Equipment used on the critical care unit was stored in demarcated areas or by the patient’s bedside when being used or ready to be used. We performed random checks and saw that equipment was in date and had recently been serviced.

We randomly checked six pieces of equipment to see if they had identification tags showing servicing dates. All equipment had stickers and were tagged correctly. The service used a serial number that contained an identification descriptor. This was used as a way of ensuring that equipment was serviced at regular intervals and followed up-on when needing repair. We were told that if equipment needed to be repaired a form would be completed and attached to the piece of equipment and this would then be checked by the estates team and fixed. We were told that specialist equipment repairs were carried out by the manufacturer.

Staff received training in specialised equipment used in the intensive care unit to ensure safe practice. We were provided with evidence that staff completed equipment awareness training and competencies on the use of the equipment in the unit. We saw on an individual training log that frequency of training and level of training was used as part of the equipment and training log competency check for training. Staff told us that new equipment introduced to the unit was provided by the manufacturer or by a member of staff that was identified as a superuser or had the ability to train others in the safe use of the equipment. The completion of the training log was supervised by the member of staff’s appraiser and by the clinical educator.

We saw that patient hoists were available, cleaned and serviced. The hoist had information attached to it showing how to use it correctly and identifying the appropriate patient weight that equipment could support.

We were told how fire evacuation processes were conducted and saw clear demarcations of exit zones as well as escape route signage. We saw fire extinguishers were readily available and in date. Fire exits were clear and unobstructed.

**Assessing and responding to patient risk**

Staff had easy access to a folder that consisted of emergency situations and their respective algorithms for the management of acute clinical emergencies. This enabled staff to have quick access to this information should they need it. This document helped support decisions and what action should be taken in case a patient presented with sepsis. This folder was located near the nurse’s station and was accessible to staff who needed it.

The outreach team provided critical support cover 24 hours a day, seven days a week and covered all wards and departments at PRH. The team accepted requests for assistance for deteriorating patients from any member of staff. Nurses who were a part of this team had specialist training in advanced physical assessment and responding to deteriorating patients. Training was done in the Intensive Care Unit course and through the university mentorship course. The outreach team also supported the critical care team if they were short staffed.

The trust used the national early warning score system for the monitoring of vital signs in adult patients to highlight early signs of when a patient’s condition may be deteriorating and may require a higher level of care. This was in line with the Royal College of Physicians (2012) National Early Warning Score (NEWS) standardising the assessment of acute-illness severity in the NHS: There should be a hospital wide standardised approach to the detection of the deteriorating patient and a clearly documented escalation response.

The critical care unit demonstrated that the NEWS was in place before the patient was transferred to the ward areas. Staff were also knowledgeable about how to complete the records of this
system accurately. We saw evidence of this in the three records we reviewed. Additionally, the outreach team promoted a standardised approach to the detection of the deteriorating patient and presented clearly documented escalation responses.

Staff completed relevant risk assessments and care bundles. For example, pressure ulcer, venous thromboembolism and intravenous cannula risk assessments were completed within the three patient records were reviewed.

Staff in the critical care unit could access mental health support for patients if they were concerned about risks associated with a patient’s mental health. Some of the nurses working in the critical care unit also supported with mental health evaluation and were aware of their scope of practice and when to liaise with specialist mental health services. We were told the response from the mental health team met the needs of the service.

We heard staff identify points of good coordination between wards, departments and the critical care units and how this was supported by the outreach team and the pathway coordinator at PRH.

We heard how patient flow and bed status on the critical care unit, any unwell patients on the wards and any patients potentially needing surgery were constantly reviewed and discussed in the team meetings. This ensured a coordinated approach to assessing and managing patient risk on a regular basis.

The trust also told us how they had done a significant amount of training in increasing awareness of NG tube intubation and developing new feeding guidelines which involved a multidisciplinary approach as well as cross professional training and updating.

### Nurse staffing

The trust has reported their staffing numbers below for two different times; March 2017 and April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>As at 31/03/2017</th>
<th>As at 30/04/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>All sites</td>
<td>186.5</td>
<td>203.8</td>
</tr>
</tbody>
</table>

In March 2017 the trust reported they had filled 91.5% of their planned staffing. This decreased to 86.4% in April 2018.

No site breakdown is available as the trust did not report the data at site level.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

### Vacancy rates

From May 2017 to April 2018, the trust reported a vacancy rate of 12.3% in critical care. This was higher than the trust target of 10.5% in March 2018. This target will reduce incrementally to 9.0% by March 2019.

- Princess Royal Hospital: 16.5%
- Other sites: over-established by 17.6%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)
Turnover rates

From May 2017 to April 2018, the trust reported no staff turnover in critical care. This was better than the trust’s overall target turnover rate of 14% in March 2018. This target will reduce incrementally to 11% by March 2019.

No site level detail was provided to allow for a site level breakdown of this data.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From May 2017 to April 2018, the trust reported a sickness rate of 5.6% in critical care. This was worse than the trust overall target sickness rate of 4.20% in March 2018. This target will reduce incrementally to 3.50% by March 2019.

A site level breakdown is shown below:

- Princess Royal Hospital: 9.3%
- Other sites: 3.0%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

The trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff in all cases. Therefore, we have been unable to analyse bank and agency usage as a proportion of the total shifts needing to be filled.

The table below shows the numbers of shifts in this core service from June 2017 to May 2018 that were covered by qualified nursing and nursing assistant bank and agency staff or left unfilled.

For qualified nurses, 2,523 shifts were filled by bank staff and 2,014 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses. In addition, 1,080 shifts were not filled by either bank or agency staff.

For nursing assistants, 291 shifts were filled by bank staff and 1 shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants. In the same period, 65 shifts were not filled by either bank or agency staff.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Qualified nurses</th>
<th>Healthcare assistants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>2,523</td>
<td>291</td>
<td>2,814</td>
</tr>
<tr>
<td>Agency</td>
<td>2,014</td>
<td>1</td>
<td>2,015</td>
</tr>
<tr>
<td>Not filled</td>
<td>1,080</td>
<td>65</td>
<td>1,145</td>
</tr>
</tbody>
</table>

Unfortunately, we are unable to provide a site-specific breakdown of nursing bank and agency usage in this core service, due to the format of the data provided by the trust.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Staffing on the intensive care unit at the PRH was planned to be at a ratio of one registered nurse for each level three patient and one registered nurse for every two, level two patients. This was in
line with the Guidelines for the Provision of Intensive Care services, 2015. Each shift also aimed to have a supernumerary nurse in charge but we were told this was not always possible. However, during inspection, we saw a supernumerary nurse always present on the ward.

Staff told us that that they felt that staffing was at a correct level for the patients that were on the unit. We were told how the critical care unit had tried to not allocate nurses to support other wards thus ensuring staffing levels were always safe. However, staff did tell us that they often rotated between the PRH and county site hospital to support the needs of each service depending on the level of patients that were in the critical care units at the time.

The outreach team was also well staffed and had a cover of one nurse per 12-hour shift. The outreach team was composed of 10 to 14 nurses that provided the service 24 hours a day, seven days a week.

The critical care service also had a half-time band seven practice educator and a critical care audit nurse which was shared between the PRH and county site hospital.

**Medical staffing**

The trust has reported their staffing numbers below for two different times; March 2017 and April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>As at 31/03/2017</th>
<th>As at 30/04/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>All sites</td>
<td>31.3</td>
<td>44.5</td>
</tr>
</tbody>
</table>

In March 2017 the trust reported they had filled 70.4% of their planned staffing. This increased to 85.5% in April 2018.

No site breakdown is available as the trust did not report the data at site level.

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

**Vacancy rates**

From May 2017 to April 2018, the trust reported a vacancy rate of 18.9% in critical care. This was higher than the trust target of 10.5% in March 2018. This target will reduce incrementally to 9.0% by March 2019.

No site level detail was provided to allow for a site level breakdown of this data.

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

**Turnover rates**

From May 2017 to April 2018, the trust reported no staff turnover in critical care. This was better than the trust’s overall target turnover rate of 14% in March 2018. This target will reduce incrementally to 11% by March 2019.

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

**Sickness rates**

From May 2017 to April 2018, the trust reported a sickness rate of 2.2% in critical care. This was
better than the trust overall target sickness rate of 4.20% in March 2018. This target will reduce incrementally to 3.50% by March 2019.

No site level detail was provided to allow for a site level breakdown of this data.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

From April 2017 to March 2018, the trust reported that 287 shifts within this core service trust-wide were filled by bank staff and 2 shifts were filled by locum staff. There were 20 shifts which were not filled by either bank or locum staff. A breakdown of bank and locum usage by staff type at the trust is shown below.

Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
<th>Unfilled shifts</th>
<th>Total shifts (bank + locum + unfilled)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>287</td>
<td>2</td>
<td>20</td>
<td>309</td>
</tr>
<tr>
<td>Junior</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>287</td>
<td>2</td>
<td>20</td>
<td>309</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Critical care services were meeting the Guidelines for the Provision of Intensive Care Services, 2015 for consultant cover. Consultant work patterns delivered continuity of care with a consultant in intensive care medicine available 24 hours a day, seven days a week. Consultants also attended daily ward rounds.

There were sufficient trainee or junior doctors at the critical care service and an airway doctor was available on site should they be needed. However, we were told that there was a shortage of middle grade doctors for critical care. As a response to this the trust had developed a simulation training fellowship post and echo training posts to make junior posts more attractive, as well as looking to recruit research fellows.

Medical staff told us how they kept services safe and up to date regarding patients by using electronic communication systems to support cover for each other during week nights and weekends, as well as facilitating handovers.

The critical care service operated a six-week rotation at consultant level.

Records

The critical care service at PRH used manual records to ensure that patient's individual needs as well as their clinical data was managed in a way they kept people safe. There was an approved business case to implement an electronic record database at the service by December 2018.

We saw three sets of patient records which were complete and included charts designed to capture all patient observations including fluid charts, pain assessment, nausea scores and
recording of all nursing interventions. We saw that observations were being recorded regularly and data and patient observations were complete and regularly appointed.

Patient documentation included care bundles and risk assessments. Nursing records were accurate, complete and in line with trust and professional standards. Of the 3 records we reviewed, all of them showed evidence of holistic assessments which focused on details other than physical health needs. For example, we saw additional information for patients with confusion or delirium was recorded.

Medical documentation was complete, in line with trust and professional standards and recorded that care was delivered in line with the Guidelines for the Provision of Intensive Care Services, 2015. There was evidence of a consultant review on admission to critical care and of daily input from the multidisciplinary team.

The physiotherapy team completed records that met the National Institute for Health and Care Excellence (NICE) CG83 (rehabilitation after critical illness): requirements during a patient’s stay in critical care.

The critical care admission and discharge forms presented clear documentation of the time and decision to admit to intensive care. This was in line with the NICE CG50 acutely ill adults in hospital: Recognition and response to acute illness in adults in hospital.

**Medicines**

The critical care service at PRH had access to pharmacy support by telephone. Staff said they had not experienced any difficulties with medication management and that that this arrangement supported them for the level and need of the service.

Pharmacy was unable to attend all ward rounds. This meant that pharmacists were not capturing issues at the point of presentation and potentially medicines may be given that may have not been reconciled by the pharmacist. However, we saw no evidence of incidents due to medicine mismanagement and were made aware that the pharmacist would attend and do medicine conciliation if requested.

Staff explained the existence of cross-site working with pharmacy for the use and access to complex drugs. This system worked well for the service and allowed safe access to medicines when needed.

The critical care service had an appropriate system to ensure that medicines were handled safely and stored securely. Controlled drugs were appropriately stored with swipe card access.

The medicine storage room was accessed using a swipe card. We were told that access to the room was restricted to staff that had a clinical need to access the room. During the inspection we saw that any member of the housekeeping team could access the medicines storage area. This was raised with the matron who said there was always a member of staff present when cleaning was taking place. This was done because there were unlocked fridges in the storage room that contained various medicines that had the potential to be abused.

Staff kept accurate records of medicines and performed daily balance checks in line with trust policy. We checked three patient drug charts which were complete and included patient’s medical history and allergies. We saw all drugs were signed as given.
Staff used the ‘five rights’ of medicine administration system. This required staff to check the right patient, right drug, right dose, right route, right time. The five rights would then be checked three times. We heard an example when this system had prevented a medicine administration error.

We also checked the controlled drugs register. We were assured of good practice as the daily balance checks were documented and correct. We saw evidence that the controlled drugs risk assessment was also checked daily.

Fridge and freezer temperatures were checked and recorded daily. We saw evidence of accurate logging, defrosting and recalibration when needed. This ensured that stored drugs and products were kept at a temperature that maintained the integrity of the drugs.

**Incidents**

**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 2017 to May 2018, the trust reported no incidents classified as 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 2017 to May 2018.

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

At the time of the inspection the trust had 42 open incidents that were being investigated. This had been reduced significantly since the previous inspection when there were approximately 250 outstanding incidents. Of those there were still eight overdue incidents in August 2018 at the PRH critical care services. The service explained that this was because these were situations that involved complex investigations and the number of incidents being reported was kept at the same level as those being resolved.

Incidents were discussed in monthly team meetings such as the mortality and morbidity meeting. Additionally, at ward level there were weekly ward meetings known as improvement huddles that highlighted minor incidents and how to best prevent them. The learning was described as improvement opportunities. The huddles used a structured format and were conducted using language that all staff could understand. We witnessed how issues were discussed among staff in an open way and how the team worked to provide solutions and better outcomes to the problems raised. The service also produced a newsletter called ‘Risky Business’ where learning from incidents could be shared.

Staff we spoke with understood their responsibility to raise concerns and record safety incidents and near misses. There had been an improvement in the reporting culture and staff were more...
confident in reporting any incidents. This was reflected when speaking with a range of staff on the unit. Incident reporting was completed using an electronic system and staff were aware of who to contact if they needed support in completing any reports.

Despite not having any recent never events or serious incidents the service had a governance structure that assured that investigating safety and safeguarding incidents was well established and relevant. We were assured how staff and people who used the services were involved in the reviews and investigations and the level of support they would receive should any of these events occur. We also heard there was crossover learning with the county site and we were told how staff shared learning and investigations. We heard of an incident that led to simulation training of an occlusion incident to understand why it occurred and how to prevent future occurrence.

Staff told us they also participated in appraisals and reviews of investigations by other services and organisations. We saw an example of this when staff identified a safeguarding issue and raised it with an external agency, the result of this was shared among all staff members.

The service had in place a dissemination structure that would allow for safety alerts, recalls, inquiries and investigations to be shared amongst staff. This was achieved through improvement huddles, team meetings and appraisals. We were told there was also an electronic email sent describing any recent changes or any updates that would affect the service to ensure rapid dissemination of information.

Staff could recognise when the duty of candour had to be applied. We were assured that this was the case as part of the complaints and incident procedure included prompting so that patients and families received relevant information during investigations.

Safety thermometer

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 ten days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported six new pressure ulcers, one fall with harm and no new catheter urinary tract infections from July 2017 to July 2018.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls with harm and new urinary tract infections at Brighton and Sussex University Hospitals NHS Trust
Patients were being assessed for venous thromboembolism on the critical care unit. This was in line with NICE QS3 Statement 1: All patients, on admission, receive an assessment of venous thromboembolism and bleeding risk using the clinical risk assessment criteria described in the national tool and NICE QS3 Statement 4: Patients are re-assessed within 24 hours of admission for risk of venous thromboembolism and bleeding. Patients were also assessed for pressure ulcer and falls risk and reviewed on a risk basis.

The critical care audit nurse looked at the data for venous thromboembolism, pressure ulcer and falls risk and ensured the information was complete and accurate for each patient. We were told if a risk assessment was missing this would be prompted immediately and if any risks were identified these would be reviewed on ward rounds. Staff was also alerted where omissions were found on completion of fluid charts and NEWS.

Staff said improvement and safety huddles in the critical care service shared and promoted good practice regarding safety thermometer measurements. This helped promote a continuous culture of safety awareness.

**Is the service effective?**

**Evidence-based care and treatment**

The critical care ward used policies, protocols and care bundles that were based on guidance based on guidance from National Institute for Health and Care Excellence (NICE), the Intensive Care Society (ICS) and the Faculty of Intensive Care Medicine (FICM). We saw evidence of this in the algorithms folder that highlighted a range of critical care clinical emergencies and also through best practice and updating of the most recent guidelines. Staff demonstrated awareness of the policies and knew how to access them both online and through the algorithms folder.

Protocols, policies and national safety standards were clearly documented on the hospital’s intranet system and resource folders easily accessible at the units. We also saw that local safety standards had recently been reviewed for nasogastric tubing, pressure ulcer prevention and management and feeding and nutrition.
Staff told us they could deal with mental health needs in an appropriate way and knew how to access both emotional and psychological support. We saw evidence of this in the daily handovers and safety huddles were patients, carers and relatives’ emotional needs were documented and highlighted.

The service ensured that intensive care society standards and policies were reviewed and communicated to all staff. This was done using the supervision and appraisal system and through information being cascaded from the leadership team through the huddles and team meetings. There were also close links to the county site hospital and information was shared through governors’ meetings if any policies or practices needed to be changed.

Staff used evidence-based care and treatment in line with the National Institutes for Clinical Excellence (NICE) QS66 statement 2: Adults receiving intravenous (IV) fluid therapy in hospital are cared for by healthcare professionals competent in assess patient’s fluid and electrolyte needs, prescribing and administering IV fluids and monitoring patient experience. We also saw evidence based care delivered in line with NICE QS3 statement 5: patients assessed to be at risk of VTE are offered VTE prophylaxis in accordance with NICE guidelines.

We reviewed and were assured that data was being recorded regularly and discussed in the improvement huddles. The service highlighted how data should be recorded particularly around the discharge process and maintaining treatment in line with nice discharges.

**Nutrition and hydration**

Nursing staff assessed patients’ nutrition and hydration needs using the malnutrition universal screening tool (MUST). We reviewed two records that were accurately completed and presented records of the dietitian referral and evidence of dietetic reviews. This was in line with guidelines for the provision of intensive care services, 2015: the ICU lead dietician will be involved in the assessment, implementation and management of appropriate nutrition support route.

The critical care unit had a feeding protocol in place that provided guidance for staff on feeding patients who were unable to eat or needed to be fed by nasogastric tubing. Staff also had access to information resources about nutrition in a folder as well as the support of a dietitian and speech and language therapist. This was in line with guidelines for the provision of intensive care services, 2015: all patients unable to take oral intake should normally have nutrition support (enteral or parenteral) commenced on admission to ensure adequate nutrition to facilitate rehabilitation.

The critical care ward was supported by a dietitian 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.

For patients able to eat, there were appropriate meals that considered patients nutritional needs. Staff told us they would support patients who were able to eat or assist them if they required any additionally support. Staff also highlighted that they would regularly educate families and how to feed patients to maximise independence.

Water was available and within reach for patients who could drink and staff actively engaged patients asking if they were thirsty or needed any help with hydration.

**Pain relief**

The critical care unit reviewed patients’ pain regularly during ward rounds. Pain manifestation was scored using a visual analogue scale while non-communicative patients had their pain assessed using the critical care pain observation tool. This was in line with guidelines from the faculty of pain
All in-patients with acute pain must have regular pain assessment using consistent and validated tools, with results recorded with other vital signs.

Pain relief was monitored every 4 hours and recorded on the patients’ notes. However, we heard and saw that patients with a pain score of 0 did not always have their score recorded. This was actively being addressed by the critical care unit as part of the improvement huddle and staff were looking to actively address this issue by ensuring pain scores of 0 were recorded at regular intervals.

Where possible staff supported analgesia and pain management using information from the patients’ medical history. The service used an analgesic ladder that supported most of pain management decisions for continued care and to better understand the pain history of patients.

There were updated patient controlled analgesia and epidural policies. Patients also told us their pain was well managed.

Patient outcomes

The trust 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. This was in line with Guidelines for the Provision of Intensive Care Services, 2015: The intensive care unit should participate in a National database for Adult Critical Care. We used data from the 2016/17 Annual Report.

ICNARC Participation

The trust had 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))

Hospital mortality (all patients)

Princess Royal Hospital

For the Intensive Care Unit at Princess Royal Hospital, the risk adjusted hospital mortality ratio was 0.9 in 2016/17. This was within the expected range. The figure in the 2015/16 annual report was 0.8.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>500 admissions</td>
<td>Risk-adjusted hospital mortality ratio (all patients)</td>
<td>0.8</td>
<td>0.9</td>
<td>1.0</td>
<td>none</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

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

Hospital mortality (for low risk patients)
Princess Royal Hospital

For the Intensive Care Unit at Princess Royal Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.3. This was within the expected limits. The figure in the 2015/16 annual report was 0.8.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>378 admissions</td>
<td>Risk-adjusted hospital mortality ratio for patients with predicted risk of death &lt;20% (lower risk)</td>
<td>0.8</td>
<td>1.3</td>
<td>1.0</td>
<td>none</td>
<td>Within expected limits</td>
</tr>
</tbody>
</table>

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

The information presented assures us that the intended outcomes for people using this service were being achieved within the critical care unit.

The audit nurse for the critical care unit showed us the monthly audit calendar and there was evidence that data was being regularly imported and documented correctly. This was in line with guidelines for the provision of intensive care services, 2015: presence of an ordered calendar which is regularly updated and acted upon.

The service also participated in monthly mortality and morbidity meetings. The most recent meetings showed active discussion of recent cases. There was evidence this forum was active in addressing issues such as final diagnosis, mode of death and summary of learning points and recommendations.

The critical care outreach team participated in the rehabilitation of intensive care patients and supported patients on the ward following discharge from critical care. The team liaised with the critical care consultant regularly to ensure patients referred to the team had appropriate plans of care in place.

**Competent staff**

The service ensured staff were competent for their roles. Information provided by the trust showed that 65.7% percent of nurses in the intensive care unit had a post-registration award in critical care nursing in June 2018. The service was meeting the national guidelines minimum recommendation of 50% specialist nurses for the provision of intensive care services. Additionally, the critical care unit at PRH had a 100% completion rate in training in specialised unit equipment.

Staff said there were learning opportunities for the nurses in the critical care unit. Staff said they had regular teaching and learning opportunities doing ward rounds and there was a culture of openness to identify learning needs and improving competencies. We saw evidence of this during the improvement huddle we shadowed. Staff would also use meetings, supervision sessions,
appraisals and journal clubs as opportunities to continue to identify and develop their competencies.

Staff were involved in quality improvement programmes. One programme we heard of was the preceptorship programme for band 5 nurses. This programme was part of the ICU steps handbook and was aimed at developing skills and identifying competencies for newly qualified nurses in critical care. We were shown a clear competency and training package for all new band five nurses. Further educational courses were available that were fully funded. New band five nurses told us how they were given five weeks of supernumerary practice at the beginning of their employment and how their induction, training and education were good. During the inspection we were told that the supernumerary period had increased to six weeks. We were also told that senior staff were supportive and helped with staff’s development.

Junior medical staff we spoke with told us how they had been well supported by the critical care lead consultant. We heard there was a good teaching programme supervised by the consultant team and good peer learning.

Other medical staff told us that nurse leadership was good, that the service was now more integrated and that real value was put on the skill of individuals. This in turn had meant that everyone’s skill sets had improved and that the units felt safer with more neuro competent staff around. There was also particularly emphasis on the use of training sets and manual handling as well as competencies with equipment.

The critical care unit supported the advanced critical care practitioner (ACP) training. This ran with the support of a junior doctor role to enable staff to have the practical skills of line and catheter insertion and other small invasive procedures. It also supported the development of assessment and diagnostic skills for the ACP that would be able to support junior doctors in future practice.

The outreach team also supported education with training in portable ventilators as well as establishing teaching sets. We heard examples of the NIV education training and acute study day as part of this programme.

**Appraisal rates**

During the inspection we were shown evidence that the overall appraisal rate for all staff groups at PRH had reached 96% in August 2018. This was better than the trust target of 90%. This information had been validated through human resources and the electronic system for monitoring appraisals.

There was a monthly meeting between the service leads and human resources to review progress. All staff that we asked about their appraisals told us that they had them and that they were useful and provided them clear direction.

**Multidisciplinary working**

Staff we spoke with told us there was good teamwork and communication within the multidisciplinary team. We also heard that the necessary staff including those in different teams and services within the organisation were involved in assessing, planning and delivering care and treatment. We saw examples of strong positive multidisciplinary working on the unit and at bedside during our inspection.

Multidisciplinary staffing at the PRH was not in line with Guidelines for the Provision of Intensive Care Services (GPICS) standards 2015. This was because there was no permanent pharmacist
on the team from Monday to Friday and there was no permanently allocated rehabilitation team at
the critical care service. However, there were arrangements that if a pharmacist or pharmacist
advice was needed a direct line was in existence.

Referrals for physiotherapy, occupational therapy, speech and language therapy and dietitian
were made to the hospitals in-patient rehabilitation teams. These teams supported the critical care
ward from Monday to Friday during working hours. Additionally, there was an allocated on-call
physiotherapist for respiratory needs throughout the weekend. We saw in patient records that
referrals to the multidisciplinary team were responded promptly and notes were taken
appropriately to address multidisciplinary needs.

