Listening Event Summary

CareQuality Commission

We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

Brighton and Sussex University NHS Trust

Royal Sussex County Hospital, Eastern Road, Brighton, BN2 5BE

Tel: 01273696955

Date of Events:	20 December 2013
	19 December 2013
	28 January 2014

Details about this Trust

Registered Provider	Brighton and Sussex University Hospitals NHS Trust
Overview of the service	Brighton and Sussex University Hospital NHS Trust is registered with the Care Quality Commission and has a total of seven locations. These locations include:
	Bexhill Hospital
	Brighton General Hospital
	Hove Polyclinic
	Lewes Victoria Hospital
	Park Centre Breast Care Services
	Princess Royal Hospital
	Royal Sussex County 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 and more specialised and tertiary services for patients across Sussex and the south east of England.

Princess Royal Hospital hosts Hurstwood Park which is the regional centre for neurosciences.

The Princess Royal Hospital campus is home to the Royal Alexandra Children's Hospital and is the major trauma centre for Sussex and the South East. As part of Brighton and Sussex University Hospitals NHS Trust, the Princess Royal Hospital provides a full range of general acute services, accident and emergency department and a maternity unit.

The Trust currently treats over 750,000 patients each year and employs 7,500 members of staff across the seven locations.

Regulated activities	
	Assessment or medical treatment for persons detained under the Mental Health Act 1983
	Diagnostic and screening procedures
	Maternity and midwifery services
	Surgical procedures
	Termination of pregnancies
	Treatment of disease, disorder or injury

Contents

Why we carried out pre inspection listening events

A number of concerns had been raised with the Care Quality Commission (CQC) by senior staff within the Trust, individuals who did not want to be identified and also specific concerns raised by the National Health Service Black and Minority Ethnic Network (NHS BME Network). The NHS BME Network is a National Network of NHS Staff whose purpose is to be the "Independent and effective voice for BME staff, BME Patients and BME Service users to ensure the NHS delivers on its statutory duties regarding race equality".

In addition to a team of inspectors visiting a number of the locations and meeting with staff and patients, the Chair of CQC David Prior visited the Trust on the invitation of the Chair of The NHS BME Network to specifically listen to the issues raised by members of the local Brighton and Sussex University NHS Trust BME Network.

Due to the complexities of the concerns that were raised with CQC, we considered that further information was needed to ascertain the potential impact that those concerns may have had on patient safety and patient experiences. By listening to a wide range of people we would then be able to use the information that we captured to develop a richer and broader understanding of the quality of services provided. This will help us focus on specific areas when we inspect the trust under the new acute hospital inspection model. We have not used this information to form judgments regarding the Trust's compliance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We have however, sought assurances from the Trust where the information may have resulted in the potential risk of harm to patients that action has been taken. We will continue to monitor the actions the Trust has taken between now and the inspection in May 2014.

How we carried out this pre inspection listening event

To enable us to speak with as many people as possible, we informed the Trust that we would be holding a number of listening events and would be visiting various locations and wards across the Trust on 19 and 20 December 2013. Our visit team included CQC inspectors, managers and specialist clinical advisors. The team also included Professor Sir Mike Richards, the Chief Inspector of Hospitals.

During the event the team:

Met with patients, staff and members of the public who either worked or attended the Accident and Emergency Department, Medical wards, the Cardiac unit, Maternity unit and Renal units at the Royal Sussex County Hospital.

Met with patients, staff and members of the public who either worked or attended the Accident and Emergency Department, Medical and Elderly Care wards at the Princess Royal Hospital.

We also provided an e-mail account for staff to contact us in a confidential way.

We made provision for staff to meet with us to share their views at both hospital sites through 12 focus groups, where we met over 150 staff including nurses, student nurses, consultants and other medical grades, physiotherapists, occupational therapists, matrons, pharmacists and radiographers. We spoke with and interviewed a range of other staff including the Chief Executive, Medical Director and Chief Nurse.

David Prior visited the Royal Sussex County Hospital and met with members of the local Brighton and Sussex University Hospitals NHS Trust BME Network, as well as visiting the hospital's Emergency Department and the Royal Alexandra Children's Hospital.

We looked at the personal care and treatment records of patients, observed how patients were being cared for and talked with patients. We talked with carers and / or family members, talked with staff, reviewed information given to us by the Trust and reviewed information sent to us by other regulators and /or the Department of Health. We considered information sent to us by other authorities, and we analysed information sent to us by local groups of people in the community or voluntary sector and talked with other regulators and /or the Department of Health.

Overall Summary

Many staff we spoke with from across the Trust were positive about the team they worked with and the standard of care they delivered. There was a focus on patient safety with access for staff to report concerns and incidents. The feedback from staff was that learning from incidents, accidents and complaints was not always shared to help prevent future occurrences.

Patients consistently spoke positively about the care and treatment they received. We were told about various projects and initiatives that had been introduced to help enhance the patient journey; specifically within the Emergency Department and on the Care of the Elderly Ward where we were told a Dementia Nurse Specialist had been appointed.

A number of patients felt that there were not always enough staff on the Maternity Unit which resulted in staff appearing rushed; patients felt that their individual needs may not have always been met as a result.

Some staff were concerned that there was a lack of cohesive working between members of the multi-disciplinary teams which had the potential to affect the patient experience.

We found there were concerns about insufficient numbers of staff such as junior doctors and occupational therapists in some areas. Managers told us that the process to fill vacant positions was slow and often resulted in staff not being appointed due to delays in processing job offers.

Staff we spoke with across the Trust gave a mixed view of supervision and appraisal with some reporting supervision was not regular and some had received no supervision or appraisal. While significant progress had been made to address this, staff reported ongoing problems in accessing training.

We received variable feedback from staff members regarding the support provided by their direct line managers; some staff spoke positively about the support they received whilst others spoke negatively stating that their departmental management hierarchy had become

ineffectual.

Staff told us about the continued challenges of working in some environments that were out-dated and no longer fit for purpose. For example, there was a lack of equipment storage space on a number of wards and poor connections between the various out-buildings on the Royal Sussex County Hospital Campus which resulted in patients experiencing long transfers. The Trust told us of the plans for the 3Ts major redevelopment for some of its sites. A funding decision is expected from the Treasury in the near future. Other building work is planned and will continue as part of the estates and facilities work programme

Where we had received information of concern from staff before, during and after our visit, we have maintained their confidentiality. This has included information regarding the professional conduct and behaviours of individual staff members. We have passed the information to the Chief Executive to investigate and report back to us on the findings so that any potential patient safety concerns could be identified and appropriate actions put in place to reduce the risk of potential harm. He is keeping us informed of the progress.

During and after our visits staff told us that there were significant tensions amongst staff. This was in particular for staff from Black Minority Ethnic (BME) groups who told us they felt disadvantaged and at times, subject to racially motivated bullying and harassment. Some of these concerns had previously been raised with the Trust directly who were able to provide us with confirmation of the actions they have taken to address those concerns.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Care and welfare of people who use services

People should get safe and appropriate care that meets their needs and supports their rights

Summary

At the Royal Sussex County Hospital we visited the Cardiac unit, Albion ward, cardiac theatres, and the cardiac surgery ward 7A. We spoke with staff and patients and reviewed information sent to us by the Trust. We looked at two patient treatment records, theatre records and daily care notes. We found that these were up to date and reflected the treatment being delivered. We saw that the record of a completed World Health Organisation (WHO) checklist was stored with the patient's clinical records. The WHO checklist is a recognised system that ensures key aspects of patient safety in the operating theatre are checked before during and at the end of the procedure.

We looked at 10 patient files to check the use of the national early warning system (NEWS); this alerts staff to changes in a patient's condition which can be acted upon. It was explained that the NEWS score should be documented with every set of recorded observations for a patient. Some patient NEWS scores could be high but not alarming because of their medical conditions and this was taken into account. A high score where the patient's condition had deteriorated would result in emergency crash calls and urgent reviews. We were told this happened twice the day before with patients being reviewed and transferred to other wards for monitoring and treatment.

We visited the Accident and Emergency departments (A&E) at the Royal Sussex County Hospital and the Princess Royal Hospital. At the Princess Royal Hospital there were no delays in patients being seen and treated within the four hour target and we saw the reception area was dealing effectively and swiftly with people when they booked in. We saw patients being referred to triage waited only a short time before being seen by the triage nurse.

We were told by the Matron that the previous weekend had been "very difficult" and one patient stayed in the Clinical Decision Unit for three days because of the lack of suitable beds elsewhere. The impact of this bed situation was still being felt on the day of the visit. We observed care being delivered in all areas of the department. Although clearly busy, the nurses and health care staff spoke to people with compassion and dignity, and offered them choices. However, we could clearly hear conversations from behind the curtains, some of which contained personally identifying information such as a diagnosis.

While in the A&E at Royal Sussex County Hospital we met with senior staff and were informed that patient flow within the department could affect the safety and effectiveness focus of the department. They told us that there were breaches of the four hour target but that staff worked hard to meet them. The main barrier was being able to find beds to transfer patients to wards. For example patients were transferred from A&E to the Acute Medical Unit (AMU), which had 36 beds. They would spend up to 24 hours there, but sometimes that rose to 48 hours or more. On occasion, a patient may stay longer for clinical reasons or if

they are awaiting a specialist bed. One patient file we looked at indicated that they had been in the AMU with nausea and vomiting for 11 days on the day of our visit. Another patient file we looked at in AMU showed they were triaged in A&E at 2.47am on the day of the visit and were transferred to a bed on AMU at 10.20am. The Chief Nurse informed us that a number of measures had been introduced to help manage the patient journey. The Trust were monitoring the number of patients who were medically fit for discharge but were unable to be discharged due to social or other logistical difficulties such as referrals to community hospitals or to rehabilitation placements. The Trust was aware of the occupancy issues experienced across each of the sites and we were told that they continued to work with external stakeholders such as Clinical Commissioning Groups and Social Services.