The team demonstrated cohesive multidisciplinary working during patient handovers. Patient
handovers happened twice a day and addressed issues such as patients’ well-being, risk of
developing physical and non-physical morbidity as well as identifying what other therapies or
multidisciplinary work would be required for the patient. There was also close liaison in identifying
dischargeable patients or patients that required further support for their families and carers.

The critical care unit regularly worked with other teams such as the medical wards, surgery and
mental health teams. We witnessed evidence of the multidisciplinary team identifying risks and
needs to liaise with other teams through the safety huddle. An example of this was the discussion
around a patient’s need for cardiac and vascular team support as well as follow-up from the
clinical immunologist.

Multidisciplinary working in the improvement huddles supported doctors and nurses in identifying
new improvements, escalations and work in progress. However, these meetings were not regularly
attended by health care professionals.

There was also significant cross site working with the Royal Sussex County Hospital site. This
ensured that the multidisciplinary teams introduced experience from other medical and nursing
staff and supported well-established pathways for the patients. An example of this were the cross-
site mortality and morbidity meetings which identified action plans that had implications for both
sites.

Further evidence of multidisciplinary working with other wards was seen within the outreach team.
This team supported other services in identifying and escalating protocols for deteriorating patients
as well as supporting discharges and ensuring that patients rehabilitation needs were being met.
The outreach team was also responsible for referring patients to other specialist services such as
the dietitian, nursing and mental health team while ensuring a safe transition of patients during
discharge from the critical care ward.

**Seven-day services**

Critical care services could safely monitor patient outcomes and support care being delivered
seven days a week.

A consultant in intensive care medicine was available and completed ward rounds seven days a
week. This was in line with NHS Services, Seven Days a Week, Priority Clinical Standard 2: Time
to first consultant review: All emergency admissions must be seen and have a thorough clinical
assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the
time of arrival at hospital.
The critical care outreach team provided a seven-day service 24 hours a day. This team supported both the critical care unit and other wards in escalating and supporting the discharge of patients that were critically unwell.

Diagnostic services were accessible 24 hours a day, seven days a week. Reports were completed and delivered within stipulated time frames. This was in line with NHS Services, Seven Days a Week, Priority Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology.

Consultant-directed diagnostic tests and completed reporting will be available seven days a week: Within one hour for critical patients, within 12 hours for urgent patients and within 24 hours for non-urgent patients.

The critical care unit did not have a dedicated pharmacist. However, we were told that there were arrangements for round the clock telephone support through the hospitals’ pharmacy services. If required a pharmacist could visit the unit to check prescriptions and reconcile patients’ medicines.

The critical care unit could access the hospitals rehabilitation teams for provision of treatment five days a week during work hours. An on-call physiotherapist was available overnight and during weekends to support respiratory rehabilitation, assessments or queries.

Health care assistants were also available throughout the week to support patients and their relatives and personal care needs respectively.

**Health promotion**

Staff helped people who were identified as needing extra support with the management of long-term conditions or with their emotional needs.

The critical care unit had procedures in place to support patients withdrawing from drugs or alcohol. We were told of programmes supporting patients to make healthier lifestyle choices including promotion of knowledge in diabetes, smoking cessation and support for alcohol and drug dependency.

Staff completed assessments about patients’ individual needs on admission and monitored progression during their stay at the ward. We were told how the multidisciplinary team provided health and self-care advice to patients to enable them to manage their own conditions when possible.

Staff also offered advice surrounding intensive care visitors’ guides, sepsis briefing and smoking cessation. Additionally, the unit had access to psychiatric support through the mental health liaison team.

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance including the mental Capacity Act, 2005. We observed staff obtaining verbal consent from patients before carrying out any intervention when the patient had capacity to consent. Staff also told us they would speak to the nurse in charge or a member of the medical team if they had concerns regarding a patient's capacity.
Mental Capacity Act and Deprivation of Liberty training completion

Mental capacity act and deprivation of liberty training was part of the compliance training programme at PRH. The trust did not provide individualised data at core service level for the completion rate of this training module. However, we were informed that the completion rate for mandatory training, which included training in the mental capacity act and deprivation of liberty, was 93% for PRH which was above the trust target of 90%. The critical care service at PRH should maintain an easily accessible log with completion training rates for each training module.

The critical care unit operated on a best interest emergency care decision up to 21 days after the patient’s admission if the patient could not give consent or was too unwell to give consent. Where possible, patients were supported to make joint decisions with staff regarding their care and information sharing.

We were told examples of how the application of the depravation of liberties was used and reassured that staff made the best decision for the cases explained to us.

The service promoted a supportive practice that tried to avoid the need for physical restraint. We were assured that when physical restraint was necessary the service used it in a safe, proportionate and monitored way. Staff we spoke with could explain the processes they would follow for the use of restraint, such as the use of mits, and where they would document this.

Staff told us that on occasion they encountered difficulties obtaining information from social services to determine previous mental capacity before the patient was critically unwell.

During a review of the records we did not see any formal assessments for dementia undertaken in critical care. We were told that if it was suspected that a patient had dementia the team would assess the patient or liaise with the hospital mental health team.

Is the service caring?

Compassionate care

Staff understood and respected the personal, cultural, social and religious needs of people and how these may relate to the care needs. Staff spoke to the patient when possible and family to identify cultural and religious needs. We saw that staff took attention to what was said to them and relayed this information during handovers.

Staff took time to interact with people who used the service and those close to them in a respectful and considerate way. We saw examples of this when staff would approach patients and ask them how their day was going as well as asking patients if they were feeling comfortable. This was in line with NICE QS15 Statement 1: Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.

Staff showed an encouraging, sensitive and supportive attitude to people and the families who used the critical care services. Staff were always aware of the patient history and needs and established open communication links with the patients’ family and carers. We saw that staff were always available to answer questions and support people.

Staff demonstrated that they knew how to raise concerns about disrespectful, discriminatory or abusive behavioural attitudes. We also heard examples of how patients may behave in this way because they are frightened or confused. Staff said they would balance what was happening and try to understand and identify what caused the behaviour. Incidents of this nature would be
brought forward to the team meetings and huddles so that people could share how to deal with these situations and how to treat people compassionately and understand what they were going through.

Patient's privacy and dignity needs were understood and always respected including during physical or intimate examinations. Additionally, staff introduced themselves to the patient before any interaction asking for consent and would close the curtains if any intimate care or examinations were occurring. This was in line with NICE QS15 Statement 3: Patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.

One patient told us staff responded in a compassionate, timely and appropriate weight when they requested any help. They also highlighted how staff were reassuring at times of distress and tried to make the ward a calm place despite the very busy nature of it.

**Emotional support**

Staff had a good understanding of the impact that a person's care, treatments and condition could have on their wellbeing and those close to them both emotionally and socially. We heard staff identify how they would be able to support people with emotional needs by finding them a quiet space to step aside from any situation that may raise anxiety or offering some time to talk and help process their emotions.

Staff felt they had time to support patients, relatives and visitors and told us that this was the reason they loved their work. We heard how staff supported families through counselling services as well as establishing links with the mental health team if they were unable to support the persons’ needs. Patients and families who received life-changing diagnosis were also given emotional support by staff.

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 wrote and kept a critical care diary next to patients. This diary had entries detailing the story of how the patient's journey had been through critical care and highlighting any thoughts or ideas that the patient wanted communicated. This diary was considered an essential step in the critical care journey to help patients understand what they had been through as well as being able to support bereaved families.

Staff told us how they encouraged families and carers to bring small personal belongings to help patients recover and minimise the impact of being in a hospital. They also encouraged families, relatives or friends to keep conversations with patients even when these may not have been conscious. Staff did this in an assuring and private way that supported dignity and respect of all those involved. We heard of a situation where staff supported a family in seeing the patient before the funeral arrangements were made and how this helped the family overcome their bereavement period.

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

Patients and those close to them consistently said that staff were clear about explaining the treatment being provided and offering condition specific information. This was evident in several compliment cards that the service had received over time with people stating how staff were...
always open, honest and like family. This was in line with the NICE QS15 Statement 2: Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills.

Staff demonstrated an understanding of equality, diversity and other characteristics and demonstrated sensibility to these.

Staff ensured that people who used critical care services and those close to them could find further information including community and advocacy services or ask questions about future treatment options. Staff highlighted how they were always had time to provide advice to people and were aware of services and resources they could use to support patient queries.

A patient told us how staff had supported and involved them in the planning and decision-making process about their care and treatment. They said that everyone was understanding and sensitive when explaining difficult procedures and risks as well as involving family when required. This was in line with NICEQS 15 statement 5: patients are supported by healthcare professionals to understand relevant treatment options, including benefits risks, and potential consequences.

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. We heard how staff always tried to involve the family and patient when possible on the decision of organ donation. Staff were sensible on their approach and said that they took into consideration matters such as a person's health, emotional status and the patient and family's readiness for the discussion.

Staff assured us that information provided by patients was treated confidentially and in a way that complied with the data protection act. Any sensitive information would be communicated in a private setting or in one of the side rooms. We were also told that if this wasn't possible staff would draw the curtains and speak in a low voice so that other people present on the ward would not be able to hear any sensitive conversations.

Is the service responsive?

Service delivery to meet the needs of local people

There was signposting around PRH indicating where the critical care unit was located. Signs were not clearly visible or presented in dementia or visual deficit friendly colours. Additionally, there was no different colouring for different services and all indications were written in brown letters. However, staff at the information desk and volunteers were helpful in guiding people to correct locations.

The intensive care unit was an eight-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. The unit had two guestrooms available to accommodate relatives.

There were two relatives’ rooms adjacent to the intensive care unit. In the first room we saw leaflets and information provided to those visiting. There was a range of information leaflets available in English and a leaflet in nine different languages saying that if people wanted more...
information about the unit this was available and readily translated. Relatives could stay in this
room overnight if necessary. The room was large enough to accommodate a small number of
people and had a TV that could be used by anyone staying if they wanted to. The room also had a
hot and cold drinks dispenser. If anyone visiting required food there were indications to the nearest
shop and vending machine. The other relatives room was used as a quiet space to offer people
somewhere to talk in private or a more segregated place to deal with emotional situations.

Critical care provision was flexed to meet the differing care needs of level one, two and three
patients. At the time of inspection visiting times were responsive to peoples’ needs. The service
suggested that visiting started after 11:00am as mornings were very busy and recommended a
resting period for patients between 1:00pm and 2:30pm. When patients were very unstable there
were no restrictions to visiting times.

The outreach team supported critical care discharges to the hospital wards. This team also
supported handovers and feedback between the critical care units and the wards so patients could
experience good continuity of care particularly in cases of patients that were anxious about the
transfer or those who presented with mental health conditions.

There was a support group for former critical care patients in the Royal Sussex County Hospital
and the Princess Royal Hospital. This group was aimed at supporting patients, carers and their
relatives to talk about what they had been through and continue to help recovery from critical
illness.

**Meeting people’s individual needs**

The service identified and met the information and communication needs of people with a disability
or sensory loss. All communication needs and disabilities were recorded on admission and
monitored regularly through ward rounds and huddles. The unit used communication aids such as
picture charts and booklets with basic sentences. Support from the speech and language therapist
was also available for assessment and specialist communication intervention when necessary.
Staff also said they would involve relatives and family members to support communication. This
was in line with NICE QS15 Statement 9: Patients experience care that is tailored to their needs
and personal preferences, considering their circumstances, their ability to access services and
their coexisting conditions.

The unit had one side room which was used for patients who benefited from isolation. We were
told that this room was used to provide individualised care for people with mental health conditions
or support the management of patients at risk.

There were no shower or private wash facilities for ward ready patients. These patients had to rely
on wash bowls by the bedside to have a wash.

Staff told us they tried to provide same sex accommodation for critically ill patients in accordance
with the Department of Health guidance but within a critical care area this was not always
possible. To maintain patients’ privacy the bed spaces were separated by curtains and on the day
of inspection all bed spaces were appropriately screened to maintain patient’s privacy and dignity.

The critical care unit provided evidence of strong links with external services such as GP’s, district
nurses 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 through the
nursing staff and matron. 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.

Staff we spoke with knew how to access translation services for patients whose first language was not English. Translation could be provided face to face or over the telephone.

The service offered support for bereavement and aimed to make the patient and their relatives comfortable and prepared for a dignified death. Additional support was available through the hospital chaplaincy and bereavement team.

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 too 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 care given at critical care.

**Access and flow**

The decision to admit to the unit was made by the critical care consultant. We reviewed three patients’ notes and all patients had been reviewed in person by a consultant in the intensive care unit within 12 hours of admission to intensive care. This was in line with Guidelines for the Provision of Intensive Care Services, 2015: Patients should be reviewed in person by a Consultant in Intensive Care Medicine within 12 hours of admission to Intensive Care.

To support monitoring, access and flow within the hospital the critical care service had close liaison with a clinical pathway co-ordinator following the morning and evening handovers. We saw critical care patients identified as ward ready being discussed and recorded by the clinical pathway co-ordinator. However, we were told that that intensive care patients were prioritised below patients recently admitted from A&E.

Staff on the critical care unit said that initial assessments, test results, diagnosis and treatment were completed and followed up as per guidelines. We saw evidence of this in the three records we reviewed. Records viewed were up to date, complete and detailed future activities in care and assessment.

**Bed occupancy**

From July 2017 to June 2018, Brighton and Sussex University Hospitals NHS Trust has seen adult bed occupancy remain stable, this is about the same as the England average.

**Adult critical care Bed occupancy rates, Brighton and Sussex University Hospitals NHS 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)

The trust had a target to admit 100% of patients within four hours of the decision to admit being made. The critical care unit at PRH had been unable to meet this target for any of the months between April 2018 and August 2018. This ranged from 73% in July 2018 to 93% in June 2018. The latest figure for August 2018 was 85%.

The service was aware of this challenge and it was explained to us that this was mainly the result of challenges relating to patient flow, particularly delayed discharges, as these affected delays in admissions of emergency and elective patients.

Delayed discharges

Princess Royal Hospital

For the Intensive Care Unit at Princess Royal Hospital, there were 2,920 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 12.0%. This compares to the national aggregate of 4.9%. This meant that the unit was not in the worst 5% of units. The figure in the 2015/16 annual report was 7.7%.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,920 available critical care bed days</td>
<td>Crude delayed discharge (% bed-days occupied by patients with discharge delayed &gt;8 hours)</td>
<td>7.7%</td>
<td>12.0%</td>
<td>4.9%</td>
<td>0%</td>
<td>Not in the worst 5% of units</td>
</tr>
</tbody>
</table>

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

The trust had a target of zero bed days occupied by patients with delayed discharges. The critical care unit at PRH had been unable to meet this target for any of the months between April 2018 and August 2018. This ranged from 7 bed days in April 2018 to 29 bed days in July 2018. The latest figure for August 2018 was 23 bed days.

The trust told us this was not a challenge unique to this trust and was identified as a national challenge that led to mixed sex accommodation breaches. The trust also told us that this issue was affected by delays in admissions of emergency and elective patients. However, there were active counter measures and improvement programmes in place to address delayed discharges. Some of these included improving the morning decision process to enable theatres to start on time.
and improve flow, weekly look forward to assess demand and capacity and publishing and reviewing surge documentation to ensure elective patients are agreed by all parties each day.

Non-clinical transfers

Princess Royal Hospital

For the Intensive Care Unit at Princess Royal Hospital, there were 554 admissions, of which 0.5% had a non-clinical transfer out of the unit. This was within the expected range. The figure in the 2015/16 annual report was 0.4%.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>554 admissions</td>
<td>Crude non-clinical transfers</td>
<td>0.4%</td>
<td>0.5%</td>
<td>0.4%</td>
<td>0%</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

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

During inspection we were given data that showed that the critical care unit at PRH had recorded zero non-clinical transfers between April 2018 and August 2018.

Non-delayed out of hours discharges to the ward

Princess Royal Hospital

For the, Intensive Care Unit at Princess Royal Hospital, 1.0% of admissions were non delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. This was within the expected range. The figure in the 2015/16 annual report was 3.5%.

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Metric</th>
<th>2015/16</th>
<th>2016/17</th>
<th>National aggregate</th>
<th>Asp Standard</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>393 admissions</td>
<td>Crude, non-delayed, out-of-hours discharge to ward proportion</td>
<td>3.5%</td>
<td>1.0%</td>
<td>1.9%</td>
<td>0%</td>
<td>Within expected range</td>
</tr>
</tbody>
</table>

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

The trust had a target of less than 6.3% non-delayed out of hours discharges to the ward. The critical care unit at PRH had been able to meet this target for all the months between April 2018 and August 2018 except June 2018 where the score was 13%.

Additional data provided during our inspection indicated that the critical care service at PRH had a target to have less than 1.2% of patients readmitted to critical care within 48 hours of discharge. The service met this target between the months of April 2018 to August 2018 with an average score of 0%.
PRH critical care services also set a target that no elective surgery would be cancelled due to the lack of a critical care beds. This target was met from April 2018 to June 2018.

Learning from complaints and concerns

Summary of complaints

From April 2017 to March 2018 there were six complaints about critical care, three which related to access to treatment or drugs. The trust took an average of 68 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed within 25 days. These complaints all related to Royal Sussex County Hospital.

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

The critical care services at PRH did not receive any formal complaints between April 2018 and August 2018. Despite not receiving any formal complaints, staff told us they had received some informal complaints but these were dealt with immediately and apologies provided to patients. Staff said they encouraged people to make complaints and raise concerns and that they would initially try to understand and see if they could de-escalate the complaint by talking to the patient or those close to them. However, if the complainant did not feel satisfied they would direct them to the Patient Advice and Liaison Service (PALS). Staff also made the matron aware of any complaints and how these were primarily addressed. Leaflets with information on how to raise concerns and complaints were also readily available.

Staff and PALS assured us that should any formal complaints occur these were recorded, people were given regular updates and an explanation of the outcome of their complaint or concern was given. This is in line with the NHS constitution which gives people the right to have complaints dealt with efficiently and be investigated and know the outcome of the investigation.

Staff said they would raise their own concerns with their immediate senior staff, during supervision and huddles or with the freedom to speak up guardians. Some staff said they would get advice from their professional bodies or trade unions. The matron told us she operated an open-door policy in case something needed to be said privately or needed her mediation.

Number of compliments made to the trust

From April 2017 to March 2018 there were no compliments within critical care.

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

At the time of the inspection there had been 20 plaudits received by the service between April 2018 and August 2018. During this period the service managed to equal its target of receiving 20 plaudits on a yearly basis. Staff said they felt valued and engaged when they received compliments and that these compliments acted as fuel to promote the service and continue delivering quality of care for patients using the service.

Is the service well-led?

Leadership

The leadership structure for the critical care services at Brighton was in line with the guidelines for the provision of intensive care services, 2015. Critical care services were established as a full
directorate within the specialist division. This was accompanied by the addition of a directorate manager and deputy directorate manager. The trust was also recruiting for the role of a directorate lead nurse.

Staff told us that changes to the leadership structure had been positive for critical care services as there was more support and engagement. Staff also told us they were aware of who their line manager was. We were told by staff that they felt supported by their supervisors and knew who to speak to if they had any questions relating to the role or responsibility.

Leaders we spoke with understood the challenges to quality and sustainability of the critical care services. They could identify key issues such as flow and the impact of the county site redevelopment on the services at PRH. They were also aware of the risks identified through the risk register and the ongoing development strategies to address these issues.

The leadership team told us they tried to make themselves visible and accessible to staff. Staff said they were aware of who their leaders were and felt they could contact and access them. We heard of staff who met their leaders through the recently introduced team days as well as meeting leaders in the corridors of the hospital. Staff also said that any issues, concerns or feedback could be raised through team meetings or with the matron and then raised through the matron to the leadership team.

Leaders had clear priorities for ensuring a sustainable, compassionate, inclusive and effective leadership. We saw this through the patient first programme and the 3T’s development program. PRH had already graduated in wave 1 of the patient first improvement programme and was currently in wave 2.

The critical care directorate did not have a specific lead for mental health within the service. However, one of the consultants lead investigations and incidents that related to patients with mental health needs. The service also worked closely with the mental health team at the hospital.

Vision and strategy

The trust had a clear vision and set of values with quality and sustainability as top priorities. This was part of the trust’s true north continuous improvement programme. The true north objectives for the trust where sustainability, people, quality improvement and systems and partnerships. The critical care service at PRH identified one key driver to deliver against the true north objectives which was improving rehabilitation. Additionally other initiatives included delivering metavision at PRH, improving eye care in critical care, training of staff in manual handling transfer systems and improving patient experience.

Leadership showed a realistic strategy for achieving their priorities and delivering good sustainable care. The strategy for achieving priorities was linked to the five-year 3T’s plan which included the development of a major trauma ward, development of tertiary services and improvement and development of treatment areas. We were told plans were advancing within expected range.

Staff said they identified with the trusts and critical care services vision and values. They felt that with the development of the patient first programme they were working collaboratively to deliver better services for their patients. Staff also said they felt they were listened to and consulted in the delivery of the objectives.

Leaders supported the delivery of their strategy with the use of strategy deployment reviews. These were conducted weekly to continuously identify and reassess progress of identified improvement drivers. The trust used a delivery and accountability tool named A3 to deliver this.
On this the improvement tool a project was identified alongside nine steps to successfully implement the driver. Steps included: current situation, vision and goals, analysis, opportunities, action plan and progress and follow up.

The clinical strategy for PRH was one of sustainability and there was continuous engagement with other services to develop this. The critical care unit’s strategy considered A&E demand, theatre’s strategy and staffing through both corporate and clinical governance.

**Culture**

Staff we spoke with felt supported, respected and valued. Staff said there had been a change in how the critical care unit was perceived and it now felt more part of the hospital team. Staff also said they felt confident in asking questions and highlighting issues to the leadership.

Both leadership and staff had a culture centred around the needs and experience of the people using critical care services. This was evidenced through the patient first programme and how all decisions considered the quality of care delivered to the patient and their relatives. This was reflected by the outcomes in patient and quality of care.

Staff said the culture in the service encouraged openness and honesty at all levels within the service. We attended an improvement huddle and saw how staff at all levels could contribute to the improvement of the service. Staff said they felt this allowed them to have a closer link to leadership and have a say in how the service was run.

There were mechanisms for staff at every level to appraise their developmental needs and have career development conversations. Leaders supported this through their appraisal system as well as the use of tools such as the A3 and improvement huddles. Leadership also had a strong emphasis on training and key skills development. Examples of this were the use and development of the clinical educator role at PRH as well as the development of the neurological education strategy.

Leaders had a strong emphasis on the safety and wellbeing of staff. We saw how leadership supported staff through difficult occurrences. We also saw evidence of co-operative and supportive relationships among staff.

**Governance**

We were told by a variety of staff how the arrival of the new executive team and the move to a new governance structure, in which critical care was its own directorate in the specialist services division, had all combined to show real benefits to critical care. This had been largely achieved through the patient first programme but there was now a sense that critical care specific matters were dealt with and resolved more quickly.

There were effective structures processes and systems of accountability to support the delivery of the critical care strategy and to provide quality based sustainable services. We saw assurances these were regularly reviewed and improved.

Leaders explained the audit program development scheme which looked to review a range of data including ICNARC and trust wide and local data. The results of this programme were being used to improve the quality of the critical care service. We saw evidence that recent audits were displayed on notice boards in the unit and were easily accessible through the audit critical care nurse. Dissemination of results was made via team meetings, huddles and handovers or during appraisals if these were relevant to the person.
All levels of governance and management functioned effectively and interacted with each other appropriately. An example of this was how governance used the strategy deployment reviews to support the monthly clinical governance leadership meetings by looking at reported incidents, trends and themes such as staffing and recruitment. Leadership also made the decision of following the monthly clinical governance meetings with the finance meeting to be able to follow up and support any decisions that would need to be made regarding projects and improvement programmes or implementing new strategies.

Governance also included the divisional clinical governance meeting which looked at never events, significant incidents, duty of candour and use of exception reports. These were escalated to the board and were conducted on a bi-monthly basis. Outcomes of this meeting were also fed back to leaders at staff level to encourage dissemination of information and learning and involve staff in the conversation about themes.

We were not made aware of any arrangements with partners, third party providers or any existing service level agreements that impacted on the governance of critical care services.

**Management of risk, issues and performance**

Leaders monitored significant risk to the service using a risk register for the critical care services. Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. All risks entered on the trust risk management system were assigned a current and target risk rating. We saw controls were identified to mitigate the level of risk and recorded with an action plan.

Leaders were aware of the main risks and performance issues in the critical care services. The two main issues identified at PRH were delayed discharges and infection prevention and control. Risks were reviewed on a regular basis and discussed at governance meetings and escalated according to risk status. An example of decisions being made using this system was the reinstatement of infection control meetings. Leaders also told us how they were addressing performance issues such as delayed discharges.

During the inspection we were told by a range of staff about the introduction of the improvement huddle and how it led to changes being made that had improved safety and mitigated risk. The huddles were held daily, although there were plans to run one per shift in the future. All staff in critical care were welcome to attend. Staff completed a ‘ticket’ with ideas about how anything could be improved. This ticket was then attached to the board. At the start of each session, the member of staff running the improvement huddle, which could be any member of staff, regardless of their role would look at the ticket and present it to the huddle. All those present would then use a pick chart to show if the idea could be implemented or dismissed and whether it was easy or challenging and what the impact would be. Tickets would then be moved around the board depending whether they were a work in progress, whether they were part of a problem solving exercise using the ‘plan, do, study, act methodology. There was then an area where all tickets could be stored that showed all the ideas that had been implemented.

There was a systematic programme of clinical and internal audit to monitor quality, operational and financial processes. This was incorporated into the governance structure and could identify where actions should be taken at different levels as well as assigning responsibilities.

Staff and leadership were aware of the main issues and risks to the service as well as mitigating actions being taken. This was evidenced through the discussion points held at improvement
huddles, through appraisals we reviewed and through the strategy deployment review meetings. Additionally, staff were aware of the risk register and the top priorities in the risk register.

Leadership and staff had a consistent approach to the patient first programme. This ensured that any developments to the service or efficiency changes would have impact and quality assessments that considered the patients’ needs. We saw evidence of quality and sustainability being assessed and monitored through governance meetings such as the mortality and morbidity meetings minutes.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. There was trained staff responsible for pulling data to run risk assessments. As an example, we asked to review trends on the ongoing audit for delayed discharges. The data was easily accessed and up to date. We were told how outcomes from the audit would be monitored and reviewed and how data was regularly fed back to the governance meetings. Information data relating to performance and safety was collated and shared with senior staff on a regular basis.

The service also collected information it needed for submission to ICNARC by collating data from the patient notes. Data was then extracted and provided to the matron on a weekly basis. This included data on delayed discharges and out of hours discharges. There was also a monthly report around the safety thermometer and a safer staffing report.

The critical care directorate kept a dashboard for each of their critical care units. The dashboard contained a wider range of information about the team’s performance, staffing, infection prevention and control as well as data about the access and flow to and from the critical care units. The dashboard also contained data about how the teams were performing in relation to the overarching drivers for improvement. We reviewed the data collected and saw that it would provide the leadership team with up to date information. It also analysed any trends which showed where improvements had been made or where performance had dropped.

There were effective arrangements to ensure that information used to monitor manage and report on quality and performance was accurate, valid, reliable, timely and relevant particularly in regard with ICNARC data. However, when we highlighted our concerns regarding the ‘five moments of hand care’ leadership said they would have to review this auditing process to ensure more accurate measuring.

In addition to the previously mentioned data, the service was also using the unit score card from the patient first programme to provided a score of how the unit was approaching patient care. Scores were indicating a successful unit and were going to be used as a benchmark for quality of care.

Staff had access to relevant guidance and policies through the trust intranet and in policy folders kept on the unit.

Staff were aware of the importance of data protection and policies were in place for this. Leadership highlighted the importance of this during appraisals and team meetings.

Staff in the critical care outreach team collected data on their activity and patient outcomes and were responsible for completing handovers to other teams when patients were deemed ready to go to wards. We were assured these practices were in keeping with secure information governance.
Engagement

The critical care service engaged well with patients, staff and the public to plan and manage appropriate services and collaborated with partner organisations effectively. An example of this were the trauma packages given in liaison with another major hospital.

Patients and their relatives’ views were valued and considered an essential part of running and developing the service. Staff regularly used patient and relative interactions to continually improve the shape of the service. These views were regularly discussed at huddles and appraisals. We saw this information being collected through patient feedback both informally and through thank you for cards.

Staff were actively engaged so that their views were reflected in planning and delivering services and shaping the culture on the ward. Staff used the A3 tool and improvement huddles to support development from ward to board. These were also used as engagement tools to communicate development and service collaborations.

We were not made aware of any senior staff members who were required to regularly report on aspects of patients’ mental health or emotional well-being.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system. The trust was part of the south east critical care network and had regular engagement with the network. The trust also worked regularly with NHS England and Clinical Commissioning groups to meet the needs of the relevant population. An example of this was the engagement and information sharing regarding mixed sex breaches.

Learning, continuous improvement and innovation

Leaders and staff strived for continuous learning and improvement. There were robust systems and processes for learning, continuous improvement and innovation.

The critical care directorate had appointed a directorate manager in January 2018. To assist with some areas that had previously been dealt with by the clinical staff. They had been able to develop a positive working relationship with the medical and nursing staff in critical care. The directorate manager would attend meetings with the organ donation team, estates and maintenance teams and nursing team meeting. This then allowed them to take forward any issues that had been raised.

Staff told us how changes that have happened across the critical care directorate had not been dramatic but instead based on small improvements that led to bigger change. The approach to incident investigations, recognising themes and approaching any problems with an open mind had meant that patients were safer. It was felt the team now have more awareness of their role and how they can influence daily practice.

Staff and leaders shared learning to make improvements. We were told multidisciplinary talks and huddles encouraged shared learning. Huddles were also used to disseminate safety messages and learning from courses and clinical practice.

Leaders were sent regular database reports and monitoring trends from a wide variety of sources. We were told this helped leadership be more proactive with identifying and managing issues. An example of this was an internal audit looking at the quality of discharge data and the impact this had on patient outcomes.
Critical care services showed examples of learning, development and competence training. We saw this through the appraisal programme, the band 5 preceptorship programme, the ICU steps programme and the patient first improvement system. Staff told us that they used their appraisals and supervision sessions to identify personal and competency based learning needs. We were also told that team meetings were used to disseminate learning as well as have an opportunity to discuss improvement and innovation.

Maternity

Facts and data about this service

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

Brighton and Sussex University Hospitals NHS trust (BSUH) provides maternity services on the Royal Sussex County Hospital (RSCH) and Princess Royal Hospital (PRH) sites. The trust has stated that, at the RSCH site, there are approximately 3,500 babies delivered per annum. They host a community maternity service which achieves a high rate of home deliveries and host antenatal services at Hove Polyclinic. The trust has also stated that, at the PRH site, there are approximately 2,500 babies delivered per annum.

(Source: Routine Provider Information Request – Acute sites)

From April 2017 to March 2018 there were 5,056 deliveries at the trust.

A comparison from the number of deliveries at the trust and the national totals during this period is shown below.

Number of babies delivered at Brighton and Sussex University Hospitals NHS Trust – Comparison with other trusts in England (April 2017 to March 2018)

A profile of all deliveries and gestation periods from January 2017 to December 2017 can be seen in the tables below.
Profile of all deliveries (January 2017 to December 2017)

<table>
<thead>
<tr>
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<th>BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST</th>
<th>England</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Single or multiple births</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>4,967</td>
<td>98.1%</td>
</tr>
<tr>
<td>Multiple</td>
<td>98</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

| Mother's age         |                     |              |               |
| Under 20             | 118                | 2.3%         | 3.0%         |
| 20-34                | 3,382              | 66.8%        | 74.8%        |
| 35-39                | 1,249              | 24.7%        | 18.1%        |
| 40+                  | 316                | 6.2%         | 4.1%         |

| Total number of deliveries |                     |              |               |
| Total                    |                      | 5,065        | 592,194       |

Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

Gestation periods (January 2017 to December 2017)

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<tr>
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<th>BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST</th>
<th>England</th>
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<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Gestation period</td>
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</tr>
<tr>
<td>Under 24 weeks</td>
<td>8</td>
<td>0.2%</td>
</tr>
<tr>
<td>Pre term 24-36 weeks</td>
<td>251</td>
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</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>3,193</td>
<td>89.1%</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td>132</td>
<td>3.7%</td>
</tr>
</tbody>
</table>

Total number of deliveries with a valid gestation period recorded

| Total                |                      | 3,584        | 490,944       |

Note: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

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

(Source: Hospital Episode Statistics - HES Deliveries (April 2017 - March 2018))

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

All trust staff completed five days of mandatory training each year which included one day of online training. Each day of training incorporated several aspects of the required training. Staff booked themselves onto each day throughout the year. There was an additional specific mandatory training day for support workers. Training dates were well advertised throughout the trust. The trust told us staff must be up to date with mandatory training before additional training and development is supported.

Clinical staff received mandatory training on how to recognise patients with mental health needs, learning disabilities, autism or dementia.

Staff provided care that met patients’ needs. Maternity staff received effective training in safety systems, processes and practices. Topics included measurement of fetal growth, cardiotocography training (recording fetal heartbeat and contractions during pregnancy) and obstetric anal sphincter injury care bundle training.
The governance team told us the content of mandatory training was influenced by learning outcomes from incidents. The team attended the third mandatory training day and discussed the previous year’s serious incidents.

Since the last inspection, the trust had increased its target for completion of mandatory and statutory training from 75% to 90%. This was now a similar target to other NHS trusts. As of September 2018, all medical, nursing and midwifery staff across maternity at PRH had met this new trust target for all mandatory courses, except fire safety. However, the completion rate of 88% for fire safety was slightly better than the completion rate at the previous inspection of 86%.

**Mandatory training completion rates**

**Medical staff**

The trust set a training compliance target of 90%.

A breakdown of compliance for mandatory courses for medical staff working in maternity at Princess Royal Hospital as of September 2018 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Safety Training</td>
<td>5</td>
<td>6</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety Training</td>
<td>5</td>
<td>6</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention - Clinical</td>
<td>5</td>
<td>6</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>5</td>
<td>6</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Inanimate Loads</td>
<td>5</td>
<td>6</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Five out of the six eligible medical staff had completed training for all five mandatory training courses.

(Source: Additional Data Request DR06)

**Nursing and midwifery staff**

The trust set a training compliance target of 90%.

A breakdown of compliance for mandatory courses for nursing and midwifery staff working in maternity at trust level as of September 2018 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Patients</td>
<td>26</td>
<td>26</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Nursing and midwifery staff met the target in four of the five mandatory training courses. The only course not to meet the target was fire safety training at 88% compliance, this equates to three staff members.

(Source: Additional Data Request DR07)

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

As of September 2018, nursing staff working in maternity have an 87% completion rate for mental capacity act training which is slightly lower than the trust target of 90% while medical staff have a 53% completion rate.

(Source: Additional data request DR33)

**Safeguarding**

The trust had a named nurse, named doctor and named midwife for safeguarding. The named midwife role was shared between two midwives to provide full-time cover and the safeguarding midwife worked 30 hours a week across both sites. Staff we spoke with could identify the safeguarding midwife and knew how to contact her. The safeguarding midwife attended monthly team leader meetings at PRH to review and discuss safeguarding referrals.

The specialist midwives for substance misuse, teenage pregnancy and mental health, worked with the safeguarding midwife to support potentially vulnerable women.

The maternity safeguarding leads attended supervision every other month with the named safeguarding nurse for Kent, Surrey and Sussex. The maternity safeguarding leads also received alerts from the local safeguarding authority. This demonstrated good collaborative working with local authorities and agencies.

Staff could identify signs of abuse and knew how to escalate their concerns. The safeguarding leads had a group email address which ensured all referrals were reviewed when one lead was off. Staff gave examples of when they had raised safeguarding concerns about expectant mothers and their families. This demonstrated staff understood the scope of safeguarding and protected people in their care from abuse and neglect.

We reviewed six adult safeguarding referrals. We saw that women’s records considered the needs of both mothers and babies, and documented other agencies that were either involved with the women already or were referred to by the midwife. For example, the local authority safeguarding team, social workers, housing charities and the local food bank.
Systems were in place to check whether families were subject to any safeguarding concerns including child protection plans. Safeguarding leads contacted the local safeguarding authority or used their smartcard to access the national child protection information system to obtain this information. Only the safeguarding leads and the ward clerks had authorised access to this system. We saw a child protection plan and how staff implemented this on the labour ward when facilitating supervised contact with the baby.

Staff showed us there was a tick box on the front of women’s records to highlight whether the woman was subject to any safeguarding concerns. The context of the safeguarding concern was contained inside the notes in a yellow plastic divider.

The maternity safeguarding leads attended serious case reviews with the local authority. Maternity staff could shadow these meetings with the safeguarding leads and share the learning in their clinical area.

The trust safeguarding shared good practice and policy updates in a safeguarding newsletter. We saw the newsletters for January, February, May and June 2018. These newsletters signposted staff to additional training events, highlighted relevant policies and covered learning from serious case reviews such as PREVENT (safeguarding people and communities from the threat of terrorism), adverse childhood experiences and domestic abuse.

Since September 2014, it has been mandatory for all acute trusts to provide a monthly report to the Department of Health on the number of women who have had Female Genital Mutilation (FGM) or who have a family history of FGM. In addition, where FGM is identified in women, it is mandatory to record this in the patient’s health record. The maternity services reported a total of 11 FGM cases between January and May 2018. The trust’s FGM policy was in date and included a risk assessment and information on how staff could support women affected by FGM.

Staff had a good awareness of domestic abuse and understood their role to report concerns. We observed midwives sensitively asking women during their antenatal appointment about domestic abuse. This is in line with National Institute for Health and Care Excellence (NICE) QS116 statement 1: people presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion. There was a health independent domestic violence advisor based at the RSCH to train and support staff across both sites.

Since the last inspection, the trust had increased its target for safeguarding training from 75% to 90%. This was now a similar target to other NHS trusts. As of September 2018, all medical, nursing and midwifery staff across maternity at PRH had met this new trust target for safeguarding adults at risk training (97%). For safeguarding children and young people level three training, the completion rate was 81%. This was worse than the trust target of 90%, however this was a significant improvement from the previous inspection when the compliance rate was 44%.

Safeguarding training completion rates
Medical staff

The trust set a training compliance target of 90%.

A breakdown of compliance for safeguarding courses for medical staff working in maternity at Princess Royal Hospital as of September 2018 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults at Risk</td>
<td>5</td>
<td>6</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children and Young People Level 3</td>
<td>3</td>
<td>6</td>
<td>50%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Five out of the six eligible medical staff had completed training for safeguarding adults at risk training course but only half the eligible staff had competed the safeguarding children and young people level three course.

(Source: Additional Data Request DR09)

Nursing and midwifery staff

The trust set a training compliance target of 90%.

A breakdown of compliance for safeguarding courses for nursing staff working in maternity at trust level as of September 2018 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults at Risk</td>
<td>26</td>
<td>26</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children and Young People Level 3</td>
<td>23</td>
<td>26</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff had 100% completion rate for safeguarding adults at risk training course and 88% for the safeguarding children and young people level three course, this equates to three staff members not completing the training.

(Source: Additional Data Request DR09)

The trust had a baby abduction policy which outlined the steps staff should take if a baby was abducted from the hospital. It outlined key contact numbers during and out of office hours. The policy required all mothers to wear one identity band and all babies to wear two identity bands. This practice was adhered to on the wards we visited. During our inspection we observed staff with faded identity badges which made identifying their name and role difficult. This is not in line with the policy, which stated, “staff must wear identity badges with photograph and name clearly identified.” We noted the trust planned to audit staff knowledge and compliance to the policy every three years and a was not due until 2019.
Cleanliness, infection control and hygiene

Hand hygiene audits were not consistently completed by all departments and those that were provided limited assurance of compliance to good hand hygiene. The maternity service undertook weekly hand hygiene audits. Data showed a 99% compliance rate for the antenatal clinic and central delivery suite for returned audits. Between September 2017 and September 2018, the antenatal clinic only returned 75% of the hand hygiene audits and the delivery suite returned only 56%.

All areas we visited were visibly clean and dust free. The maternity service continued to use cleaning schedules for all areas. The schedules highlighted what cleaning responsibilities each staff member had and how often it was to be carried out. This meant staff knew what tasks other staff had completed and minimised the risk of areas not being cleaned.

The Trust had a rolling programme of deep cleaning which meant all hospital beds, ward furniture and equipment were steam cleaned to prevent the spread of infection. The maternity areas had been deep cleaned within the past 12 months. In addition to deep cleans, areas had additional spot cleans and terminal cleans completed as advised by the infection prevention and control team.

We observed that clinical staff complied with the, ‘five moments for hand hygiene’ as set out by the World Health Organisation (2009) and with the trust’s hand hygiene policy. We saw hand gel dispensers were available and in working order across the service. Staff, patients and visitors use the hand gel. Staff felt empowered to challenge their colleagues when hand hygiene was not completed and we saw this in action during a ward round.

There was a risk equipment might be used without being cleaned as there was no indication of when cleaning had occurred. At the previous inspection, staff used ‘I am clean’ stickers on equipment to indicate that the equipment had been cleaned and was safe to use. However, on this inspection, we did not see these stickers in use.

Personal protective equipment was available in all clinical areas and staff followed trust policy and NICE guidance in relation to this.

Not all staff were bare elbow the elbows. Bare below the elbows was introduced nationally to control the spread of infection by ensuring sleeves must be short or rolled securely up to the elbow to allow access to the wrist for good hand washing and so reduce the spread of germs. Thirteen out of 17 staff we observed were bare below the elbows. Those staff who were not, wore short sleeve tunics but with long sleeve tops underneath.

Specific hand washing sinks were available in all rooms and at the entrance to bays on Bolney ward and the Central Delivery Suite. There were also dedicated hand washing sinks, separate to other sinks, in the dirty utility rooms. Sinks had hand washing technique posters displayed to ensure staff used the correct technique.

Volunteers on the unit cleaned the children’s toys twice a week as part of the units cleaning schedule. Curtains around each assessment area were changed by housekeeping staff as per the cleaning schedule. All chairs in the antenatal clinic and day assessment unit were made of wipeable material which enabled thorough cleaning to reduce the risk of infection.

Side rooms were available for women that needed isolation, or protection from infections. On Bolney ward, only mobile patients with one baby could occupy a side room. Staff told us if a patient required a side room for infection control reasons but did not meet these criteria, they would escalate to the maternity co-ordinator and potentially use bays that were not occupied. To
protect patients from the risk of health acquired infections during their admission, this bay would be deep cleaned afterwards.

Data provided by the trust showed no *clostridium difficile* (*C. diff*), *escherichia coli* (*E. coli*), *methicillin*-sensitive *staphylococcus aureus* (*MSSA*) or *methicillin*-resistant *staphylococcus aureus* (*MRSA*) bacteraemia cases at the Princess Royal Hospital maternity unit in the last 12 months.

**Environment and equipment**

The maternity unit at PRH consisted of the following:

- labour ward with eight birthing rooms (two of which are pool rooms)
- obstetric theatre
- bereavement room
- antenatal and postnatal ward with 18 beds and seven side rooms (only two have bathrooms)
- triage bay with three beds and two recliner chairs for monitoring
- antenatal clinic with six clinical rooms, two scanning rooms and a quiet room
- day assessment unit with one bed and two chairs for monitoring

There were minimal delays in the women transferring between ward and theatre. The obstetric theatre and the delivery suite were located on the second floor. This was in line with The Royal College of Obstetricians and Gynaecologists (RCOG) guidelines. Mothers recovering from birth on Bolney ward could visit, spend time with and breastfeed their babies as the neonatal unit was also located on the second floor.

The maternity unit was well equipped to deal with emergencies when they arose as staff had access to a second theatre for emergencies. We observed the co-ordination of a theatre team to handle an emergency case during our inspection.

The maternity unit had enough equipment to ensure safe care. Staff had access to pod storage which contained spare equipment such as thermometer covers and blood pressure cuffs. Both wards had sufficient resuscitation equipment and the central delivery suite also had an emergency delivery trolley. They were well maintained and staff completed a daily checklist to ensure equipment was safe to use and available. Although the maternity day unit did not have its own resuscitation trolley, it resided on the neighbouring ward, staff knew where it was located and there were signs within the department to show its location. Ward staff took responsibility for checking this trolley and we saw evidence to show daily checks were completed.

The ward did not have assurance that equipment was calibrated, if applicable and its contents safe to use. Staff undertook daily equipment checks on the wards. The checks covered ten items and included drug fridge temperature, resuscitation trolley, glucometers (a machine to test blood sugar levels) and the milk fridge. We reviewed completed checks for the past 25 days on Bolney ward and found only 74% of checks were completed and signed for.

During daily safety huddles staff discussed any problems. In theatres, we heard staff escalate that there were no large blood pressure cuffs but an order had been processed and on Bolney ward they discussed the faulty sink being fixed and the faulty door swipe had been reported. This
demonstrated staff took responsibility for ensuring there was sufficient supply of working equipment.

During our previous inspection in 2017, we highlighted concerns around fire safety and outstanding actions relating to fire safety. At this inspection, we saw all areas had up to date risk assessments and clear evacuation plans displayed. The maternity service had trained several midwifery staff to act as fire wardens who ensured the correct procedures were followed in case of a fire. A fire warden was available on each shift.

The obstetric theatre ventilation system had been inspected by an external party. During our last inspection this had been in breach of national recommendations and posed an infection control risk. The ventilation system was now performing within the recommended number of air changes. At the most recent verification in July 2018 the airflow was compliant with the recommendations

Assessing and responding to patient risk

Risks to people who used the services were assessed, monitored and managed on a day to day basis. These included signs of deteriorating health, medical emergencies and challenging behaviour.

Staff completed comprehensive risk assessments for women on booking stage and at every visit to the department. This ensured up to date risks were always considered. Risk assessments contained information on women’s mental health, social and medical assessments and referrals. This is in line with NICE QS22 Antenatal Care, which indicates that risk assessments should be completed for each pregnant woman. This includes body mass index, smoking, gestational diabetes, pre-eclampsia and venous thrombosis.

The service had access to a specialist Mental Health Wellbeing Nurse and/or other specialist mental health support if staff were concerned about risks associated with a patient’s mental health. One staff member had a special interest in mental wellbeing. Staff arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm and had signs of deteriorating mental health.

Women were assessed for venous thromboembolism, in-line with NICE QS3 statement 1: All patients, on admission, receive an assessment of venous thromboembolism and bleeding risk using the clinical risk assessment criteria described in the national tool.

Staff used the maternity early obstetric warning score (MEOWs) to measure individual clinical risk. This tool helped staff recognise signs of physical deterioration in women by monitoring their physiological parameters such as blood pressure, heart rate, respiratory rate and temperature. Maternity services did not undertake any audits of MEOWs charts to monitor compliance but this was in their audit plan. However, notes were audited as part of every incident investigation and the trust reported there was no clinical evidence of detrimental care due to staff not following MEOWs. The trust planned to implement electronic observation records which would enable it to audit notes more easily.

There was an escalation policy for women with presumed or confirmed sepsis who required immediate review. Staff used a sepsis screening tool for the management of patients with suspected sepsis. This was a maternity specific tool to ensure women were treated in line with recommended NICE guidelines, for example receiving antibiotics within an hour. The Sepsis Clinical Nurse Specialist told us there were plans to update the maternity sepsis policy as the
terminology was outdated and amendments were underway to the MEOWs charts so they reflect national guidance.

Staff used the World Health Organisation’s, five steps to safer surgery checklist in maternity surgery. It was highlighted within the Divisional Clinical Governance structure that staff were not completing the debriefing element of this checklist in all cases. The theatre management team implemented daily audits to monitor compliance with two steps of the checklist, briefing and debriefing. Weekly audits of 20 patient records selected at random also occurred to monitor compliance with the other three steps; sign in, time out and sign out. The audits took part during handover to recovery staff, which enabled notes to be rectified in real time. The trust reported the move to daily audits had resulted in a sustained improvement in the five steps to safer surgery. We observed completion of the WHO checklist during our inspection and saw all staff were engaged in the process.

The service had an emergency maternity admission policy which was due for review. This contained a flowchart which outlined the pathway staff should follow should a woman present to accident and emergency. Any pregnant woman admitted to non-maternity wards would be discussed on the labour ward round and a medical review arranged.

There was a dedicated triage service available 24 hour a day, women could call with any concerns or worries and for advice.

Daily safety huddles were an opportunity for staff to raise concerns about any patient that may require additional oversight or clinical input.

The trust had a local agreement with the local NHS ambulance services for when they needed to attend emergencies or when a transfer was required for homebirths. In addition, the emergency maternity admission policy clearly set out the criteria for when women required direct admission to the labour ward. Paramedics attended a homebirth emergency workshop organised by the trust reflecting women’s stories and experiences.

The department used a system of ‘fresh eyes’ on all cardiotocography monitoring (CTG). CTG is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy. The cardiotocography printout was reviewed by another midwife or medical staff to check there was agreement in its interpretation. Staff recorded half-hourly CTG and hourly fresh eyes reviews on a specific sticker within the patient notes. This system helped to identify possible misinterpretation.

Staff assessed and responded to patient risk well. We reviewed a root cause analysis for a maternal cardiac arrest which was downgraded to a low harm incident following investigation. It highlighted good practice amongst the maternity theatre team in escalating care quickly, working together to minimise patient risk and thorough documentation of the emergency which demonstrated compliance to trust policies.

**Midwifery and nurse staffing**

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

The trust had a target of 100% for one to one care in labour which is in line with NICE NG4 Safe Midwifery Staffing guidelines. Since August 2017, the trust had sustained a compliance rate between 99% and 100%. This is significantly better than the compliance rate reported at the previous inspection between 65% and 85%. 
There were effective systems in place to quickly address any possible lapses in one to one care. Maternity services had an escalation protocol which outlined steps staff should take if the area was identified at green, amber or red alert. The maternity unit at PRH reported no divers or unit closures within the last year due to low staffing levels.

Maternity services undertook a nationally recommended maternity specific staffing review in January 2018. The review suggested staffing levels should be one midwife to every 26 patients, however the template in use at the time of our inspection was one midwife to every 30 women. We noted the maternity services staffing document was out of date as it had not been updated since January 2016. Staff were aware of a business case to increase the template but it had still not made any significant progress.

According to the template, the maternity unit at PRH were eight whole time equivalent midwives short. However, data from the trust showed between April 2017 and March 2018 the trust had a ratio of one midwife to every 24.3 births, which was better than the recommended level. Most midwifery staff we spoke with were positive about staffing levels and stated there were no vacancies.

The labour ward employed two shift coordinators which ensured there was one shift coordinator available on every shift. This was in line with the Safer Childbirth guidelines.

Maternity leads met once weekly to discuss operational issues such as staffing. They reviewed the following week’s rotas and agreed actions to resolve any staffing issues. This ensured any concerns were escalated early to ensure safe staffing levels.

Staffing levels were discussed at the daily safety huddle in all departments which the shift coordinators attended. Staff told us if they were short staffed due to an unexpected absence, they escalated this to the relevant maternity lead who reviewed staffing levels across the department to see if staff could be moved. If this was not possible, the department sourced staff from the internal bank.

Staff numbers were not displayed outside all inpatient areas in line with NHS England and CQC guidelines. On Bolney ward, we saw a small whiteboard behind the nursing station detailing the names of staff on shift. It was not clear from this whether the ward had sufficient staffing as details of planned and actual staffing levels were not included.

The maternity department employed maternity support workers who could perform a range of tasks including taking observations, supporting women with breastfeeding, attending to the needs of the women, catheter care, taking bloods and cleaning. The trust had developed workbooks to support maternity care assistants in their learning and development.
Planned vs actual

The trust reported the following midwifery and nursing staff numbers in maternity for two snapshots in time; 31 March 2017 and 30 April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>As at 31/03/2017</th>
<th>As at 30/04/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>sites</td>
<td>195.0</td>
<td>201.2</td>
</tr>
</tbody>
</table>

The trust fill rate for midwifery and nursing staff in maternity at 30 April 2018 is greater than the trust fill rate at 31 March 2017 (99.2% compared to 96.9%). At 30 April 2018, the trust had 1.7 fewer WTE midwifery and nursing staff in maternity than they had planned.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From May 2017 to April 2018, the trust reported an overall vacancy rate of 4.1% for midwifery and nursing staff in maternity. This is lower than the trust target for vacancy of 10.5% (as at March 2018). A site breakdown can be seen below:

- Royal Sussex County Hospital maternity services department: a vacancy rate of 1.0%.
- Princess Royal Hospital maternity services: a vacancy rate of 4.4%.
- Staff assigned to ‘other’ sites within maternity at the trust: a vacancy rate of 15.0%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From May 2017 to April 2018, the trust reported a turnover rate of 11.5% for midwifery and nursing staff in maternity. This is better than the trust turnover target of 14% that was set for March 2018 (the trust has said that they are aiming to reduce this target incrementally to 11.0% by March 2019). The trust was unable to provide this data at site level.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From May 2017 to April 2018, the trust reported a sickness rate of 4.3% for midwifery and nursing staff in maternity. The trust has set a sickness target of 4.2% as at March 2018 reducing incrementally to 3.5% by March 2019. A breakdown of sickness rates by site is found below:

- Royal Sussex County Hospital: 3.6%
- Princess Royal Hospital: 5.8%
- Staff assigned to ‘other’ sites within maternity: 0.6%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)
Bank and agency staff usage

Please note that the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff in all cases. Therefore, we have been unable to analyse bank and agency usage as a proportion of the total shifts needing to be filled.

The table below shows the numbers of shifts in maternity at a trust wide level from April 2017 to March 2018 that were covered by qualified nursing and nursing assistant bank and agency staff or left unfilled.

For qualified midwifery and nursing staff, 2,587 shifts were filled by bank staff and 6 shifts were covered by agency staff to cover sickness, absence or vacancy for qualified nurses. In addition, 248 shifts were not filled by either bank or agency staff.

For healthcare assistants, 1,100 shifts were filled by bank staff and no shifts were covered by agency staff to cover sickness, absence or vacancy for healthcare assistants. In the same period, 62 shifts were not filled by either bank or agency staff.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Qualified nurses</th>
<th>Healthcare assistants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>2,587</td>
<td>1,100</td>
<td>3,687</td>
</tr>
<tr>
<td>Agency</td>
<td>6</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Not filled</td>
<td>248</td>
<td>62</td>
<td>310</td>
</tr>
</tbody>
</table>

Unfortunately, we are unable to provide a site-specific breakdown of nursing bank and agency usage in maternity due to the format of the data provided by the trust.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

Midwife to birth ratio

From April 2017 to March 2018 the trust had a ratio of one midwife to every 24.3 births. This was similar to the England average of one midwife to every 25.7 births.

(Source: Electronic Staff Records – ESR Data Warehouse)

Medical staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

The maternity service met the recommended 40 hours of obstetric consultant staffing levels as recommended by Safer Childbirth (2007). These hours were 8.30am to 5pm Monday to Friday. A specialist registrar was rostered to cover the labour ward 24 hours per day on a shift basis. Staff told us there were two consultant vacancies but recruitment into these roles had begun. Where the service could not be covered internally, the service used a regular consultant locum who was familiar with the unit. All staff we spoke with, felt the consultants were very supportive, easy to get hold of and quick to attend the hospital when asked.

Women were reviewed and had their management plan updated regularly. A consultant undertook twice daily board rounds and telephoned in for handover at 10pm. This is line with Safer Childbirth guidelines which state, “There should be a minimum of twice daily ward rounds”.

The maternity service provided 24 hours, seven days a week cover for obstetric theatres. In addition, there was an on-call service for any untoward situations such postpartum bleeding. The obstetric theatre team consisted of an anaesthetic practitioner, a scrub practitioner, a recovery practitioner and a healthcare assistant.

The service was proactive and worked as a team to maintain patient safety. Anaesthetists were available throughout the day including weekends, we saw anaesthetists attending the daily safety huddle in theatre. The consultant anaesthetists provided specialist obstetric anaesthesia between 8am and 6pm Monday to Friday. At weekends or out of hours, an onsite registrar or fellow and a non-resident on-call consultant provided cover. Staff told us if there was an unplanned absence, an in-house locum would provide cover or occasionally a consultant would step down.

**Planned vs actual**

The trust reported the following medical staffing numbers in maternity for two snapshots in time: 31 March 2017 and 30 April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>As at 31/03/2017</th>
<th>As at 30/04/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>All sites</td>
<td>59.4</td>
<td>55.4</td>
</tr>
</tbody>
</table>

The trust fill rate for medical staff in maternity at 30 April 2018 is less than the trust fill rate at 31 March 2017 (93.2% compared to 107.3%). At 30 April 2018, the trust had 3.8 fewer members of midwifery and nursing in maternity (WTE) than they had planned.

(Source: [Routine Provider Information Request (RPIR) – Total staffing tab](https://example.com))

**Vacancy rates**

From September 2017 to August 2018 the trust reported an annual vacancy rate of 4.3% for medical staff in maternity. The trust target was 10.5% in March 2018, the trust plans to reduce its vacancy target incrementally to 9.0% by March 2019.

(Source: [Additional data request DR20](https://example.com))

**Turnover rates**

From September 2017 to August 2018 the trust reported an annual turnover rate of 17.8% for medical staff in maternity. The trust target was 14% in March 2018, the trust plans to reduce its turnover target incrementally to 11% by March 2019. Please note that training grade doctors are not included in the turnover rates as they participate in six monthly placement rotations.

(Source: [Additional data request DR19](https://example.com))

**Sickness rates**

From August 2017 to July 2018 the trust reported an annual sickness rate of 2.7% for medical staff in maternity. The trust target was 4.2% in March 2018, the trust plans to reduce its sickness target incrementally to 3.5% by March 2019.

(Source: [Additional data request DR21](https://example.com))
Bank and locum staff usage

For the period covering April 2017 to March 2018, the trust reported that no shifts were covered by bank or medical locum staff in maternity.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix

In March 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.

Staffing skill mix for the 51.2 whole time equivalent staff working in maternity at Brighton and Sussex University Hospitals NHS Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>35%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>2%</td>
<td>9%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>55%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior*</td>
<td>8%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty  
~ Registrar Group = Specialist Registrar (StR) 1-6  
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Women held their own paper maternity records and took them to antenatal appointments. Babies had a separate (Red book) record created after birth. Red books are used nationally to track a baby’s growth, vaccinations and development.

We looked at five sets of patient records on the central delivery suite and post-natal ward. All records contained completed risk assessments, past medical history and patient preferences. Management and treatment plans for women were clearly recorded. There was very detailed documentation of triage and escalation. Most entries included the healthcare professional’s designation and name. However, we noted not every page within the inpatient records had the patients name and hospital number at the top. This could lead to healthcare professionals potentially writing in the wrong patient notes. In one set of notes, there were inconsistencies between the midwifery and medical documentation. The medical documentation was insufficient to describe the events in theatre and in another set of notes it was not clear whether the registrar was supervised during the delivery or if they were lone working.
In each department we visited, we saw patient records were stored in locked trolleys at the nursing station. This maintained security and prevented unauthorised access of patient records.

The trust did not carry out scheduled audits of maternity records. However, maternity records were part of a continuous audit undertaken within incident review meetings. At these meetings actions are identified such as changes to documentation and the learning is shared across the department.

Staff told us that it was very rare for patients to be seen in the antenatal clinic without their medical notes. Data showed only 3% of patients seen in outpatients trust wide last year were seen without their medical notes available. If notes were not available, a temporary set of notes were made up, at the clinic, and then sent to the central library to be joined with the original notes.

**Medicines**

At handover, the message of the week was discussed amongst staff. During inspection, the message related to patient own medication and the requirement for two midwives to check and record the medicines that were stored in the patient’s own locker by their bedside. Women were not provided with individual drugs for self-administration but could ask staff for medicine when required.

Controlled drugs were stored, monitored and administered in line with NICE NG46 guideline controlled drugs: safe use and management. Controlled drugs are medicines which are controlled under the Misuse of Drugs legislation. Staff told us controlled drugs were checked once per shift before handover. We checked the controlled drug logbooks on Bolney ward and the central delivery suite and found no omissions. One staff member told us if there were any discrepancies, they would review the administration charts, escalate concerns to pharmacy, contact the police and report it as an incident. She was unaware of any such incidents occurring.

Staff did not have assurance the medicines were safe to use. Staff explained the department held a stock of regular medicines to aid discharge and wait times as the pharmacy were busy. All medicines stored were in date and clearly segregated by type such as liquids, tablets and intravenous fluids. We saw four opened bottles of medicines without a date on them to indicate the date of opening. We escalated our concerns to the midwife in charge who took immediate action and disposed of the opened bottles. We saw new bottles were received from pharmacy with ‘open date’ stickers.

Medicines within the treatment boxes were available and safe to use. Staff told us the haemorrhage and hypoglycaemia treatment boxes were checked every day as part of the daily checks. We saw completed records of these checks with no admissions.

The trust undertook a safe and secure audit in June 2018 and developed action plans in response to this. Following this, pharmacy undertook two walkabouts in August 2018 and fed back to staff directly. The maternity department was audited again in September 2018 and highlighted actions to be taken against recording fridge and room temperatures, and security.

All medical and clinical rooms were locked during inspection and accessible only by swipe card. This ensured all medicines were securely stored.

Medicines that needed to be stored within fridges were stored at the correct temperatures. Fridges were checked daily and the minimum and maximum temperatures recorded. Staff signed to say these had been checked and we saw a protocol which should be followed if the fridges were not in the correct temperature limits. This protocol was in line with best practice guidelines.
Staff did not have assurance medicines stored in the room were safe to use. On the central delivery suite, we saw only seven out of 25 days had a recorded temperature. In addition, we noted one day whereby the temperature was outside of the acceptable range but there was no record of what action was taken in response to this. We escalated our concerns to the midwife in charge who told us she believed the recorded temperature was incorrect but she would remind staff on the importance of recording the room temperatures accurately.

On Bolney ward we saw staff signed to say the room temperature was checked but there was no record of the temperature. Therefore, there was no audit trail of minimum, maximum and actual temperatures. We escalated our concerns to the midwife in charge who told us this was an oversight as changes were made to the recording template. We also noted Bolney ward and the Central Delivery Suite used different templates to record room temperatures.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and reported them in line with trust policy. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

**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 2017 to May 2018, the trust reported no incidents which were classified as never events for maternity.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in maternity which met the reporting criteria set by NHS England from June 2017 to May 2018.

This was a screening issue meeting SI criteria which took place at antenatal clinic in RSCH.

(Source: Strategic Executive Information System (STEIS))

The maternity services took a multidisciplinary approach to investigating incidents. There was a maternity governance team which consisted of a governance manager, a risk midwife, a protocol midwife and a risk administrator. The maternity service held weekly incident meetings. The governance manager and risk midwife investigated all incidents and attended serious incident review meetings. The team told us at these meetings there would also be two obstetricians, a patient safety team member, a lead midwife, a bereavement midwife and an anaesthetist.

Learning from incident investigations were disseminated throughout the department. Any action plans from serious incidents were reviewed monthly by the maternity governance team. The team
also had a presence at mandatory training days and discussed lessons learnt from the previous year’s serious incidents.

We reviewed the root cause analysis for a serious incident which was downgraded to a low harm incident following investigation. We saw there were nine panel members who participated in the investigation which consisted of a notes review, a guideline review and staff statements. Documentation showed the duty of candour was correctly applied. The Duty of candour is a regulatory duty under the Health and Social Care Act (Regulated Activities Regulations) 2014, where as soon as reasonably practicable after becoming aware that a notifiable safety incident had occurred a health service body must notify the relevant person that the incident had occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. The head of midwifery conducted a debrief with staff involved on the incident and we saw evidence of shared learning in the women’s services quality newsletter.

The governance team fed back learning from incidents to maternity staff. Staff told us they received an email, monthly, called the quality tweet and received a message of the week to discuss at daily safety huddles. The team also fed back to maternity leads and education supervisors who disseminated this to their clinical teams.

Staff understood their responsibility to raise concerns and report safety incidents or near misses. Staff provided examples of when they raised concerns and knew who to contact if they wanted feedback. Staff reported receiving feedback from incidents they had reported and felt that the culture was open and they did not feel blamed when things went wrong.

We saw examples where changes in practice had occurred following on from incidents. There had been an incident where a member of staff required assistance urgently due to a patient collapse but was unable to summon help easily as staff were with patients in the clinic rooms. As a result, the trust had implemented a pendant alarm for staff in the day assessment unit to alert others of an emergency.

A screening midwife in the antenatal clinic provided an example of learning from a maternity related never event which occurred at the other hospital site. This demonstrated cross site dissemination of learning from incidents.

**Safety thermometer**

The service collected and reported safety monitoring results. Safety thermometer results from September 2017 to August 2018 showed 99.3% of patients across the women’s and children’s division received harm free care. This was better than the trust average of 95%.

Although there was not a specific maternity safety thermometer, the trust did measure the metrics for perineal trauma, post-partum haemorrhage and shoulder dystocia. Shoulder dystocia is a rare emergency where your baby’s shoulder becomes stuck during the second stage of labour. These metrics were discussed at the weekly incident meeting.

It was reported that the total number of babies born with shoulder dystocia was worse than the target set by the trust of 0.5% between April and July 2018, except for May 2018 when it was zero. The highest percentage was recorded in July 2018 with 3.7%. The trust planned to audit these cases to identify any themes or areas for improvement.

It was reported that the percentage of women with a blood loss of over 2000 millilitres was better than the target set by the trust of 1% between April and July 2018, except for May 2018 when it was 1.1%.
It was reported that the total number of women who sustained a third or fourth degree tear was better than the target set by the trust of 5% between April and July 2018.

Is the service effective?

Evidence-based care and treatment

Maternity services holistically assessed and delivered treatment in line with legalisation, standards and evidence based guidance. There were systems to monitor the effectiveness of care and treatment and the service used the findings to make improvements. They compared local results with those of other services to learn from them.

Women were risked assessed for gestational diabetes and offered glucose tolerance testing. We observed staff undertake this assessment in the antenatal clinic and document the outcome with the pregnancy care record. This is in line with National Institute for Health and Care Excellence (NICE) CG3 diabetes in pregnancy.

Care was offered in a coordinated and flexible way. In July 2018 the trust was recognised as one of the top performing hospitals in the UK for helping diabetes patients control their glucose levels. The trust offered a one stop diabetic clinic for women identified as at risk of gestational diabetes. The clinic was multi-professional and included dieticians, obstetricians, and specialist diabetes midwives. Staff at PRH could refer patients to this clinic located at RSCH. In the two years since this was first developed there had been no diabetes birth defects experienced by mothers.

Women had their blood pressure monitored throughout their pregnancy. We observed staff take women’s blood pressure in the antenatal clinic. Notes we reviewed on the labour ward showed blood pressure completed at antenatal appointments were available. This meant staff could identify trends for each woman. This is in line with NICE QS35 hypertension in pregnancy.

Women were cared for by a named midwife throughout their pregnancy. We saw evidence of continuity of care with the woman’s named midwife despite multiple antenatal contacts. This is in line with NICE QS22 antenatal care.

Staff measured and recorded the symphysis fundal height from 24 weeks. This measurement is used to assess fetal growth and development during pregnancy. The pregnancy care record contained a growth chart and the associated escalation protocol. We saw evidence of staff recording fetal growth at each antenatal appointment and subsequent ultrasound scans performed. This is in line with MBBRACE-UK (2015) and NICE CG62. Women were also encouraged to monitor the baby’s movement between antenatal appointments as a method of fetal surveillance.

Women and their partners were supported and encouraged to have skin to skin contact with their babies. Skin-to-skin contact with babies soon after birth supported parental bonding and improved temperature regulation of new-born infants. The service had a series of posters promoting their ‘let’s get naked’ project which aimed to raise awareness of the advantages of skin to skin contact with babies. This is in line with NICE QG190 intra-partum care for healthy women and babies.

The safety and quality team identified newly published or updated NICE guidance. The team circulated the guidance and a gap analysis to the lead clinician within maternity, the pharmacist and divisional management team. The lead clinician reviewed the guidance, determined whether it was relevant to maternity services and completed the gap analysis. The safety and quality team recorded the lead clinician’s response on a trust database. This ensured all protocols and policies
were updated in accordance to national guidance and evidence best practice. The department had 117 protocols, of which five were in the process of being updated. Staff told us all guidelines were accessible on the trust intranet and reported no problems in assessing these.

Opportunities to participate in benchmarking and peer review were proactively pursued, including participation in approved accreditation schemes. Brighton Hospital University Trust was one of three pilot sites for the Healthcare Safety Investigation Branch (HSIB). HSIB became operational on 1st April 2017, its purpose was to improve safety through effective and independent investigations with no apportion of blame or liability. Within maternity they used the National Perinatal Mortality Review Tool to review all eligible cases. The review included external members to ensure fresh eyes and input from the Clinical Commissioning Group.

The department had increased the numbers of midwives undertaking New-born Infant Physical Examination (NIPE) training. The training developed by the Advanced Neonatal Nurse Practitioners and supported midwives being able to deliver NIPE checks at home. This allowed women to return home without delay when they were ready, and allowed mothers who had birthed at home to remain there without the need to visit hospital. The department had also purchased Bilirubinometers (a device that directs light into the skin of the neonate and measures the intensity of specific wavelength that is returned to detect jaundice) to support babies with jaundice to remain at home avoiding hospital visits.

The maternity service had a bereavement pathway for women and families. We saw a flowchart for follow up bereavement support for parents which outlined the bereavement team’s responsibilities and role during initial contact through to discharge. Ward staff had checklists covering a range of baby deaths such as stillbirth over 24 weeks, born with signs of life and miscarriage under 24 weeks. This ensured each family were given tailored support and staff followed the correct checklist which aligned to best practice.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. The service met the needs of women with religious, cultural and other preferences. The trust website contained leaflets for women regarding nutrition and hydration in pregnancy and breastfeeding.

Women helped themselves to breakfast between 8am and 9am. Staff would serve breakfast to women who were unable to mobilise. Lunch and dinner were protected times and served outside of visiting hours. If a woman missed a meal or felt hungry they could request a snack box. Women had access to free hot drinks but visitors were asked to make a small contribution.

Women received support to breastfeed after birth and this continued on the post-natal ward. Breastfeeding initiation was consistently above the trust target of 85% with figures averaging 87%. There were also leaflets on breastfeeding available on the trust website and within the wards. We saw posters advertising the drop-in breast-feeding service. There was a breastfeeding room for women to use with accessible breast pumps and a fridge to store breastmilk. If women wished to bottle feed, sterilisers were readily available.

Staff knew which women required support with feeding their baby as staff discussed baby feeding regime at handover. This included the women’s feeding preference, their progress with feeding their baby and babies who had artificial feeding.

Some women had fed back to the service to say they received mixed messages in relation to breastfeeding. Since the previous inspection, the service employed a breastfeeding midwife who was based in the antenatal clinic but visited the wards when requested. Nursery nurses offered 24
hours a day, seven days a week support as did midwifery care assistants. The introduction of these roles meant women were better supported with feeding their baby.

**Pain relief**

Women had access to a range of pain relief methods in accordance with NICE guidance CG190. This included pharmacological pain relief such as Entonox (gas and air), pethidine (a morphine-based injection) and epidurals during labour. Epidurals were available 24 hours, seven days a week. Staff could refer women to the community hypnobirthing and aromatherapy specialist midwives.

Women also had access to non-pharmacological pain relief such as aromatherapy and birthing pools. Alternative pain management was encouraged including the use of transcutaneous electrical nerve stimulation machines. These are machines which are used as an alternative to medication, and they can ease pain in some people with certain types of pain.

Patients had access to information regarding pain relief. There were posters in the central delivery suite outlining pain relief options to patients as well as leaflets in the antenatal clinics and on the trust website.

The department did not undertake pain audits. The trust told us there was an expectation from staff to incident report any delays in care. These delays were discussed at weekly incident meetings; however, the trust had not identified any trends around delays in pain relief.

Staff discussed women’s level of pain and subsequent management plans during handover. This ensured all staff knew which women required review of their needs in relation to pain.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The department had recently been identified as an outlier for third and fourth degree tears. These tears are referred to as Obstetric Anal Sphincter Injuries (OASI). The department had undertaken a piece of work called the ‘ORB’, which stands for OASI Reduction at Brighton and Sussex University Hospitals NHS trust. The project encompassed research and evidence from other trusts and focused on position, guidance, protection and pace of delivery. Since the introduction of the project the rates of OASI had reduced significantly with rates of 2.3%. This is much better than the previous high of 7.7% and was also better than the trust target of 5%.

Previously the maternity dashboard showed that the department had not met expected targets in some patient outcome indicators. We saw an improvement in many of these indicators, and where the department was not meeting targets there were action plans in place to ensure patient outcomes remained high. An example of this was the number of women who experienced shoulder dystocia. The department had understood the challenges of this and was undertaking a deep dive and audit to ensure no learning opportunities were missed.

Successful vaginal birth after a caesarean procedure were slightly below the target of 75% at 70% success, however this was an improvement from the previous 2016/17 figures which indicated only 62% were successful.

The department had maternity specific tools throughout the department as women’s maternity needs were different to that of other patients within the hospital. For example, the maternity
department had a separate sepsis screening tool that was completed and placed in all women’s notes. This had maternity specific questions such as if a woman may be suffering with mastitis (infection of the milk ducts).

**National Neonatal Audit Programme**

Princess Royal Hospital

In the 2017 National Neonatal Audit Princess Royal Hospital’s performance in the two measures relevant to maternity services was as follows:

- **Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?**

  There were 28 eligible cases identified for inclusion, 84.0% of mothers were given a complete or incomplete course of antenatal steroids.

  This was within the expected range when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.

  The hospital did not meet the audit’s recommended standard of 85% for this measure.

- **Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?**

  The data for Princess Royal Hospital for this question was suppressed due to low numbers.

(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)

**Standardised Caesarean section rates and modes of delivery**

From January 2017 to December 2017 the total number of caesarean sections was as expected. The standardised caesarean section rates for elective sections as expected and rates for emergency sections as expected.

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England Caesarean rate</th>
<th>England Caesareans (n)</th>
<th>BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST Caesarean rate</th>
<th>BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST Caesareans (n)</th>
<th>Standardised Ratio</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective caesareans</td>
<td>12.4%</td>
<td>738</td>
<td>14.6%</td>
<td>1,531</td>
<td>107.8 (z=0.7)</td>
<td>Similar to expected</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.7%</td>
<td>793</td>
<td>15.7%</td>
<td>1,531</td>
<td>97.9 (z=-0.2)</td>
<td>Similar to expected</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>28.1%</td>
<td>1,531</td>
<td>30.2%</td>
<td>1,531</td>
<td>102.4 (z=-0.3)</td>
<td>Similar to expected</td>
</tr>
</tbody>
</table>

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.
Delivery methods are derived from the primary procedure code within a delivery episode.

In relation to other modes of delivery from January 2017 to December 2017 the table below shows the proportions of deliveries recorded by method in comparison to the England average:
Delivery rates at the trust for all three delivery methods described in the chart above were similar to the England average.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

Maternity active outlier alerts

As of 14 August 2018 the trust reported no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

The maternity department was involved with the trusts ‘Learning from Deaths Programme’. The trust appointed the Chief Medical Officer and a Non-Executive Director to oversee any learning from deaths across the trust. The Deputy Medical Director for safety and quality presented to the Grand Round about learning from deaths, this included case presentations on neonatology mortality. For neonatal mortality Brighton and Sussex University Hospital was the 6th best level three unit (with surgery) out of 26 in the country.

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 5.72.

This is more than 10% lower than the average for the comparator group rate of 6.71. The trust’s performance for this audit was much better than the national comparator group.

(Source: MBRRACE UK)

Maternity achieved an average of 4.4% births at home. In recent months (April to July 2018) this had further increased to 5.1%. This was better than the national average of 2.1%.

Progress against safety alerts was monitored by the safety and quality lead who escalated any concerns regarding implementation to the deputy medical director for safety and quality. National patient safety alerts are issued by NHS Improvement to rapidly warn the healthcare system of risks. These were reviewed in detail to determine whether the trust was currently compliant with the alert. Where the trust was not compliant, actions were taken or planned to ensure future compliance. In the last 12 months, there had been eight alerts published that were relevant to BSUH.
All safety alerts were incorporated into the draft audit forward plans that were circulated to departments in March of each year. From recent alerts published, the trust had undertaken an audit of resources to support the safety of girls and women who were being treated with valproates. Valproates are medicines primarily used to treat epilepsy, bipolar disorder and to prevent migraine headaches.

Brighton and Sussex University Hospitals Trust were taking part in the Maternal and Neo-Natal Health Safety Collaborative. This was a national initiative to reduce the rates of maternal deaths, stillbirths and brain injury. The introduction to this scheme was attended by the matron, obstetric lead and labour ward leaders. The obstetric consultant at the trust was the lead for the county on this initiative. This showed a commitment to achieve better rates of intrauterine fetal death and stillbirth. At the time of our inspection, the trust had a lower number of stillbirths per 100,000 births than the national average.

**Competent staff**

Staff had the correct skills, knowledge and experience to deliver effective care, support and treatment. There were comprehensive training and education opportunities available to staff.

A practice development midwife and a clinical skills facilitator worked across maternity to ensure staff had access to training and worked within the department to offer midwives support when needed.

Maternity services had introduced a new model of midwifery supervision. All supervisors of midwives were transferring to the professional maternity advocate (PMA) role. PMAs are experienced practising midwives trained to support and guide midwives to deliver care developed nationally and locally. Staff had received an email containing the PMA contact details. Staff told us supervision was much more apparent than PMAs and they had not had much contact with their PMAs. However, this role had only been in place for a month at the time of the inspection and therefore it was too soon to assess its effectiveness.

Midwives rotated between Bolney ward, the day assessment unit and the labour ward every eight months. Staff reported they enjoyed this as it kept the job varied and enabled them to maintain their skills in all areas.

Staff were actively encouraged to undertake training to further their skills. Staff had been involved in developing regional teaching for nursery nurses and extended training in advanced neo-natal life support. They also attended skills drills, one off specialist study days and online courses in topics such as obesity and cardiac care. Midwives told us they had enough opportunities for continuing professional development to be able to complete their revalidation.

Stillbirth and Neonatal death charity training, had been undertaken by a total of 80 maternity, gynaecology & neonatal staff. Bereavement training was also now included in all mandatory training within the department.

There were opportunities to review practice and improve clinical knowledge. For example, there was a weekly meeting to discuss all cardiotocography readings for category one and two caesarean sections from the previous week. Cardiotocography is an assessment of a baby’s heart rate in the third trimester. Staff told us this meeting was well attended by doctors. We observed junior doctors providing teaching and support to medical students during a ward round. The trust performance, in the recent General Medical Council survey, demonstrated an improvement in trainee doctor experience.
At the last inspection, we noted consultants completed the cardiotocography training package every three years which was not in line with other staff. At this inspection, all staff undertook cardiotocography training yearly.

The infection prevention nurse told us sepsis management was discussed at the nursing and midwifery induction to ensure all staff are aware of the trust policy. Midwives also attended additional sepsis study days, the most recent being in August 2018 and midwives were encouraged to share learning from this day with their colleagues.

Maternity services held a maternal mental health study day and planned to hold a ‘whose shoes’ workshop in March 2019 which aimed to increase awareness of patient experience during labour.

**Appraisal rates**

From May 2017 to May 2018, 81.2% of staff within maternity at the trust received an appraisal compared to a trust target of 78%. The trust target is correct at March 2018; however, they have commented that the target will increase incrementally to 90% by June 2018. Below is a split of appraisal completion rates by staff group in maternity.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals complete</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>151</td>
<td>129</td>
<td>85.4%</td>
<td>78%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>72</td>
<td>55</td>
<td>76.4%</td>
<td>78%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>6</td>
<td>2</td>
<td>33.3%</td>
<td>78%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>229</strong></td>
<td><strong>186</strong></td>
<td><strong>81.2%</strong></td>
<td><strong>78%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

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

**Multidisciplinary working**

Staff, teams and services within maternity services worked together well to deliver effective care and treatment.

Staff told us there was structured board rounds which included the full obstetrics team and were midwife held. We observed this during our inspection and found all staff were engaged in the process.

We observed safety huddles in all areas we visited. These were newly implemented at our last inspection. These were short multidisciplinary briefings designed to give, clinical and non-clinical, staff opportunities to escalate and discuss any operational concerns. Staff felt these briefings were beneficial and inclusive to all staff.

Midwives told us consultants actively encouraged multidisciplinary working and they liaised with the co-ordinating midwives throughout the day.

Meetings across the department were attended by multidisciplinary teams. The service held incident reporting meetings every Monday at lunchtime on the labour ward. All staff were invited and staff told us it was attended by the obstetric consultant, the maternity manager, members of
the maternity governance team and midwives. This demonstrated a multidisciplinary approach to learning and improving standards of care. We saw an incident investigation report that highlighted good practice in the maternity theatre team on working together to minimise patient risk.

Staff worked across health care disciplines and with other agencies when caring for women with mental health or safeguarding needs. Ward staff referred women for daily visits by the community midwife called targeted care. Hospital midwives reported a good working relationship with the community midwives. Community midwives reported feeling happy to call the day assessment unit for advice as the hospital staff were receptive.

**Seven-day services**

Consultant and midwife support was available 24 hours a day, seven days a week at the hospital. The community midwife team also ran a homebirth team, 24 hours a day, seven days a week.

The day assessment unit opened between 8.30am and 6pm Monday to Friday. Outside of these times, there was a dedicated 24-hour telephone triage service. This service could be accessed at any stage of pregnancy.

The antenatal clinic offered consultant clinics three days a week and midwife led clinics twice a week which included birth options and a one stop clinic for substance misuse, the travelling community and perinatal mental health.

Routine ultrasounds examinations were available between 8am and 5pm Monday to Friday within the antenatal clinic.

**Health promotion**

Staff supported women to live healthier lives. At the initial antenatal visit, staff risk assessed women for immunisations and past medical history. We observed a midwife discuss the whooping cough and influenza vaccine with a woman and advised her to access these through her GP.

Women had access to a variety of information on health promotion during pregnancy. In the antenatal clinic, the television featured short pregnancy related videos. We saw a clip which spoke about pregnancy related stretch marks. There were leaflets and posters within the department offering advice to women on healthy eating during pregnancy and stopping smoking.

Women who were identified as needing additional support could be referred to specific antenatal classes, the smoking cessation service or dietician. The community team offered a range of antenatal classes including a healthy eating class and a class for women suffering from pelvic pain.

Staff referred patients, suspected to be deteriorating in their mental health, for a mental health assessment with the psychiatry team. Staff would also seek support from the mental health wellbeing nurse. All patients completed the Whooley questions at postnatal discharge to assess for depression and further support.

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

During our inspection, there were no women who were detained under the Mental Health Act. However, staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. They
knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Staff followed the trusts Policy for Consent to Examination or Treatment dated 18th February 2016. We reviewed this document which was detailed and highlighted the duty to appoint an Independent Medical Capacity Advocate for patients who lacked capacity. Staff sought consent for women undergoing procedures. We saw staff verbally gaining consent before commencing any treatment. Staff fully explained procedures and the associated risks of accepting the treatment or not.

Women were given opportunities to understand their options and give informed consent. Staff discussed birthing options with women in the antenatal clinic. We observed these clinics and saw staff were non-bias and advised women to spend time between clinic appointments to think about their options.

Is the service caring?

Compassionate care

Staff took the time to interact with women and their families in a respectful and considerate way. Staff apologised to a woman and her partner for a delay to her procedure and explained this was caused by an emergency on the ward. Staff kept the woman and her partner up to date with any developments.

Staff understood and always respected the privacy and dignity needs of women in their care. During a ward round, the co-ordinator ensured women were covered to respect their dignity and curtains were pulled around bed spaces before intimate examinations were performed. This is in line with NICE QS15 statement 1: Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.

Staff responded in a compassionate, timely and appropriate way when women experienced physical pain, discomfort or emotional distress. An anaesthetist demonstrated excellent communication skills by providing a step by step explanation to a women as epidural pain relief was administered. This is in line with NICE QS15 statement 2: patients experience interactions with staff who have demonstrated competency in relevant communication skills.

Staff introduced themselves and made women and their families aware of their role and responsibilities. During ward rounds and in the anaesthetic room, all members of the team introduced themselves to the patient. This is in line with NICE QS15 statement 3: patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.

Staff displayed understanding and a non-judgemental attitude when talking about women who had mental health needs. During handover, staff discussed the additional help and support some mothers may require during their stay and after discharging due to having mental health disorders. One midwife at the trust had received royal recognition for supporting a patient with a history of mental illness during her teenage pregnancy. One midwife on Bolney ward told us, “my aim is to ensure each woman goes home feeling cherished.”

The patients we talked with during the inspection were very complimentary about the care and attention they had received. Comments included, “really impressed with the service” and “staff are always helpful and the discharge process was good”.


We also reviewed the comments on NHS choices website. Most of the comments left within the inspection time frame were positive. Examples of the comments were “the high level of compassion continues on the Bonney ward. Staff work long shifts but nothing is too much trouble and they are there to support you at every opportunity”, “All the maternity staff do a fantastic job day in day out and whilst it was extremely busy when I was there looking after everyone was their top priority” and “one of the best things I saw was 3 nurses at the nursing station each with a baby in their arms rocking the babies and giving the mums a break.” The trust had taken the time to respond to all patient feedback and when a negative comment was made, the trust signposted the patient to the patient advice and liaison team.

**Friends and Family test performance**

**Friends and family test performance (antenatal), Brighton and Sussex University Hospitals NHS Trust**

From June 2017 to June 2018 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average.

There is no available data for the trust for eight of the 13 months included in the chart below and this is the reason the dips in the chart. Where data was available the trust scores were 100% for all months other than September 2017 where the trust score was 83% compared to the England average score of 97%.

![Graph showing Friends and Family test performance (antenatal)](image)

**Friends and family test performance (birth), Brighton and Sussex University Hospitals NHS Trust**

From June 2017 to June 2018 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was in line with or greater than the England average for all months other June 2018, where the trust’s score fell to 94% (compared to the England average of 97%).

![Graph showing Friends and Family test performance (birth)](image)
Friends and family test performance (postnatal ward), Brighton and Sussex University Hospitals NHS Trust

From June 2017 to June 2018 the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average. In the latest month of available data (June 2018) the trusts FFT performance for its postnatal wards was 91% compared to the England average of 95%.

(Source: NHS England Friends and Family Test)

Friends and family test performance (postnatal community), Brighton and Sussex University Hospitals NHS Trust

From June 2017 to June 2018 the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally below the England average. In the latest month of available data the trusts FFT performance for postnatal community was 94% compared to the England average of 98%.

(Source: NHS England Friends and Family Test)
The trust performed similar to other trusts for 14 out of 16 questions in the CQC maternity survey 2017 and better than other trusts in the other two questions.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>8.67</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>8.81</td>
<td>Best performing trusts</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.88</td>
<td>Best performing trusts</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>9.44</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.44</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>8.38</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.49</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.45</td>
<td>About the same</td>
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<tr>
<td></td>
<td>If you used the call button how long did it usually take before you got the help you needed?</td>
<td>8.68</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.48</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.41</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>9.23</td>
<td>About the same</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>7.80</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>8.13</td>
<td>About the same</td>
</tr>
</tbody>
</table>
The trust was amongst the best performing trusts for two of the four survey question metrics relating to labour and birthing areas.

- During your labour, were you able to move around and choose the position that made you most comfortable?
- If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

**Emotional support**

In the antenatal clinic, midwives risk assessed patients for mental health concerns at their booking appointment and signposted expectant mothers to ‘time to talk’. This was a NHS funded talking therapy service which patients could self-refer to.

The service continued to run the ‘birth stories’ clinic for women who had previously experienced a traumatic birth. Midwives told us women could self-refer to the clinic within one year of giving birth or midwives could refer the mother by internal email. The clinic ran every Wednesday afternoon.

The hospital had a dedicated pregnancy loss consultant. Women who had experienced a bereavement in the second or third trimester received an initial and a two week follow up appointment with the consultant. If the woman became pregnant again, she was seen by the same consultant so she did not have to go through the painful experience of retelling the traumatic story.

The trust had two specialist bereavement midwives, covering a full-time role across both hospitals. Staff could contact the midwives by text, telephone or email. The midwives offered support to all families who had experience the loss of a baby after 14 weeks. Support included home visits, help with funeral arrangements and referrals to counselling.

The antenatal clinic had a quiet room where midwives broke bad news to expectant mothers. The maternity unit had access to cooled cots which allowed bereaved families to have time with their baby. The central delivery suite opened a refurbished bereavement room in October 2017, which was located outside the main ward. The room provided a sympathetic environment in which families spent time with their babies without being surrounded by the sounds and activities of birth and babies. Women and their families were given a star to write on and place on the wall in remembrance of their baby, to help with the grieving process.

Staff were able to provide women and their families with appropriate emotional support and information following a bereavement. In 2018, all midwives received mandatory bereavement education and attended specialist training provided by a stillbirth and neonatal death charity. This training covered supportive listening skills, breaking bad news and creating memories.
Understanding and involvement of patients and those close to them

Maternity staff provided advice and explanations tailored to women’s needs about the benefits and risks of each location for birth. We observed consultants in the antenatal clinic discuss birthing options, explain the risks and benefits of each to expectant mothers without bias. This is in line with NICE QS15 statement 5: patients are supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences.

Women we spoke with said midwifery staff involved them in decision making and women felt they had made an informed decision about their birthing plans. We spoke with eight women, partners and relatives during our inspection. They were all satisfied with the information and advice they had been given; leading up to and during labour; following the birth of their baby; or whilst receiving care and treatment.

Across the maternity services women, their partners, friends and relatives had access to a variety of information. For example, on the central delivery suite there was a display of practical tips for birthing partners and a poster advertising a breastfeeding support drop in clinic.

Women were supported with breastfeeding immediately following delivery and this continued once they were on the ward. Midwives discussed each women’s preference for feeding and highlighted women who required further support with breastfeeding during handover.

Is the service responsive?

Service delivery to meet the needs of local people

The services provided did not always reflect the needs of the population served. The maternity unit was consultant led, the hospital did not have a midwife led birth unit. This restricted choice over place of birth for low risk women planning a normal birth in their local area. However, the trust’s community midwives continued to run an award-winning homebirth service for women who chose to give birth at home.

The service provided women with personalised care that was responsive to their needs. It ran a ‘one stop’ clinic whereby women could access help with alcohol or drug addiction from a variety of healthcare professionals all in one setting. Women could also access the service over the phone for help and advice.

There were staff members in place to aid the delivery of care to women in need of additional support. The trust employed a teenage pregnancy midwife who supported women aged 19 years old or younger at point of conception. The midwife was based at the Brighton site but visited PRH once a week. The midwife tailored the service offered to meet the needs of the women which included home visits, tour of the maternity facilities, attendance at antenatal clinics and a texting service.

Women identified as homeless were referred to the substance misuse and traveller’s specialist midwifery services. The department had access to the homeless team and had a specialist homeless midwife who offered help and advice on how to access other useful services.

The services provided ensured flexibility and choice for the population they served. The maternity services offered women a choice of antenatal courses on a variety of subjects. For example, water birth and homebirth sessions were offered at PRH for women at 34 weeks. These classes were
advertised on the trust’s website and women could self-book onto these courses which were held locally. This encouraged attendance by taking services closer to where women lived.

Women could also be referred to the Day Assessment Unit (DAU) for various reasons throughout pregnancy if their GP or community midwife had concerns. Women could also self-refer to DAU if they had concerns for example, reduced baby movements, pain or bleeding.

On Bolney ward, partners could stay the first night following the birth of their child. They wore a green wristband to allow for identification and signed a behavioural contract. However, staff told us there were no shower facilities for partners and limited number of recliner chairs. The ward staff planned to run a stall at the next village fair to fundraise for recliner chairs.

Information leaflets were available throughout the maternity unit and on the trust’s website, however we noted these were in English only. Staff told us they could access leaflets in different languages if required. There were virtual tours available on the trust website of the maternity facilities at PRH to help women prepare for their arrival.

Where people’s needs and choices were not being met we saw this was identified and used to inform how services were improved. An example of this was the development of a transgender and non-binary protocol. This included building the teams presence at relevant local events and working alongside local transgender support groups to encourage and support those who wished to have a family.

**Bed Occupancy**

From October 2016 to March 2018 the bed occupancy levels for maternity were generally higher than the England average, with the trust having 92.0% occupancy in quarter 4 of 2017/2018 compared to the England average of 58.5%.

The chart below shows the occupancy levels compared to the England average over the period.
Meeting people’s individual needs

The service took account of patients’ individual needs. Reasonable adjustments were made and action taken to remove barriers when people find it hard to use or access services.

Women had access to translation services if English was not their first language. The department tried to ensure this was face to face, but if this was not available then they could access language line for immediate translation. Although the service had access to British Sign Language interpreters, the antenatal clinic did not have any hearing loops however staff said they had not experienced women with hearing difficulties. A hearing loop is a special type of sound system for use by people with hearing aids.

Women who were victims of domestic abuse were signposted to the trust’s independent domestic violence advisor. The advisor also linked with the safeguarding midwife, who provided support and referral to a local independent charity that helped people affected by domestic abuse. We observed midwives make sensitive enquiries about domestic abuse to women in the antenatal clinic.

Women with specific needs or care needs due to physical disabilities or wheelchair access were referred by their community midwife to the labour ward leads who met with the woman. They discussed the women’s needs and developed a plan to best support the women. This included the use of appropriate rooms, whether self-transfer is possible and bathroom facilities. All facilities were wheelchair-accessible.

Women who had experienced trauma during labour and birth saw a specialist birth stories midwife. It provided a one to one counselling session with patients’ obstetric notes available and was an opportunity to understand events, talk through feelings and raise any concerns for a subsequent pregnancy or labour.

The antenatal clinic had a quiet room for the provision of breaking bad news. The central delivery suite had a bereavement room for use by women and their families to grieve. The room had a telephone for women to phone the nursing station directly, shower facilities, a pull-out bed for partners, a coffee machine and a television. Staff told us they planned to extend the room so women would not have to go to the labour ward to give birth.

A specialist perinatal mental health midwife provided support to women with mental health issues and more recently those with tokophobia (an intense anxiety or fear of pregnancy and childbirth). Women had access to a perinatal mental health clinic which provided advice, assessment and treatment for women with a past or current history of severe mental illness. There were appropriate discharge arrangements for women with complex health and social care needs. At discharge, staff discussed signs of postnatal depression with women and their partner.

Women could attend a ‘vaginal birth after caesarean’ (VBAC) clinic. This served to help women who wished to have a VBAC and offered information and advice from an obstetrician and a midwife. An average of 27% of women opted to try for a VBAC, the trust did not set a target for this but this figure had fallen since our previous inspection where 46% of women attempted VBAC.

We saw leaflets showing staff how to access the learning disability liaison nurse and team. Women with learning disabilities were referred or signposted to a specialist midwife and safeguarding midwife, who liaised with the appropriate team leaders. The specialist midwife also liaised with labour and postnatal wards to ensure care plans were circulated, followed and
appropriate support was in place. This included women who wished to deliver at home where the
birth options midwife would also be contacted for further support. The trust learning disability
liaison team were also involved in these cases. Staff had access to a communication book which
included pictures, signs and symbols to help patients become partners in their care and treatment.
The trust also had ‘this is me’ passports for people with communication or memory difficulties. This
support tool facilitates person centre care. We did not see this in use as there were no patients
who had communication difficulties during our inspection.

There was a system in place to signal to healthcare professional that a parent had experienced a
bereavement. Staff told us they placed a pink tear sticker at the front of patient records to signal to
healthcare professionals that a woman has experienced a bereavement. This ensured care could
be tailored to meet the needs of the women.

Access and flow

Women could access care and treatment in a timely way. Women had access 24 hours, seven
days a week to a triage phone line for advice. The triage system for all women went through a
dedicated triage midwife on the labour ward.

The maternity services had a ‘provisions and schedules of antenatal care’ policy. This policy
outlined what risk assessments and appointments women with an uncomplicated pregnancy
should have. All women saw a midwife for a booking appointment at 10 weeks following self-
referral via the e-referral system on the ‘my pregnancy matters’ website. This is in line with NICE
QS22 statement 1. Women also had a dating scan in the first trimester. At 16 weeks women had a
screening and further risk assessments completed at the midwife led antenatal clinic. At 20 weeks,
women had an anomaly scan. At 28 weeks, all women discussed birthing options and commenced
planning for their forthcoming birth. Women were then seen in clinic every fortnight between 34
and 38 weeks for discussion about labour including pain management, breastfeeding and post-
natal depression. Additional antenatal appointments were scheduled for first time mothers or
women receiving increased surveillance. This was in line with NICE clinical guidance 62.

The service managed women who did not attend antenatal appointments appropriately. After a
woman missed two antenatal appointments, the midwife emailed the women’s community midwife
before calling the women in case there had been a bereavement. After three missed antenatal
appointments, the midwife emailed the community midwife and the safeguarding team.

There was an average of 10 to 20 transfers between units within the trust each month. All of these
women were postnatal. The service had a midwifery escalation protocol which was due for review
in September 2019. It outlined the rational for unit closures. There had been no unit closures in the
past six months. We reviewed the trusts transfer policy ‘Brighton and Sussex University Hospitals
Transfer Policy’ dated March 2016. This included numbers for the local ambulance service in
cases of emergency transfers. Babies requiring level three support were often transferred to
BSUH where the special care baby unit could support the babies postnatally.

Midwives managed women’s expectations at initial booking. Women were told that the maternity
service was a one hospital trust which provided maternity care over two sites. Women were made
aware that they may be asked to attend a different hospital site if one maternity unit was full.
However, staff told us there had been no unit closures at PRH in the past 12 months.

Discharge of patients was well managed and planned. Women undergoing a caesarean section
were given an estimated discharge date on arrival and recovered under an enhanced recovery
protocol. This protocol meant women could be discharged without doctor review providing they
met a set of criteria. This sped up the discharge process. Staff discussed this protocol as part of the daily safety huddle.

There was a separate triage area on Bolney ward. Staff told us this had recently moved which they felt was sensible. Triage was run by one senior midwife and one antenatal midwife and supported by the ward medical team.

One imaging administrator told us she had changed the screening appointment templates which had reduced patient waiting times. The templates streamlined services for patients so there was a clear direction from scanning to screening.

Data provided by the trust showed between May 2017 and April 2018, there were 376 moves at night on Bolney ward and 1728 on the central delivery suite.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. There were leaflets available in the maternity department which showed patients how to make a complaint about the service. This included speaking to the patient advice and liaison service. Patients could seek further information on how to raise a complaint on the trust’s website.

We reviewed three recent complaints. We saw these complaints contained a written response and an apology where appropriate. The Head of Midwifery had streamlined the complaints process over the last year as she felt it was not effective previously. She acknowledged there was still work to be done but that the process had been much improved. The Head of Midwifery reviewed all complaints personally and if possible arranged a face to face meeting to ensure the needs of the complainant were fully met.

Lessons from complaints were shared with maternity staff via a monthly ‘quality tweet’ which we saw displayed on a board on the central delivery suite. It included an anonymous patient account of the birth stories clinic and subsequent lessons learnt which included the importance of perinatal mental health in providing holistic care. However, we noted some lessons identified the root cause rather than the change in practice. For example, ‘inadequate analgesia and inaccurate information given to client on tongue tie’. This failed to identify the correct practice needed to avoid the same outcome.

The trust held bi-monthly mandatory training called ‘Responding to Complaints’ for all healthcare professionals.
Summary of complaints

From April 2017 to March 2018 there were 31 complaints about maternity at the trust. The trust took an average of 56.9 days to investigate and close complaints. This exceeds the trust target of 25 days to complete a complaint.

The table below shows that 68% of complaints relating to the maternity services at the trust were regarding access to treatment of drugs.

<table>
<thead>
<tr>
<th>Complaint subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to treatment or drugs</td>
<td>21</td>
</tr>
<tr>
<td>Patient care</td>
<td>4</td>
</tr>
<tr>
<td>Communication</td>
<td>3</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>2</td>
</tr>
<tr>
<td>Staff numbers</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>

A breakdown of complaints by site for maternity services can be found below.

- Royal Sussex County Hospital: 22 complaints
- Princess Royal Hospital: eight complaints
- Royal Alexandra Children’s Hospital: one complaint

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

Number of compliments made to the trust

From April 2017 to March 2018 the trust received 956 compliments; 23 (2.4%) of these related to the maternity services at the trust. The split of compliments by site can be found below.

- Royal Sussex County Hospital; 14 compliments
- Princess Royal Hospital: nine compliments

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

Is the service well-led?

Leadership

The trust had managers at all levels with the right skills and abilities to run the service.

The division is led by a three-person leadership team, the chief of service, head of nursing and director of operations. Maternity forms part of the Children’s and Women’s division which incorporates gynaecology, maternity, neonatal, obstetrics and paediatrics.

There were three matrons across the service: one at RSCH, a community matron and a matron at PRH. These were supported by ward managers and risk leads.

Midwives on the labour ward were supported by labour ward co-ordinators.

The antenatal clinic and day assessment unit were managed by a part time band seven midwife. The clinic and DAU midwives are supported by maternity care assistants and maternity support worker who assist with the antenatal screening programme.

All staff we spoke to knew who the maternity matron was at PRH. Staff reported a big difference in the leadership of the maternity unit since the new maternity matron and head of midwifery
commenced their roles. Although not all members of staff could name the head of midwifery, they reported an open culture and felt able to escalate concerns as leaders operated an open-door policy and were visible.

Positive staff comments included, “...amazing support regarding a maternal cardiac arrest especially from the head of midwifery”, “very supportive, always thanked at the end of my shift so I feel appreciated and trusted” and “the new board structure has made a massive difference as there is more joined up thinking.”

The department had direct access to the trust board every month through the divisional governance board meeting. Several meetings fed into this meeting including the patient safety team, audit meeting and safety and quality meeting. This allowed information to be fed up to the board and back to the frontline staff.

**Vision and strategy**

The division had a clear vision and a credible strategy to deliver high quality sustainable care. It had robust plans to help achieve and deliver this. The division was working with the trust to contribute to a revised BSUH clinical strategy. This included a review of the environment and estates, especially the provision of a midwifery led unit at PRH, a review of the maternity IT systems and a review of staffing levels and specialist roles. In addition, the division wanted to develop as a regional centre of excellence for clinical services, teaching and research.

A quality improvement strategy called, Patient First, was being rolled out across the trust. The focus of the initiative was to put the patient at the heart of improvements and gave frontline staff the opportunity to implement change. The head of midwifery and ward managers were currently undertaking the ‘Patient First Fundamentals’ programme.

**Culture**

The inspection team were welcomed into the unit by all staff members. Staff were willing to talk with us and be open about what the service was like. This showed an open work force who welcomed review.

Staff we spoke with reported a huge culture change within the past 12 months. Staff felt more connected, more involved in decision making and able to raise concerns without fear of reprisal.

Midwives reported they had a good relationship with consultants and felt they were accessible. They described a non-hierarchical relationship which enabled open discussions and mutual respect. Staff also stated the consultants encouraged multidisciplinary working and liaised well with the co-ordinating midwives.

Staff told us there were issues between midwives and middle grade doctors. We were told there were incidents of bullying, victimisation and undermining of clinical abilities. Midwives told us they reported any non-engaging doctors to the consultant who was very supportive. Some staff believed there was communication issue as English was not always a staff members first language. A meeting had been arranged to address the working relationships between midwives and the middle grade doctors.

Staff told us midwives recruited from abroad reported feeling isolated at PRH and transferred to BSUH. Staff reported there was an ethnically diverse doctor group but the midwifery staff group was mainly white middle class.
Hospital midwives reported good relationships with the community midwives. During our inspection, there was high praise by all staff groups for the bereavement midwives. We heard they were always accessible, very passionate about their roles and supported staff through difficult times.

The maternity department recently demonstrated full compliance with the NHS resolution and Clinical Negligence Scheme for Trusts premium incentive scheme. Maternity had met the 10 strict national safety criteria including clear and effective plans for staffing levels, training, and ensuring that patients had effective ways to give feedback. Patients could feedback to staff in a variety of ways including the trust website, NHS choices website, ‘plaudit’ cards, and the friends and family test. Managers informed staff of patient feedback and patient feedback was widely disseminated to staff through the monthly quality tweet.

**Governance**

There was a maternity governance team which consisted of a governance manager, a risk midwife, a protocol midwife and a risk administrator. The team attended the following meetings:

- Monthly directorate board meeting
- Monthly perinatal meeting with the special care baby unit
- Monthly perinatal mortality review tool meeting
- Monthly safety and quality meeting
- Monthly audit and protocol meeting
- Weekly incident meeting
- Case review meeting

The directorate held monthly ‘directorate board’ meetings (previously women’s operational). These meetings were used to demonstrate effectiveness and progress. Governance meetings were usually cross-site so that learning could be shared. They were chaired by the maternity governance lead and were well attended by all levels of clinical staff.

All staff were invited to attend the monthly safety and quality meetings. We saw the meeting minutes for June, July and August 2018 which showed there was a standard agenda which included patient safety, clinical outcomes and effectiveness, patient experience, risk and compliance and implementing, sharing and disseminating best practice. The meetings were well attended by all staff groups which demonstrated a commitment from staff to drive improvement.

Clinical services managers and the head of midwifery represented the women’s directorate at the trust’s safety and quality meetings. The trust committee met monthly and provided quality and safety assurances to the trust board via the divisional governance board meeting.

At the last inspection, there were no assurances that all staff engaged in feedback from the trust. On this inspection, all staff we spoke with knew about risk and governance issues and were fully engaged in receiving this feedback. We saw governance boards in the ward areas. These boards displayed information on the maternity risk register, the monthly quality tweet and dates of various meetings such as audit, risk and mortality. The monthly ‘quality tweet’ summarised lessons learned from incident reviews, top reported incidents, patient feedback and lessons learned from patient experience. Staff we spoke with said they felt they had a better understanding of risk and felt included in risk management.
Management of risk, issues and performance

The trust had systems for identifying risks and plans to eliminate or reduce them. There was a commitment to best practice performance and risk management. Risk was reviewed through a series of local and trust wide meetings. There were comprehensive assurance systems, and performance issues were escalated through clear structures and processes.

We saw the directorate board meeting minutes for July, August and September 2018. It showed performance against the divisional scorecard was discussed and reviewed at these meetings. Driver metrics included training, appraisal, staffing and quality improvement projects. The trust told us the outcomes of these meetings would feed into the divisional board meeting which was in formation at the time of our inspection. Any underperformance against the driver metrics were shared with the trust’s commissioners at quarterly performance meetings.

Matrons received copies of the minutes and disseminated any learning points or changes of practice to all relevant staff. We heard from staff that they were informed about any changes in ward meetings or via e-mail.

We reviewed the directorate’s risk register which identified risks to the service and actions the trust was taking to minimise the impact of the risk. The maternity risk register consisted of 13 risks. The top three risks related to environmental temperatures, midwifery staffing levels and notes management. These risks were communicated to staff and there was a good grasp of where improvements were needed. There was an alignment between the recorded risks and what staff said they were worried about.

The chief medical officer and a non-executive director was appointed to oversee any learning from deaths as part of the trusts ‘Learning from Deaths Programme’. In September 2017, the trust published a policy for learning from deaths; this closely integrated the medical examiner programme and serious incident investigation to ensure all opportunities for learning were identified.

Any deaths within the service were thoroughly reviewed by a multidisciplinary team. During our previous inspection we had concerns the directorate did not take part in morbidity and mortality meetings. At this inspection, we saw mortality and morbidity meetings took place monthly. The maternity governance team attended this meeting. The division reviewed mortality statics and set clear actions and who should undertake them.

For neonatal mortality BSUH is the 16th out of all 57 level three units in the country. All deaths that were mandated in the guidance had been identified and had either undergone a case note review or were in the process of undergoing a review. The deputy medical director for safety and quality presented to the Grand Round about learning from deaths including case presentations on neonatology mortality.

The Antimicrobial Stewardship Group is accountable to the Infection Prevention Committee and the Drugs & Therapeutics Committee the chief of pharmacy was professionally accountable to the medical director with respect to trust-wide medicines optimisation.

The directorate held monthly audit and protocol meetings which were attended by the maternity governance team. We saw evidence of the clinical and internal audit processes working well. The department were aware of the impact of audit and how audit can be used to further the development of better systems within the department. However, we were aware that key members of staff we spoke with were not always aware of how audits were used to improve the service. An
example of this was a lack of gap analysis following national audits such as the recent MBRRACE audit report.

Information management

The IT systems used in maternity were not effective at collecting data efficiently. We were given several examples where this was a barrier to staff being able to do their job effectively. The community team had now received laptops that had improved access to test results but they were still having to complete paper records as they were not compatible with the current system. One staff member told us the computer system did not contain blood results or screening information so one midwife inputted this into the computer system for all women then printed and stapled a copy into the women’s records. The maternity service was aware of the issues and were currently seeking a new system. We also saw this highlighted on the risk register which showed the department were aware of the risks.

Relevant information was displayed on notice boards within the maternity unit. We saw posters about training opportunities, development opportunities for staff, infection control, parenting advice and educational material for new parents.

Guidelines were stored electronically on the intranet. There was a focus on not printing off copies so that the most up to date policy was always accessed. However, in the antenatal clinic we saw a folder which contained printed policies, nine out ten of which were overdue for review. This meant staff could be reading policies which contain outdated or incorrect information. Staff told us the trust intranet enabled them to access policies, protocols and other information they needed to do their job. Staff also had internet access to evidence-based guidance from bodies such as NICE and the Nursing & Midwifery Council. We saw computers available to allow staff to do this.

Patients confidentiality was not always protected and there was a risk unauthorised people could gain access to confidential information. Although patient records were stored in lockable trollies, during our inspection in the day assessment unit we observed a computer station left unlocked and unmanned. On Bolney ward, we noticed a post-it note stuck on a computer, displayed the security details needed to access the computers.

Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Staff were consulted of any changes across the department and felt they had a voice. For example, most staff were against the recent proposed initiative called ‘helping hands’ on call rota system, so this did not go ahead. In addition, staff had recently been surveyed about the prospects of wearing a uniform. We heard staff were consulted about the changes to the location of services and given a choice where they worked and had input into the changes.

Monthly ‘pulse’ check surveys are held to provide a snap shot of engagement levels in addition to the national staff survey. Overall, the engagement score for maternity services had increased from 3.63 in 2017 to 4.11 in August 2018. The staff friends and family test in August 2018 showed that 80% of staff would recommend the trust as a place to work (59.5% national average) and 90% would recommend the trust as a place to be treated (70% national average). These results demonstrated an engaged and committed workforce.
The trust told us the divisional management teams supported by human resources had undertaken staff focus groups or walkarounds of the clinical areas to meet staff and ask them questions to understand areas of concerns. Initial trust wide feedback highlighted themes about violence and aggression staff receive from patients and members of the public; the quality of appraisals, communication from senior managers and staff reported coming into work when they are feeling unwell. Staff we spoke to in maternity stated they sometimes experience violence and aggression from women and their families but they felt well supported in managing these situations.

Management carried out exit interviews with all staff leavers. The trust undertook monthly analysis of exit interview data. The reasons given by staff who left included a lack of promotion or career opportunities; wanting better pay or rewards and work-related stress. In response, the trust has developed a health and wellbeing plan and is developing a retention strategy which includes flexible retirement and working policies.

There were many ways patients and visitors could provide feedback. They could fill in an online patient survey, complete a ‘thank you' form, raise a complaint or concern, rate the trust on the NHS Choices website or complete the friends and family survey. ‘Plaudits’ are collected monthly from all ward areas and departments. All plaudits are acknowledged either by telephone, postcard or letter and a copy is shared with named staff members and managers of the area. We saw plaudits displayed in maternity services and staff we spoke to reported they received copies which they used for professional revalidation.

Maternity services held a variety of meetings for staff to improve engagement, communication and transparency. These meetings included the labour ward form, band representatives meeting, midwifery management meeting, site leads meeting, specialist midwives meeting, community leads meeting and medical model meeting. Information from these meetings feedback into the monthly directorate board meeting.

The trust engaged with Healthwatch. We saw positive response and action following environmental audits undertaken by Healthwatch at the trust between April 2017 and August 2018. These audits highlight nine themes which included improve security of rooms containing medicines and cleaning products. The trust had installed swipe card access to these areas and we saw this in use in all maternity areas we visited.

**Learning, continuous improvement and innovation**

The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. Maternity managers and matrons were enrolled on the ‘Patient First Fundamentals’ programme and had started to focus on the next steps.

A women centred World Health Organisation checklist had been developed in obstetric theatres. The aim was to make the woman the centre of the checklist by making sure all staff introduced themselves by name and designation to the woman and her partner. We saw staff do this during our inspection and feedback from women was positive.

Maternity were also part of the nationwide initiative called the theatre cap challenge, where staff names and roles are printed on their theatre caps. The aim was to flatten hierarchies, open communication channels and reduce the number of incidents in theatres. Staff took us this initiative ran for two weeks and was not yet embedded, however staff had ordered more caps so the initiative could continue.
Alongside this the maternity staff were in the process of filming a simulation setting from the woman’s perspective. They planned to use this both internally for training and to promote best practice externally.

The department were launching the ‘bobble hat’ initiative in Winter 2018, which identified babies who were at risk of hypothermia and hypoglycaemia through different coloured pompoms on top of knitted hats. The hat not only provided warmth but also acted to quickly identify if the babies needed extra care.

The department were trialling the use of fetal pillows for caesarean sections. These devices help to elevate a deeply impacted fetal head out of the pelvis during a caesarean section, making the delivery safer, easier and less traumatic for the mother and baby.

The department had a commitment to inclusive care. This included building the teams presence at relevant local events such as Trans-Pride 2018 and working alongside local transgender support groups to encourage those who previously thought having a family wasn’t possible.

The department were voted the best allied health professional teacher by fourth year medical students in 2018.

The maternity services had moved from ‘needs improvement’ to ‘outstanding’ for performance within the NHSE Maternity Transformation Programme. The programme measured maternal smoking at time of delivery, stillbirth and neonatal outcomes, patient experience and patient choice.

### Acute services

#### Outpatients

### Facts and data about this service

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

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

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

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

The service provided both consultant and nurse led outpatient clinics across a range of specialities. Outpatient clinics were held between 08:30am and 5:30pm with some additional ad-hoc clinics on a Saturday dependent on speciality.
The trust had 647,084 first and follow up outpatient appointments from May 2017 to April 2018. The graph below represents how this compares to other trusts.

![Graph showing outpatient appointments comparison]

(Source: Hospital Episode Statistics - HES Outpatients)

Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from May 2017 to April 2018.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Sussex County Hospital</td>
<td>354,339</td>
</tr>
<tr>
<td>Princess Royal Hospital</td>
<td>192,492</td>
</tr>
<tr>
<td>Sussex Eye Hospital</td>
<td>98,037</td>
</tr>
<tr>
<td>Royal Alexandra Children's Hospital</td>
<td>75,054</td>
</tr>
<tr>
<td>Brighton General Hospital</td>
<td>55,504</td>
</tr>
<tr>
<td><strong>This trust</strong></td>
<td><strong>942,638</strong></td>
</tr>
<tr>
<td><strong>England</strong></td>
<td><strong>106,555,970</strong></td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

Type of appointments
The chart below shows the percentage breakdown of the type of outpatient appointments from May 2017 to April 2018. The percentage of these appointments by type can be found in the chart below:

**Number of appointments at Brighton and Sussex University Hospitals NHS Trust from May 2017 to April 2018 by site and type of appointment**

(Source: Hospital Episode Statistics)

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

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

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

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

**Is the service safe?**

**Mandatory training**

The service provided mandatory training in key skills to all staff and made sure everyone completed it. During our previous inspection it was not possible to break down training compliance due to outpatient staff working within a number of different directorates. At this inspection, the Central Clinical Services Division contained the majority of outpatient nursing, allied healthcare professionals and administrative staff working in outpatients. The mandatory training compliance for this division was 95%, which was better than the trust target of 85%.
The trust did not have dedicated medical staff working within the general outpatient department. All medical staff running clinics were assigned to different specialities within the trust and mandatory training was reported within those specialities.

Staff we spoke with told us the online training resource was easily accessible and up to date. The system flagged when staff were approaching their refresher date and some of the training sessions were also available as face to face sessions.

Mandatory training covered a variety of topics including fire safety, health and safety, infection prevention and control, information governance, manual handling and safeguarding adults and children.

**Safeguarding**

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse. All of the staff in the Central Clinical Services Division had received safeguarding training. The trust advised us that clinical members of staff were trained in safeguarding adults level two, and safeguarding children level two. According to the Safeguarding children and young people: roles and competencies for health care staff Intercollegiate document, all non-clinical and clinical staff who have any contact with children, young people and or parents and carers require level two safeguarding children training. In addition to this, staff should be able to access a level three trained professional at any time during their work.

However, some staff had regular contact with children, such as in the paediatric clinics that ran from the main outpatient department. Clinics run from the two dedicated paediatric rooms were staffed with paediatric nurses from the Royal Alex Hospital, however the paediatric ears, nose and throat (ENT) clinic was staffed by outpatient nurses. Data we received from the trust indicated that no nursing staff in outpatients had received level three children training.

As part of a data request we asked to see the ‘was not brought’ policy for childrens appointments in the phlebotomy department. We were provided with the Royal Alexander Childrens Hospital policy which was the trust’s dedicated children’s hospital. However; staff we spoke with in phlebotomy were not aware of the policy, or of the need to escalate child patients who had not been brought for their appointment. This meant that staff may not recognise the importance of a child not being brought for their appointment being a potential safeguarding issue.

Not all staff we spoke with knew who the named safeguarding lead for the trust was but were able to describe how they would find out and how they would raise concerns. There were no safeguarding referrals made in the last 12 months by staff on the Princess Royal Hospital site.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. There were systems and processes in place to prevent and control infection.

The cleanliness of the outpatient environment audits consistently demonstrated that the standards met or exceeded the target set by the hospital which was 95%. The audits were split into three areas of cleaning responsibilities – housekeeping, nursing and estates. We reviewed cleaning audits of the outpatient areas from April 2018 to August 2018. Overall the combined scores for all months were 95% or better. The nursing team achieved the target percentage in three out of the five months, the housekeeping team achieved the target percentage or better in all five months,
and the estates team scored the target percentage or higher in four out of the five months. On the occasions where the scores did not meet the required target percentage, the score did not fall beneath 85%.

The majority of the areas that we visited were visibly clean and tidy. Patient Led assessments of the Care Environment (PLACE) audits, are a system for assessing the quality of the patient environment. Patient representatives go into hospitals as part of teams to assess how the environment supports patients’ privacy and dignity, cleanliness, dementia and disability access and general building maintenance. The PLACE assessment for cleanliness across three outpatient areas for the period 2018 ranged between 80% and 97%. The national average for cleanliness in 2018 was 98%, which meant that all assessed areas performed worse than the national average. There were no action plans associated with these results. However, patients we spoke with on inspection told us that the hospital felt very clean and that the cleaners did a good job.

We observed all staff to be bare below the elbows when interacting with patients and we saw staff using hand sanitising gel before and after patient interactions. This was in line with the National Institute for Health Care Excellence (NICE) quality standard (QS) 61, statement three. Hand sanitising gels were available both at the main entrance of the hospital, and at the entrance to the outpatient department.

Hand hygiene audits were completed weekly. Between September 2017 and September 2018, we saw that the main outpatient unit scored (excluding one week of non-return of the audit) on average 98%, neurology outpatients (excluding six weeks of non-return of the audit) scored on average 87% and the fracture clinic scored on average 98%. This meant the majority of the audits demonstrated compliance above the 85% target.

There were children’s toys available in the waiting area of main outpatients. These had a notice on to say they had been cleaned and we saw checklists that demonstrated these were being completed and documented daily.

There was a waste segregation and disposal system in place with the use of different coloured bags to identify the different categories of waste. Bins clearly stated what should be disposed in them.

Insertion of catheter audits were completed monthly. These audits checked that aseptic non-touch technique was used during the procedure to minimise the chance of infection. We reviewed audit results from April 2018 to August 2018 and saw that 100% of the insertions had been completed using aseptic technique.

**Environment and equipment**

The Patient Led Assessments of the Care Environment (PLACE) for the period of 2018 showed the hospital average, across three outpatient areas, for condition, appearance and maintenance scored between 63% and 90%, all of which were worse than the national average of 94%.

Emergency equipment was secure and well maintained. We checked the emergency resuscitation trolleys within the main outpatient area and the neurology outpatient areas which both had tamper proof seals to prevent inappropriate access. We inspected ten consumable items which were all appropriately sealed and within their expiration date. There was a dedicated paediatric drawer that was clearly marked containing consumable items suitable for paediatric emergencies. Checklists were present and we were able to see that checks had been completed throughout 2018 without any gaps other than at weekends when the department was closed. This provided assurances that the trolleys were safe and fit for purpose.
We observed at the daily outpatient safety huddle that staff were each given an area of responsibility, such as the checking of the emergency trolley. The staff allocated to the trolley had to complete the checks on the trolley and return a laminated card that could be displayed by the huddle board so that staff could easily see who had responsibility for each task on the day.

We were unable to speak to any housekeeping staff at the time of our inspection as they cleaned the department outside of normal operating hours. There were cleaning cupboards situated across the outpatient areas, all of which were locked and could only be accessed by staff swipe cards. This ensured that any hazardous cleaning products were kept securely.

The phlebotomy department was located at the front of the main entrance, opposite the entrance to the physiotherapy and occupational therapy department. The door to the phlebotomy department had a notice on to say it was a fire door and must be kept shut, but we observed this was propped open. There was a walk-in ticket system in operation with seating for approximately ten to twelve people. At the back of the waiting area there was an open storage area which had multiple boxes containing stock, stacked to above head height, posing both a risk to waiting patients and to staff manual handling. We escalated this at the time of the inspection and the number of boxes was reduced when we returned the following day, but were still a high volume. The area had previously been a three-bay area separated by curtains. There was no barrier between the waiting area and the overflow stock which posed an issue for children or other visitors. Following the inspection, a risk had been drafted for addition to the Central Clinical Services Division risk register. This identified the inappropriate storage of consumables causing a risk to patient and staff safety and the controls were listed as daily visual inspection of the storage area.

The waiting room environment in the phlebotomy appeared unclean. The carpets were marked which we commented on in our last inspection report and had still not been resolved. Staff working in the department told us that the cleaners occasionally did not clean the area and they had to contact the housekeeping team. On the day of inspection we saw the patient waste bin was full and required replacing.

The lead nurse for the outpatient department showed us the results from an audit on electrical safety testing of outpatient equipment. It demonstrated that over 100 electrical items were overdue their safety testing. We raised this with the trust who informed us that the true number of overdue equipment may be inaccurate due to the frequency required for certain items. Following the inspection the trust demonstrated that they were aware of this backlog and it had been recognised on the risk register with controls in place.

The neurology outpatient department was located in a building behind the main outpatients building. It had several waiting areas depending on what appointment a patient had attended for. In one of the waiting areas, we saw that the corridor had been painted by an ex patient and local artist of a local attraction. Staff told us that patients and visitors enjoyed this artwork.

Medical device maintenance was managed by the trust Electronics and Medical Engineering (EME) team. Staff showed us an audit they had undertaken to check equipment was up to date with maintenance and over 100 pieces of equipment were found to be overdue. We raised this with the trust who informed us that this was a known issue and was recorded on the trust risk register. There were controls listed such as the built in failsafe mechanisms on the devices which would give the user an early warning if the device was due to fail. However, this still meant that some items were not being maintained in line with the trusts Medical Devices Management policy.
Assessing and responding to patient risk

There were systems and processes to assess, monitor and manage risks to patients. Safety huddles were held every morning in main outpatients. All staff working in outpatients met at the same time every morning to discuss current safety issues relating to the premises, patient care and other relevant issues such as staffing levels that could impact on patient safety.

As part of the safety huddle, a trust initiative entitled Minimum Safe Standards of Work (MSSW) had been introduced. This was where five standards of safety were monitored. These included fire, cleaning and information governance. A laminated card with the check list for each standard was given to members of staff to complete who were responsible for checking items on the list. The laminate cards were then returned to the office and signed when completed. We observed this in practice during our inspection.

The trust informed us that if a member of staff in outpatients was concerned about the mental health of a patient not escorted by a registered mental health act practitioner, they could contact the mental health liaison team based at the Royal Sussex County site 24 hours a day. There was also nursing cover available on the Princess Royal site between 7am and 9pm, seven days a week. However, staff told us about an incident where a patient had absconded from an inpatient ward and came to outpatients where they refused to leave. Staff described the difficulty in getting mental health advice and not being able to access mental health advice promptly. Since the incident a telephone number had been placed in the nurse’s office, but not all staff were clear on what to do if this event occurred again.

World Health Organisation (WHO) five steps to safer surgery checklists were in use for patients undergoing surgical procedures such as dental extractions. These ensured that appropriate checks were taken before procedures were carried out, and minimised the risk of incorrect procedures being carried out.

There were no documented safety standards for invasive procedures carried out within the outpatient department. Instead we were told that for some treatments such as bladder instillations and compression bandaging, both of which staff were trained for and had annual competency checks, we do not have any documented safety standards.

Patients that we spoke with who were visiting the hospital regularly for long term conditions told us that the time between their follow ups had increased. For example, patients due to be seen every six months were being seen every eight months. Staff told us that clinic slots were often overbooked, sometimes triple booked, but that there was no monitoring of this by the service. Staff told us that sometimes clinics were overbooked in order to reduce the referral to treatment and waiting times for patients. We observed a 10 week rolling booking utilisation report and saw that some clinics were overbooked on an ongoing basis such as clinical immunology and nutrition and dietetics. Other clinics such as gynaecology and ophthalmology were overbooked on occasion.

We saw risk assessments in place. Following a serious incident where a patient had fallen over a chair leg, an assessment had been completed to prevent future occurrences.

There were 70 patients who had waited over 52 weeks for an appointment between September 2018 and August 2018. This had reduced in numbers since our previous inspection and as of September 2018, there were no patients who waited more than 52 weeks. Patients that waited over 52 weeks were reviewed by an executive level panel including the relevant consultant to assess whether they had come to any harm as a result of their wait.
Nurse staffing

The trust has reported their staffing numbers below for two different times; March 2017 and April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>As at 31/03/2017</th>
<th>As at 30/04/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>All sites</td>
<td>28.6</td>
<td>29.4</td>
</tr>
</tbody>
</table>

In March 2017 the trust reported they had filled 97.2% of their planned staffing. This rose to 98.2% in April 2018.

No site breakdown is available as the trust did not report the data at site level.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From May 2017 to April 2018, the trust reported a vacancy rate of 5.8% over establishment in outpatients. This was lower than the trust target of 10.5% in March 2018, reducing incrementally to 9.0% by March 2019.

Below is a breakdown by site:

- Princess Royal Hospital outpatient department: 5.8%
- Royal Sussex County Hospital outpatient department: 6.3%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From May 2017 to April 2018, the trust reported a turnover rate of 22% in outpatients. This was worse than the trust’s overall target turnover rate of 14% in March 2018 reducing incrementally to 11% by March 2019.

No site breakdown is available as the trust did not report the data at site level.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From May 2017 to April 2018, the trust reported a sickness rate of 5.6% in outpatients. This was worse than the trust overall target sickness rate of 4.2% in March 2018 reducing incrementally to 3.5% by March 2019.

A site level breakdown is shown below:

- Princess Royal Hospital: 3.1%
- Royal Sussex County Hospital: 5.2%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)
Bank and agency staff usage

Please note that the trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff in all cases. Therefore, we have been unable to analyse bank and agency usage as a proportion of the total shifts needing to be filled.

The table below shows the numbers of shifts in this core service from June 2017 to May 2018 that were covered by qualified nursing and nursing assistant bank and agency staff or left unfilled.

For qualified nurses, 1,356 shifts were filled by bank staff and no shifts were reported to be covered by agency staff to cover sickness, absence or vacancy for qualified nurses. In addition, 116 shifts were not filled by either bank or agency staff.

For nursing assistants, 818 shifts were filled by bank staff and no shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants. In the same period, 127 shifts were not filled by either bank or agency staff.

<table>
<thead>
<tr>
<th>Bank/agency</th>
<th>Qualified nurses</th>
<th>Healthcare assistants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>1,356</td>
<td>818</td>
<td>2,174</td>
</tr>
<tr>
<td>Agency</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Not filled</td>
<td>116</td>
<td>127</td>
<td>243</td>
</tr>
</tbody>
</table>

Unfortunately, we are unable to provide a site-specific breakdown of nursing bank and agency usage in this core service, due to the format of the data provided by the trust.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

Senior staff told us that they did not use agency staff within the outpatients department but that they regularly used bank staff. This was confirmed by the data provided to us pre-inspection. Data demonstrated that 226 shifts between September 2017 to September 2018 had utilised bank staff.

Medical staffing

Medical staff working within outpatients were employed within different divisions based on their specialities. There were no medical staff directly employed within general outpatients

The trust has reported their medical staffing numbers below for two different times; March 2017 and April 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>As at 31/03/2017</th>
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<tr>
<td></td>
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</tr>
<tr>
<td>All sites</td>
<td>15.1</td>
<td>15.5</td>
</tr>
</tbody>
</table>

In March 2017 the trust reported they had filled 97.8% of their planned medical staffing. This rose to 102.3% in April 2018 showing they had exceeded their planned fill rate for medical staff.

No site breakdown is available as the trust did not report the data at site level.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)
**Turnover rates**

For the period covering May 2017 to April 2018, the trust did not provide any data on turnover for medical staff in outpatients. This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. This will need to be requested during the inspection as part of standardised requests. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

(Source: Routine Provider Information Request (RPIR) - Turnover tab)

**Sickness rates**

From May 2017 to April 2018, the trust reported a sickness rate of 0.8% in outpatients. This was better than the trust overall target sickness rate of 4.2% in March 2018 reducing incrementally to 3.5% by March 2019.

Site level detail was not available from the trust to report a site breakdown.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and locum staff usage**

From April 2017 to March 2018, the trust reported that three shifts within this core service were filled by bank staff and no shifts were filled by locum staff. There were no shifts which were not filled by either bank or locum staff. A breakdown of bank and locum usage by staff type at the trust is shown below.

Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
<th>Unfilled shifts</th>
<th>Total shifts (bank + locum + unfilled)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Junior</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

Site level detail was not available from the trust to report a site breakdown.

(Source: Routine Provider Information Request (RPIR) – Medical agency locum)

**Records**

Information needed to deliver safe care and treatment was available to staff in a timely and accessible way.

Staff told us that patient notes were available for the majority of time for clinics. Between January and August 2018, less than 1% of patients were seen without their full medical record across the trust. When the full medical record was not available, staff could access the majority of results
such as radiological and haematological results on electronic systems, and referral letters could be printed from other electronical patient information systems.

The trust did not monitor the quality of the content of patient records. As part of a routine data request we asked for patient records audits. We were provided with the latest audit which was completed in 2016 and informed that there was no plan to continue with the case note audit going forwards. At our last inspection we saw that the audit identified that results were worse than the trust target. Following this there had been no further audits, so it was not possible to assess whether all records were in good physical order and contained all of the necessary history, referral sheets and other documentation. As part of our inspection we reviewed nine sets of patient’s notes all of which were legible, contained appropriate demographic information, consent documented where appropriate (circled on template) and signed and designated. However, we observed that some consultant notes were illegible.

Patient records were stored securely. This had improved from the previous inspection. All notes we saw in the clinic areas were in secure trolleys with digi-code locks. The trolleys themselves were secured to the wall. Staff told us this had been implemented a number of weeks prior to our inspection.

**Medicines**

Medicines in outpatients were managed safely. Medicines were kept in treatment room that was locked when not in use. Cupboards containing medicines were locked, and the keys for these were checked out by the security team at the beginning of the day and checked back in at the end of the day by a registered nurse.

However, on one occasion during our inspection we observed a healthcare assistant to be holding the drugs keys. This is not in line with National Institute for Health and Care Excellence (NICE) guidance MPG32. We raised this with the department manager who showed us that there were multiple keys on the secure chain, not just the drugs keys, and that the HCA had been using the keys to access a records cupboard. They advised that they would ask for this to be fixed as the key chain could only be altered by the security team. A prescription audit carried out by the pharmacy team in September 2018 identified that prescription pads in outpatients were not always managed by a registered nurse, however the actions to follow this up had been left blank, indicating that this had not been followed up or actioned.

Fridges containing medicines were locked, and we observed that checks were made daily to ensure that the fridge temperatures remained between the correct temperature range.

Patient Group Directions (PGDs) were not used in main outpatients. Medicines for patients being seen in clinic were either prescribed on an FP10 (a prescription form that could be used in any pharmacy) or hospital only prescription for medicines to take home or by prescribing clinicians in the patient’s notes if medicines were to be administered in clinic.

FP10 prescription pads were stored securely in locked cupboards with serial numbers recorded so that all forms could be tracked throughout the department. This was in line with NHS Counter Fraud Authority, Management and control of prescription forms: A guide for prescribers and health organisations, March 2018. We also observed a prescription pad audit that had been carried out in September 2018 found that all prescriptions were stored in a secure place and held registers to keep a clear audit trail of prescriptions was in place.
Incidents

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 2017 to May 2018, the trust reported no incidents classified as never events for outpatients.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the hospital reported one serious incident in outpatients which met the reporting criteria set by NHS England from June 2017 to May 2018.

(Source: Strategic Executive Information System (STEIS))

We reviewed a report of the ‘fall resulting in a fracture’ serious incident and saw that a root cause analysis of the incident had been undertaken. Immediate actions following the incident had been taken, including the removal of the chair that was outside the treatment room. The action plan also detailed that the learning from this meeting would be shared at an outpatient team meeting but we did not see this in the minutes provided to us. The trust informed us that due to the change in governance structure, the incident had not been discussed at a divisional governance meeting and was not scheduled for discussion until November. This was nearly ten months after the incident had occurred.

Between September 2017 and September 2018, the department reported 24 incidents, 23 of which were recorded as having caused no harm and one as having caused moderate harm. The majority of these incidents were reporting that clinics were overrunning, and four incidents were reported due to transport issues.

Staff told us that incidents were discussed at the daily huddles. All staff we spoke with knew about online reporting system and were able to give us examples of using it. Staff did not receive specific training on this system but found it easy to use. Staff told us that they did not always receive feedback for the incidents that they reported.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

There was only one incident in outpatients that was identified as causing moderate harm and therefore triggered the duty of candour. We saw evidence that following this incident, the patient was written to with an apology and an investigation report with actions was shared. The patient was also offered the chance to meet with the staff to discuss the findings if they wished.
Is the service effective?

Evidence-based care and treatment

The department provided care and treatment based on national guidance. There were policies and procedures in place that staff knew how to access.

Staff in the outpatient department participated in external audits. Most audits were the responsibility of the speciality that oversaw that condition, for example the Endocrine and Thyroid National Audit was overseen by the speciality medicine division, with some of the pathway occurring in outpatient clinics. Other audits with outpatient contribution included the Getting It Right First Time (GIRFT) Audit and the National Cancer Patient Experience Survey.

We saw a database containing an overview of National Institute for Health and Care Excellence (NICE) guidance for different specialities. The database indicated when the guidance or quality standards were due for updates and any areas where action was required to enable compliance. For example, we saw that in the rheumatology speciality, a specialist physiotherapy service, nurse specialist helpline and psychology input was required to enable compliance with NG 100: Rheumatoid arthritis in adults: management.

Patients who were referred on a two week wait appointment for suspected colorectal cancer were referred 'straight to test'. This was in line with National Institute for Health and Care Excellence (NICE) clinical guidance (CG 131) colorectal cancer: diagnosis and management.

Nutrition and hydration

Patient’s nutrition and hydration needs were identified and met. There was access to dietary and nutritional specialists in some speciality clinics such as diabetes clinics.

Water machines were available in the waiting areas. Patients attending main outpatients could access refreshments from a café in the main entrance area which was close to the department, and there were vending machines available in neurology outpatients, however these were not as accessible. Staff told us that patients whose appointments were delayed would be offered refreshments if they were unable to purchase these from the café. We observed a patient whose transport had been delayed being given a sandwich and offered a hot drink whilst they waited.

Staff also told us about a clinic that regularly ran outside of normal outpatient hours, and how a hot drinks round was run by the staff for patients and relatives during this clinic.

Dietary and nutritional advice and support programmes were provided through clinics within general outpatients. For example, patients with irritable bowel syndrome could access one to one or group support around dietary changes to help manage their symptoms.

Pain relief

Nursing staff told us that they did not use pain scores to assess pain, but that if they were concerned they would advise the relevant consultant who could prescribe pain relief where appropriate.
As part of monthly catheter insertion audits, checks were made to ensure staff used an anaesthetic lubricant to control pain that may be experienced during the procedure. Audits between April and September 2018 demonstrated that all procedures used this process.

**Patient outcomes**

The service monitored the effectiveness of care and treatment.

Following an appointment, the electronic patient information system had to be updated in order for the clinic to be closed. The consultant updated a paper ‘clinical outcome form’ which patients took to reception to be actioned.

The trust did not participate in the Improving Quality in Physiological Services (IQIPS) accreditation run by the United Kingdom accreditation service (UKAS). The IQIPS programme is professionally led with the aim of improving services, care and safety for patients undergoing physiological tests (such as audiology or sleep studies), examinations and procedures. There were no plans in place to participate in this accreditation scheme.

The dietetics department had developed a programme where they supported patients with irritable bowel syndrome to manage their symptoms through diet. Dietetics staff were trained to provide support through the FODMAP diet where certain foods were eliminated and then reintroduced overtime to identify the impact on symptoms. The programme provided group, one-to-one and telemedicine sessions. The service had been evaluated to include patient reported outcomes. For example, there was an overall 82% reduction in total symptom score; 81% reduction in bloating; 67% reduction in abdominal pain; 55 & 59% reduction in flatulence & belching; and, a 58% reduction in lethargy.

Staff had undertaken an audit of patients with chronic kidney disease and anaemia against NICE guidance.

**Follow-up to new rate**

From May 2017 to April 2018:

- The follow-up to new rate for Royal Sussex County Hospital was similar to the England average.
- The follow-up to new rate for Sussex Eye Hospital was higher than the England average.
- The follow-up to new rate for Princess Royal Hospital was higher than the England average.
- The follow-up to new rate for Brighton General Hospital was lower than the England average.
- The follow-up to new rate for Royal Alexandra Children’s Hospital was similar to the England average.
Follow-up to new rate, Brighton and Sussex University Hospitals NHS Trust

(Source: Hospital Episode Statistics)

Competent staff

The service made sure staff were competent for their roles by ensuring that appraisals were completed at regular intervals.

Appraisal rates

From May 2017 to May 2018, 76.9% of staff within this core service at the trust received an appraisal compared to a trust target of 78%. The trust target is correct at March 2018, however they have commented that the target will increase incrementally to 90% by June 2018. Below is a split of appraisal completion rate by staff group.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals complete</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to ST&amp;T staff</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>78%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical &amp; dental staff</td>
<td>110</td>
<td>100</td>
<td>90.9%</td>
<td>78%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>12</td>
<td>9</td>
<td>75.0%</td>
<td>78%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>28</td>
<td>15</td>
<td>53.6%</td>
<td>78%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>15</td>
<td>8</td>
<td>53.3%</td>
<td>78%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>11</td>
<td>2</td>
<td>18.2%</td>
<td>78%</td>
<td>No</td>
</tr>
<tr>
<td>Grand Total</td>
<td>182</td>
<td>140</td>
<td>76.9%</td>
<td>78%</td>
<td>No</td>
</tr>
</tbody>
</table>
It was not possible to break outpatient staff appraisal rates by site. Trust wide, data we were provided with demonstrated that 94% of staff had an appraisal in the last 12 months. This was better than the trust target of 85%.

Staff completed competency documents for certain procedures to ensure they remained confident and competent to complete particular procedures. We saw examples of bladder installation competency documents for staff.

No staff in the outpatient departments had received Mental Health Act 1983 (MHA) training. As part of a data request, the trust informed us that any patients detained under the MHA would be escorted by a registered mental health nurse. They also informed us that if a member of staff in outpatients was concerned about the mental health of a patient not escorted by a registered mental health act practitioner, they could contact the mental health liaison team based at the Royal Sussex County Site 24 hours a day. There was also nursing cover available on the PRH site between 7am and 9pm 7 days a week. However, when on inspection, staff told us about an incident where a patient that required mental health support was on the outpatients unit and there had been difficulty in gaining support.

**Multidisciplinary working**

Staff of different kinds worked together to benefit the patient.

We visited the neurology outpatients where there was a multi-disciplinary approach to various specialist clinics including the skull-based clinic. A weekly multidisciplinary (MDT) meeting occurred between an ears, nose and throat (ENT) consultant, radiologist, and a specialist nurse. This allowed staff of different roles to work together for the benefit of the patient.

Cancer multidisciplinary team meetings were a standard part of cancer pathways. Clinical Nurse Specialists attended these meetings, and also supported patients alongside oncologists and consultants in their clinic appointments.

We observed outpatients staff working alongside volunteers in the department. We spoke to a volunteer who told us that they felt part of the team and valued.

There was a multidisciplinary approach to a range of services offered by the service. This included the development of new ways of working such as clinics for patients who had been discharged home following a critical care admission. The service involved physiotherapy and dietetic input for patients as part of their recovery. In trauma and orthopaedics imaging results were being reviewed by surgeons, physiotherapists and radiologists to agree treatment plans virtually.

**Seven-day services**

As the outpatients service did not provide urgent or acute services, it was not available seven days a week. The majority of clinics operated between 08:30am and 5pm Monday to Friday with some additional clinics running on a Saturday.
Health promotion

Staff supported patients for national public health priorities such as smoking cessation. There was educational literature for patients available within the outpatient department. Information based on national guidance and best practice was provided by the clinics and was available for patients to read in the waiting areas.

Health promotion material was placed in waiting areas and around the clinics. For example we saw information leaflets advising patients how to stop smoking and how to obtain stopping smoking support in the local area. There were also leaflets for wellbeing support locally and weight loss for health.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

There was an in-date policy for consent to examination or treatment. We reviewed five records of patients who had a minor operation or procedure in the outpatient department within the last 12 months. Consent forms were signed and dated by the patients and consultant and the risks of the procedure were documented. We saw that World Health Organisation (WHO) five steps to safer surgery checklists were used for dental related procedures were used and allergies were documented clearly.

Staff told us that they obtained verbal consent before a procedure following a discussion, and the doctor asks for verbal consent immediately prior to any minor operations or investigations and documents this in the notes. This was in line with the consent policy and we observed this within the patient notes. Where consent was documented on the day of the procedure, we saw evidence in prior appointments that the procedure had been discussed and the patient had been given sufficient time to consider the risks and provide informed consent.

Staff we spoke with understood the basic principles of capacity and described occasions where they had used capacity assessments. The junior sister was the point of contact for capacity questions in the department.

The trust informed us that a programme of Mental Health Act training had been in place which was run in prioritised areas of mental health activity by the Lead Educator for this area. However, this had not included any areas of outpatients.

Mental Capacity Act and Deprivation of Liberty training completion

Mental capacity and deprivation of liberty (DOLS) training was included as part of safeguarding adults level two training and as part of a data request the trust informed us that 72% of clinical staff (nursing, allied healthcare professionals, healthcare assistants) had received this training. However, the data provided to us did not have the compliance rate for medical staff on the Princess Royal Hospital site as medical staff were managed by their individual specialities.
Is the service caring?

**Compassionate care**

Patients and visitors were treated with compassion and kindness when receiving care. Patient’s privacy and dignity were respected.

We spoke with patients and relatives during our inspection who told us that staff were “efficient and polite” and “pleasant and helpful”.

Staff gave us an example of where they had gone the extra mile for a patient who found it difficult to be in crowded areas. They were able to facilitate the patient coming in early for the first appointment, and utilised a side access door that linked the clinic area directly with the car park so that the patient could enter and leave without needing to use the busy main entrance and corridors.

We observed a staff member taking the time to provide support to a relative who was concerned about their relatives condition. The staff member took time from their lunch break to sit down with the relative and provide as much support as possible.

We observed staff raising concerns over a patient who was waiting for a long time in the waiting area following their appointment. Staff members spoke to the patient who was waiting for their transport, and were able to get an estimated time of arrival to the patient, which was not due imminently. They offered the patient hot drinks and food, and also assisted the patient with consent from their wheelchair to more comfortable seating after recognising that the patient looked uncomfortable.

All clinic rooms had signs on asking to knock and wait before entering to ensure patient’s privacy and dignity was maintained. Staff also told us about the ‘star’ initiative. This is where a star sticker was placed on the door when there was known to be a difficult or emotional consultation taking place.

At the main reception area where patients checked in, we observed receptionists using a soft tone to ensure other patients may not overhear their personal details. There was also a barrier in place indicating patients to wait behind whilst other patients were checking in to ensure privacy.

Chaperone posters were displayed in the waiting areas, advising patient they ‘were not alone — feel free to ask for a chaperone’ and we also observed staff offering this when taking patients into their clinic.

The Patient Led Assessments of the Care Environment (PLACE) for the period 2018 for privacy, dignity and wellbeing across three outpatient areas ranged from 28% to 88%, which meant some areas were better than the national average of 84%, and some were much worse.
The trust participated in the Friends and Family Test (FFT). The test is a single question survey which asks patients whether they would recommend the service they received to friends and family who need similar treatment or care. The validated and published results as published on the NHS England website of the outpatient department FFT results are shown in the below table.

<table>
<thead>
<tr>
<th>Month</th>
<th>Percentage Recommended</th>
<th>Percentage Not Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jun-18</td>
<td>94%</td>
<td>2%</td>
</tr>
<tr>
<td>May-18</td>
<td>92%</td>
<td>3%</td>
</tr>
<tr>
<td>Apr-18</td>
<td>94%</td>
<td>2%</td>
</tr>
<tr>
<td>Mar-18</td>
<td>96%</td>
<td>3%</td>
</tr>
<tr>
<td>Feb-18</td>
<td>96%</td>
<td>3%</td>
</tr>
<tr>
<td>Jan-18</td>
<td>91%</td>
<td>2%</td>
</tr>
</tbody>
</table>

In addition to this, the hospital provided us with un-validated data for July and August 2018 with response rates of 94% and 93% respectively for July and August. This demonstrated consistent positive results.

**Emotional support**

Cancer and other speciality clinics had access to a Clinical Nurse Specialist (CNS). The CNS role is one of a clinical expert within a specialist area, such as cancer, urology or multiple sclerosis. Clinical nurse specialists also had access to advanced communication skills training, which allowed them to support patients through difficult or upsetting diagnoses and to provide emotional support.

Patients we spoke with told us they were given time and support to cope emotionally with their diagnosis.

Within the neurology waiting areas there were posters for brain injuries survivors counselling services. There were details of rebuilding lives after brain injury support groups information and counselling services.

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

Patients told us that they felt involved in decisions about their care and that they received enough information regarding their treatment.

A new room had been set up in the main outpatient area called the Cedar Room. This was a room where patients or relatives could come and speak with a Macmillan nurse regarding their cancer diagnosis. The door to the room was open even when a nurse was not present so that patients could access an array of literature regarding different types of cancer and support available.

We observed in patient records that appointment letters gave patients useful information, such as hospital maps, local transport availability and what they need to bring to their appointment. Letters to patients also suggested bringing a friend or relative to the appointment if they wished, along with any questions they may have had to their appointment, so they could discuss any concerns or worries. We spoke with patients on our inspection who told us that they felt they received enough
information and always had their questions answered. Patients felt confident and happy with their relatives accessing the service.

**Is the service responsive?**

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

Service delivery generally met the needs of patients and local people.

General outpatient clinics operated between 8:00am and 6pm Monday to Friday. There were some additional clinics run on Saturday mornings which staff told us were run by the specialities staff as opposed to outpatient staff.

Patients checked into their appointments via a reception desk, both in main outpatients and in the neurology outpatients. From there, the receptionist would advise the patient which area they needed to be seated in to wait, and there were volunteers available to direct and accompany patients to the correct areas.

Following our previous report, it was highlighted that the outpatient service should develop play areas in line with national best practice. We observed a new play area in one of the waiting areas on the main outpatient area. In addition to this, two dedicated paediatric clinic rooms had been developed and had their own separate waiting area. The trust told us that children were only seen in clinics in these dedicated spaces.

There was signposting around the hospital to direct patients to the relevant outpatient areas and all patients that we spoke to told us that they easily found their way to their clinics. There was a reception desk at the main entrance to the hospital manned by voluntary staff who could help signpost those patients who were not sure where they were going.

Patients could access the hospital using local bus and taxi services. There was information on the website regarding the different bus services available, along with a link to a journey planner for patients to use. There was also a car park on the hospital site. Patients we spoke to on our inspection told us that they had been able to park, but it had taken between ten minutes and half an hour to wait for a space. Patients also told us that the parking was normally worse but that we had asked them on a ‘good day’. The trust had recently added in new machines to the parking areas to allow patients to pay by card or cash at the gate. However, on the day of our inspection, the machines were not working and we observed a relative informing a member of staff that they had to leave their car without a ticket.

Staff told us about one particular clinic that regularly ran over the normal outpatient clinic times of operation. Staff accompanied patients back to the car parking attendant to ensure they paid only the standard fee for their stay.

The service did not monitor clinic start and finish times. Staff told us they had monitored them for a period of time but that the results weren’t acted on so this practice was stopped. Senior staff told us the monitoring of clinic start and finish times was a draft indicator for the outpatient department Patient First Improvement System driver improvement project which started in September 2018 and was running for five months into 2019. However, staff in outpatients had not been informed of this and were not aware this was happening.

There were whiteboards in all of the clinic waiting areas advising who the relevant nurse and healthcare assistant attached to that clinic was. The white boards all had standard text printed and displayed advising patients of the potential for delays in clinics and apologised for this. However,
there were no specific details of wait times marked around the clinic waiting areas and staff told us they would inform them if there was a particularly late running clinic. Patients we spoke to on the days of our inspection told us that the wait times were variable, with some patients being seen ‘bang on time’ and others waiting up to an hour before being seen.

We spoke to patients during the inspection regarding the information they received in the lead up to their appointments. The majority of patients told us they received a clinic letter followed by a text message reminder. Patients told us the reminders were helpful. However, some patients told us that they had not received the texts and that they would have found these useful.

There were a range of patient information leaflets in waiting areas. These included information and support for relatives regarding long term conditions such as cancer and macular degeneration, and also information for patients who were transitioning from children to adult clinics.

Staff told us about a backlog of multiple sclerosis (MS) patients awaiting follow-up appointments. The backlog began when one of the consultant neurologists left the trust and the department were unable to recruit into this post. The trust informed us following the inspection, that 111 patients had been affected by this issue. The issue had been escalated by the neurology service to NHS England and a new model of care was agreed for full roll out by April 2019. In the interim, a multi-disciplinary (MDT) meeting had been set up in response to the backlog to ensure all patients waiting for a follow up had been reviewed by a multi-disciplinary neurology team.

We saw that this had been entered as a risk on the specialist services risk register with the controls being listed as the MS specialist nurses flagging any concerns to the MDT team.

A total of 12 complaints or patient advice and liaison service (PALS) enquiries had been made by patients waiting for follow up in the last 12 months.

Following the inspection the trust told us that following the introduction of a locum neurologist, there had been a reduction in the number of patients overdue follow up by 83% as the capacity to see the MS patients had been increased.

Did not attend rate

From May 2017 to April 2018:

• The ‘did not attend’ rate for Princess Royal Hospital was lower (better) than the England average.

A patient administration system with text reminded had been rolled out across all specialities in 2017. This meant that patients were able to respond to the text to indicate if they were cancelling, confirming or rebooking their appointment. Staff told us that 78% of patients were registered with a mobile phone and that did not attend (DNA) rates had improved since the system had been implemented.
The chart below shows the ‘did not attend’ rate over time.

**Proportion of patients who did not attend appointment, Brighton and Sussex University Hospitals NHS Trust**

![Chart showing 'did not attend' rate over time]

(Source: Hospital Episode Statistics)

**Meeting people’s individual needs**

The service took account of patients’ individual needs. The main outpatient departments were signposted, and volunteers were situated in the main hospital entrance and offered patients assistant to find a clinic if required.

The trust had a dementia strategy that was due for review in September 2018. However, there were no specific goals or assessments specific or relevant to the outpatient setting.

Dementia training was part of the trust training programme for all staff. Data provided to us by the trust suggested training compliance cross site was at 88% compliance. This was better than the trust target of 85%. Staff told us that nursing staff had dementia awareness training during the safeguarding training day and as part of their nursing induction.

The Patient Led Assessments of the Care Environment (PLACE) for dementia period 2018 over three outpatient areas ranged between 57% and 63%, all of which were worse than the national average of 78.9%.

The trust was aware of the Accessible Information Standard. The Accessible Information Standard came into effect in 2016 and requires that all NHS trusts offer reasonable adjustments to help support people with disabilities or sensory loss to fully understand the information given to them. Some of the aids available at the trust were British Sign Language (BSL) interpreting for appointments, Listening Devices, and braille for patients with visual impairment. We saw “How do you communicate?” posters on display asking patients if they needed information in a different format or additional support.

Staff knew about translation services for patients who did not speak English as a first language and interpretation services could be arranged either to be face to face or via a telephone device. There was a multi faith chapel on level one that patients, visitors and staff could use.
There were disabled toilets in the main outpatient area. All of the services in main outpatients were located on the ground floor and were accessible to those with a physical disability. The pharmacy and chapel were on the first floor and we observed there were lifts that patients could use to access these floors.

Patient Led Assessments of the Care Environment (PLACE) for disability period 2018 over three outpatient areas ranged between 53% and 79%, all of which were worse than the national average 84.2%.

Access and flow

From 1 October 2018 all outpatient referrals nationally were to be received via the NHS e-Referral System (ERS). Senior staff told us that in September 2017 the proportion of e-referral utilisation was 1% and was lowest in the South East and nationally. In August 2018 this utilisation rate had increased to 96%. At the time of our inspection all outpatient referrals were processed and triaged electronically, ahead of the 1 October deadline.

Consultants reviewed all referrals and accepted, rejected or redirected as appropriate. Any rejected referrals had to be returned to the patient’s GP within three working days. If a rejected referral was not returned to the GP in this time then the receiving clinician would be expected to see the patient as booked.

Patients could not always access the service when they needed it. Overall waiting times from referral to treatment were worse than the England average. Non-admitted pathways were overall more than 10% below the England average and performance had consistently reduced over the course of the year.

The trust had met with commissioners, NHS Improvement and NHS England for a Referral to Treatment Time (RTT) summit in early September 2018. Following this meeting the trust were constructing a range of costed options to reduce the non-admitted backlog to improve RTT performance and were due to submit these options to NHS England and NHS Improvement by the end of October 2018. At the time of our inspection the trust were in the process of analysing performance data and workforce implications to develop a plan to reduce the non-admitted backlog.

Other action that the trust had taken included using an insourcing company to provide support to specialities with short term workforce constraints that had affected the 18 week pathways. Insourcing services had been used in areas such as endoscopy; ear, nose and throat; and, vascular services. In addition, different specialities met weekly to discuss their RTTs and identify action to address them.

We spoke to patients who had long term conditions and needed to be seen regularly in clinic. They told us that the amount of time between appointments had been increasing, for example one patient who was due to be seen every 6 months was seen every 8 months. Staff we spoke to told us that there was a focus on getting patients in for their first appointment, and clinics were overbooked to accommodate these, but then there was not always capacity to add in the follow up clinics.

Waiting times for outpatient prescriptions were not monitored. The outpatient pharmacy was located on level one of the main building. We spoke to staff working in the pharmacy who told us that currently outpatient prescriptions were 50% hospital only prescriptions and 50% retail prescriptions (FP10s) that could be taken outside of the hospital. The pharmacy did not monitor
the waiting time for outpatients waiting for their prescription, but staff told us that this was rarely longer than 15 minutes. There were no patients waiting in the area to confirm this with. There was a tracking system in place for monitoring inpatient prescription wait times but this was not available for outpatient appointments. We were told the waiting time was short because the department was able to issue FP10s that could be collected outside of the hospital grounds.

There was no ‘text and wait’ system in use currently to enable patients to come back when their prescription was ready. If there was likely to be a delay, staff would advise patients to get a hot drink on the ground floor and to come back.

Opening times: Monday to Friday between 08:30 and 5pm, and Saturdays 9am to 12 for urgent prescriptions only.

The trust monitored the turnaround time of letter sent to patient’s GPs following their outpatient appointment. This was not broken down to site level. There was no target turnaround time for this according to the trust Patient Access Policy. The majority (28%) of letters sent between March and August 2018 were sent within seven and 13 days. The worst performing specialties, with over 50% of their letters taking 14 or more days, were breast care, gynaecology, renal and spinal surgery. The three best performing specialties with 50% or more of the letters turnaround between zero and two days were the hand service, neuro psychology and nutrition and dietetics.

The booking centre was based at the Royal Sussex County Hospital site but dealt with calls for all trust sites. Within the booking centre key performance indicators had been developed with daily reporting to trust key stakeholders. Call centre staff had a target of answering 90% of all calls and answering 90% of calls within two minutes. Data provided by the trust showed that the target was being achieved some of the time. For example, data for a 10 day period in April and May 2018 showed that the target for overall call answering had been met three times. The target for answering calls in two minutes had been met three times.

The call centre was visited by the Royal Sussex County site team at the time of our inspection who saw that 76% of calls had been answered but that 90% of these had been answered within two minutes. All internal and two-week wait (urgent) calls had been answered. Staff told us that a daily huddle helped them to identify issues and ensure a team approach. At the time of our inspection we were told that there were some issues with follow up appointments in digestive diseases, neurology and chest specialities. Appointment bookings were prioritised based on clinical urgency and chronological order.

Clinics were sometimes cancelled with less than six-weeks notice. This was not in line with the trust’s Patient Access Policy. Between September 2017 and August 2018, the percentage of all clinics cancelled ranged between 4% and 14%. This had increased since our last inspection.

**Referral to treatment (percentage within 18 weeks) – non-admitted pathways**

From July 2017 to June 2018 the trust’s referral to treatment time (RTT) for non-admitted pathways was consistently worse than the England overall performance. The latest figures for June 2018 showed 75.1% of this group of patients were treated within 18 weeks versus the England average of 88.5%.
Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Brighton and Sussex University Hospitals NHS Trust

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

Five specialties were above the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>100.0%</td>
<td>91.7%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>98.0%</td>
<td>95.6%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>97.0%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>94.3%</td>
<td>92.9%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>88.1%</td>
<td>84.2%</td>
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</table>

Fourteen specialties were below the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
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</thead>
<tbody>
<tr>
<td>Other</td>
<td>83.4%</td>
<td>91.1%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>79.3%</td>
<td>84.4%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>78.2%</td>
<td>89.6%</td>
</tr>
<tr>
<td>Speciality</td>
<td>Percentage 18 weeks</td>
<td>England Average</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>71.8%</td>
<td>88.7%</td>
</tr>
<tr>
<td>General surgery</td>
<td>71.5%</td>
<td>89.0%</td>
</tr>
<tr>
<td>Urology</td>
<td>71.4%</td>
<td>87.6%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>71.1%</td>
<td>86.5%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>69.0%</td>
<td>86.5%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>68.0%</td>
<td>89.3%</td>
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<tr>
<td>ENT</td>
<td>62.4%</td>
<td>86.6%</td>
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<tr>
<td>Thoracic medicine</td>
<td>60.3%</td>
<td>87.5%</td>
</tr>
<tr>
<td>Neurology</td>
<td>57.6%</td>
<td>80.5%</td>
</tr>
<tr>
<td>Ear, nose and throat (ENT)</td>
<td>48.6%</td>
<td>85.6%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>37.6%</td>
<td>81.7%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – incomplete pathways**

From July 2017 to June 2018 the trust’s referral to treatment time (RTT) for incomplete pathways was consistently worse than the England overall performance. The latest figures for June 2018, showed 83.0% of this group of patients were treated within 18 weeks versus the England average of 87.4%. Data provided by the trust from August 2018 showed that the figures remained stable at 83.0%.
Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Brighton and Sussex University Hospitals NHS Trust

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Seven specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>99.7%</td>
<td>93.2%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>99.4%</td>
<td>96.2%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>97.4%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>93.8%</td>
<td>89.4%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>91.5%</td>
<td>90.5%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>89.0%</td>
<td>85.4%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>88.8%</td>
<td>88.5%</td>
</tr>
</tbody>
</table>

Twelve specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>88.3%</td>
<td>90.3%</td>
</tr>
<tr>
<td>Urology</td>
<td>85.3%</td>
<td>87.1%</td>
</tr>
<tr>
<td>General surgery</td>
<td>82.6%</td>
<td>84.8%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>82.3%</td>
<td>89.9%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>81.2%</td>
<td>89.4%</td>
</tr>
<tr>
<td>Department</td>
<td>Quarter 1 (%)</td>
<td>Quarter 2 (%)</td>
</tr>
<tr>
<td>------------------------------</td>
<td>---------------</td>
<td>---------------</td>
</tr>
<tr>
<td>ENT</td>
<td>80.3%</td>
<td>86.9%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>79.3%</td>
<td>84.8%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>77.8%</td>
<td>82.5%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>75.8%</td>
<td>92.9%</td>
</tr>
<tr>
<td>Neurology</td>
<td>71.3%</td>
<td>87.5%</td>
</tr>
<tr>
<td>Ear, nose and throat (ENT)</td>
<td>70.4%</td>
<td>85.4%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>62.0%</td>
<td>82.9%</td>
</tr>
</tbody>
</table>

(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 has performed consistently better than the 93% operational standard for people being seen within two weeks of an urgent GP referral since 2017/18 quarter 2. 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), Brighton and Sussex University Hospitals NHS 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), Brighton and Sussex University Hospitals NHS Trust

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.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Brighton and Sussex University Hospitals NHS Trust

(SOURCE: NHS England – Cancer Waits)

Senior staff we spoke with told us that their aim was to continue to improve the overall pathway with a view to addressing the low performance in people waiting less than 62 weeks from urgent referral to treatment. In addition, weekly cancer meetings were held where the patient tracking list was reviewed to identify issues impacting on referral to treatment times. Pathway and multidisciplinary coordinators were involved in these meetings.

Senior staff told us that there had been a 50% increase in urgent GP referrals in recent years and that demand had sometimes outweighed the capacity of the service. As a result, the trust was aiming to improve output across the whole pathway, however issues such as delays in imaging and diagnostic blocks had impacted on this. We were told this was a result of staffing changes and difficulties recruiting radiologists. However, the trust had recently been successful in their recruitment.

The service had participated in a national lung pathway redesign pilot. This involved patients being booked into a scan by trust staff where this was identified as needed following a chest x-ray. The
GP would then be contacted and asked to do an urgent referral and notified that the patient already had a scan appointment or was on a waiting list for a scan.

A one-stop breast clinic was removed in May 2017. The trust told us this was due to the volume of patients being referred outstripping the capacity of the service. This had resulted in patients receiving on the day imaging dependant on when they were referred in to the service rather than being based on clinical need. This meant that, irrelevant of likely clinical risk, patients were waiting some weeks for imaging (Ultrasound and Mammogram). As a result of this review, a clinical decision was made in conjunction with the surgeons, nurses and radiologists to cease the one stop clinic arrangement and instead manage patients based on their assessed clinical risk at their outpatient appointment. This meant that clinical risk would be assessed using a physical examination and as a result patients would receive a scale rating where P1 represents normal tissue; P2 benign tissue; P3 probably benign: P4 probably malignant; P5 malignant. Patients would then be referred for imaging based on their clinical risk score. We were told that this arrangement was reviewed on an ongoing basis through discussions and presentations at clinical governance meetings.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results. However, trust wide not all complaints were responded to within the timeframe set in the trust guidelines.

At the Princess Royal site, the trust received more compliments (14) than complaints (12) during the last 12 months.

We reviewed three complaint responses whilst on site and saw that all patients had received a personalised response. We observed patient advice and liaison (PALS) and ‘how to make a complaint’ leaflets available in waiting areas.

**Summary of complaints**

From April 2017 to March 2018 there were 83 complaints about outpatients. The trust took an average of 44 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be closed within 25 days.

Analysis found that 54.2% of complaints relating to outpatient services at the trust were regarding access to treatment or drugs.

The breakdown by site is shown below.

- Princess Royal Hospital: 12 complaints
- Royal Sussex County Hospital: 52 complaints
- Other sites: 19 complaints

(Source: Routine Provider Information Request (RPIR) – Complaints tab)
Number of compliments made to the trust

From April 2017 to March 2018 there were 89 compliments within outpatients.

The breakdown by site is shown below.

- Princess Royal Hospital: 14 compliments
- Royal Sussex County Hospital: 37 compliments
- Other sites: 38 compliments

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Leadership
Since our previous inspection where outpatient services sat within the head and neck directorate, a divisional restructuring had taken place across the trust. Since April 2018 general outpatients and central administration services (CAS) had operated within the central clinical services division.

The central clinical services divisional leadership team consisted of a chief of service, a head of professions, a deputy director of operations (vacant) and divisional project support. There was a directorate manager responsible for both outpatients and the central administration service and the lead cancer nurse was the professional lead nurse for the service. There was a vacant band 8 matron post that was scheduled to be recruited to by November 2018. A band 7 nurse managed the outpatient department operationally.

The band 7 nurse manager reported to the professional lead for the service, however this was a new structure that had been put in place three weeks before our inspection. Prior to that, since the divisional restructuring in April 2018, line management arrangements for the nurse manager were not formalised. This meant that supervision and support arrangements were not in place, although the nurse manager was clear about who they could report to if the need arose. In addition, there were informal support structures in place between the nurse manager at the Princess Royal Hospital and the nurse manager at the Royal Sussex County Hospital.

Staff at the Princess Royal site told us they had seen some of the executive team in outpatients and named the chief nurse and deputy chief nurse as being visible. The senior leadership team however had not been visible on the department.

Vision and strategy

The trust values were communication; kindness and understanding; fairness and transparency; working together and excellence. The trust vision was to be locally and nationally renowned for delivering safe, high quality and compassionate care and being the regional centre of clinical and academic excellence. There were no specific vision or values for the outpatient team.

The trust was rolling out the Patient First Improvement System which was an organisational system to manage and improve quality and performance. Outpatients had been designated as the next department to engage in this system. However, this was being rolled out initially on the Royal Sussex County site. Staff told us that they knew it was coming to the Princess Royal Hospital site and understood some of the rationale behind this.

As part of a data request, the trust informed us that outpatients services were included as part of the review process within the trust-wide clinical strategy. However, this had not yet been approved by the trust board and was due to be ratified in October 2018. As a result of this, we could not ascertain whether the trust wide clinical strategy had realistic objectives applicable to the outpatients department. However, there were some clear priorities identified for delivering good quality and sustainable care within outpatients. These included;

- The implementation of e-referral and continued development of centralised booking services
- Potential re-provision of current main outpatient department at the Royal Sussex County Hospital as part of the 3Ts estates development
• Digitisation and implementation of new technologies including virtual clinics, text remind, one-stop consultation and diagnostic/treatments services such as a urology treatment centre at Princess Royal Hospital.

We spoke to staff regarding the strategy. Whilst the senior leadership team could tell us about the detail of the strategy and the plan going forwards, other members of the outpatient team had not been consulted or involved in this. We saw that the themes of the strategy had been circulated to two members of staff in outpatients approximately two weeks prior to our inspection.

Culture

Staff we spoke with told us they felt valued and that they were part of a great team. During the inspection we observed staff and volunteers supporting each other and working together to benefit the patient. Staff told us they felt it was an open culture where they could raise issues if they were concerned.

Staff working within outpatients were flexible and motivated to provide high quality care and a positive patient experience. We observed staff taking time to engage with patients, focusing on their needs and offering assistance.

We observed at the team huddle the department manager encouraging staff to take time out for their wellbeing.

However, we spoke to some staff who told us they did not always feel they received recognition from the trust when they had made innovations or improvements. For example, the outpatients team had created a chaperone poster, which was in use across the hospital. There were also examples where staff had attended conferences and had come back with ideas to improve the patient experience, but that there had been no-one to discuss this with, and therefore nothing was done. The 2017/8 staff survey highlighted the need for effective communication from senior management and acting on staff feedback.

Governance

The trust wide governance structure had undergone a re-structure since our last inspection. The structure now had six sub-committees that fed into the trust board (the audit, charitable funds, finance, quality and risk, appointment and remuneration and patient experience committee. The proposed Patient Experience committee purpose was to provide assurance to the Board that the trust managed comments, compliments, concerns and complaints from patients and the public in a sensitive and effective manner and that a process of organisational learning is in place to ensure that identified improvements are embedded within the organisational framework.

The central clinical service division held quarterly governance meetings. We saw one agenda, action log and report from the August 2018 meeting which demonstrated that patient safety, patient experience and risk were discussed. However, only senior members of the leadership team attended this and no staff such as the band 7 nurses were in attendance.

As part of a data request we were told that team meetings at each site had a standing discussion item of governance and this was fed into the divisional meetings, however we reviewed three sets of minutes from July to August 2018 and saw that no governance issues had been discussed.
This, combined with no staff attending the divisional governance meetings meant that governance issues from the department may not have been fed to the divisional governance groups.

Outpatient improvement meetings took place where key performance indicators and information such as the proportion of cancelled clinics and missed outcomes per speciality were discussed. The terms of reference of the group indicated that the lead nurse for outpatients should be involved in these meetings. However, neither of the current band 7 outpatient lead nurses at the Royal Sussex County Hospital or Princess Royal Hospital had attended the meetings and were not included in the circulation list.

Up until March 2018 there was a regular outpatient lead nurse forum, bringing together outpatient leads from a range of general and speciality services. Due to the divisional restructure in April 2018 these meetings had stopped. This meant that formal arrangements for trust wide outpatient governance were not currently in place. However, there were plans to reinstate these when the outpatient matron post was recruited to in November 2018.

**Management of risk, issues and performance**

Staff we spoke with could tell us about local risks and risk assessments, but not risks relating to the wider department and division.

We reviewed the outpatient risk register which was part of the divisional risk register. There were no risks on the register relating to the Princess Royal site. However, staff told us about a risk that had been identified regarding staff manual handling of notes. Administrative staff had calculated that they lifted up to two tonnes of notes each week and was experiencing manual handling related issues. The department manager had tried to identify different types of trolleys to help the administrative staff but these had not been approved. A porter for outpatients had also been requested but declined. There were no other control measures in place.

We were sent minutes from the outpatient improvement project meeting. This included standard agenda items regarding e-referral progress, clinic validation and missing outcomes per speciality. These meetings occurred monthly, however we noted that the circulation list included the previous Head and Neck directorate lead nurse for outpatients, who was no longer in the same post. Additionally, neither of the band 7 leads for outpatients were included in the circulation.

There was limited audit data shared to improve performance. For example, staff told us they had collected data on clinic start and finish times to try and improve waiting times for patients. However, they told us that the processes for collation of the data and feedback from this had not been in place; therefore, they had stopped collecting the data. Patient outcome forms were used within the department; however, there were no audits of these so therefore it was unclear how these were monitored to improve performance.

The 2018 Patient Led Assessment of the Care Environment (PLACE) audit data had mixed results in the outpatient departments, with some areas of high performance in the cleanliness category, with poor performance across privacy, dementia and disability. The worst results included on area scoring 28% for privacy against a national average of 84%, and 35% for disability for one area against a national average of 84%. It was not clear what actions had been taken following these results.
Information management

There were systems in place that captured key information such as incident reporting which directly contributed to the quality of patient care through the identification of themes and trends, which helped in the development of safer working practices.

Staff had access to up-to-date accurate information on patients’ care and treatment. Staff were aware of how to use and store confidential information.

Information governance training was part of the trust mandatory training requirement for all staff. Data supplied to us showed that 83% of nursing staff had completed this training, which was worse than the trust target of 90%, and that 100% of administrative staff were up to date with this training which was better than the trust target of 90%.

Medical staff could access radiological and pathological results via electronic systems in addition to the patient’s paper record. Staff in neurology told us that neurological investigations were not currently available electronically, but there was a project to allow this system to be available to medical staff.

From October 2018 all outpatient referrals nationally were to be received via the NHS e-Referral System (ERS). At the time of our inspection all outpatient referrals were processed and triaged electronically, ahead of the 1 October deadline.

Engagement

Patient information boards were in use in the waiting areas of outpatients and included feedback comments from patients in a ‘you said, we did’ format. This allowed patients to see that their feedback meant something to the department.

The outpatient department participated in the Friends and Family Test which gave patients an opportunity to feedback simply whether they would recommend their department to their friends and family. There were no other surveys in use within the department.

The trust participated in the NHS Staff Survey. In the most recent 2017/18 survey, 47% of staff recommended the trust as a place to work. This had improved by 9% from the 2016 survey. The score for recommending the trust to a friend or relative needing treatment had also improved by with a score of 58%. This had improved by 6% from the 2016 survey. Responses from the staff survey increased by an average of 18% in the 2017/18 survey.

The trust undertook snap shot staff surveys on a monthly basis within each division. Results from these showed some ongoing improvements across the trust as a whole. Within central clinical services there was evidence of an improving picture of staff engagement with an increased average engagement scores from 3.63 to 3.86 between 2018 and August 2018. Other areas of the survey also showed improvements. However, there was a reduction within central clinical services of staff feeling able to make suggestions to improve the work of their team or department.

Staff in the main outpatient areas had regular team meetings that were minuted. Staff told us that they were able to raise any issues in these and found them useful. In addition to this, the main outpatient area teams had daily safety huddles where any issues could be raised. Staff told us that this made it easy to feel engaged and part of the team.

Staff in neurology outpatients did not have a staff room or anywhere they could utilise to take their breaks between clinics.
The trust website contained a dedicated section for outpatients. This included information about who to contact if patients had any queries or wanted to change their appointment. There was also an online form available for those wishing to cancel or re-schedule their appointment online, provided this was completed two working days prior to the appointment. There was a guide to waiting times on the web pages, which explained that all patients should be seen within 18 weeks, and that some specialities were experiencing longer delays than others.

**Learning, continuous improvement and innovation**

The virtual hand fracture clinic was introduced to the trust in 2016. An audit was carried out in 2017 which demonstrated a 50% reduction in standard clinic visits following the introduction of a virtual system.

Between January and March 2018, the services only method of feedback was from FFT cards given to patients at their appointment, which generated an average of 0.5% response rate. In April 2018, more cards were given out at the point of contact at the appointment, which generated an increase in response rates. In May 2018, the service switched on the ability for patients to text their FFT feedback following their appointment, which resulted in a large increase in response rates.

The below graph demonstrates the increase in the number of responses gained for the Friends and Family Test from January to June 2018:

<table>
<thead>
<tr>
<th>Month</th>
<th>Total Responses</th>
<th>Total Eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-18</td>
<td>290</td>
<td>49,673</td>
</tr>
<tr>
<td>Feb-18</td>
<td>217</td>
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<td>Mar-18</td>
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