In order to monitor patients in the A&E the team had implemented comfort rounds for patients because of the layout of the department and not being able to visually detect if patients needed a toilet, were in pain or some kind of other distress. We spoke with two patients in the waiting room for minors and we were able to track them through to their treatment. These patients were very happy with their care. Their feedback included, "We were seen quickly and are very satisfied by the service." Staff monitored how long patients spent on the trolleys and, where possible, they moved patients on to a bed. We saw one patient still waiting for a bed after seven hours. Staff told us "We had other patients who have been in majors longer and we had to prioritise."

The impact of delays in the A&E pathway did, on occasion result in patients waiting in the cohort bay after being dropped off by the ambulance. Paramedics we spoke with that were arriving with patients, explained that sometimes, they needed to wait with patients, they said on average this was about 10 to 15 minutes, but on occasion would be one to two hours. However they did say in the last six months there had been an improvement. One said the queuing situation changed on a daily basis. In order to release paramedics to attend other cases the South East Coast Ambulance service (SECAMB) had implemented a system whereby a senior paramedic stayed at the location with queuing patients to ensure their safety after they were dropped off, so that paramedic crews could attend other cases. The feedback from the Trust when we informed them of our observations was that there had been regular engagement between the Trust and SECAMB and action plans developed to manage the situation. A new infrastructure at both sites will be implemented from 1st April 2014.

We asked about patient safety in relation to clinical pathways, in particular focussing on the care of those patients who had been diagnosed with a stroke. Staff told us getting the patient into the right ward and right bed was often difficult. This meant that patients were often "outliers" being cared for on a ward by staff who did not have the same amount of experience or knowledge as the team in the stroke ward. One method the department used was to keep patients longer in A&E without transferring them to the inappropriate ward and waiting for the correct bed to become available before moving them.

We looked at the emergency equipment in the A&E. The resuscitation and emergency equipment trolleys were checked daily by staff and restocked immediately after use. Staff in both departments were appropriately trained for their role, for example Advanced Life Support (ALS) and paediatric ALS, as well as the provision of Trauma Life support intervention training. Staff were confident of their role in a medical emergency situation and explained the department's procedures to ensure a quick response to an emergency bell.

We looked at patient records and treatment pathway plans in the A&E. The initial emergency admission proforma was clear and well documented by both doctors and nurses. Once admitted a treatment plan was instigated. This included risk assessments for nutrition, skin

integrity, intravenous cannula sites and falls. However, not all sections had been completed on the plans we reviewed. We saw that venous cannulas (a plastic needle used to administer medication and fluid into the bloodstream) had been inserted, correctly labelled and dated on most although not all occasions. Documenting the date of insertion ensures a venous cannula is not left in place longer than it should be which can be a risk for infection. While in the A&E at Royal Sussex County Hospital we noted that some patients were not positioned comfortably and correctly, and some were left without pillows. All patients were dressed in such a way that ensured their personal dignity. Curtains were drawn around when procedures were undertaken.

We saw good examples of multi-disciplinary working within the A&E and other areas linked with the emergency pathway such as the short stay unit, AMU and clinical decision unit. There were specific care and treatment pathways which had been designed to ensure that patients received the correct treatment and care. We talked to allied health professionals (AHPs), including a speech and language therapist who told us of being involved at the beginning of, for example, the stroke pathway. The Discharge team said that they were working well with A&E and patients were being discharged with appropriate support. We saw the occupational therapist and physiotherapist assessing patients before discharge to ensure they were mobile and safe. We spoke with nurses who facilitated safe discharge home for those who required extra support. They told of working closely with the occupational therapist and physiotherapist to ensure that patients were safe and ready for discharge. For example, ensuring that those discharged with a walking aid were able to use them safely, and those who had steps and stairs were able to manage them. They also told us about ensuring that carers, family or professionals were fully involved in the planned discharge home.

We visited medical wards at the Royal Sussex County Hospital and Princess Royal Hospital (PRH).

On Hurstpierpoint Ward at PRH, we observed staff had been creative in adapting the ward environment to present a less clinical environment for patients with dementia. This included day spaces and therapy rooms which were decorated with wallpaper and furnished in a domestic style with household objects. We spoke to the ward manager who told us the actions had been taken to reduce the trauma for patients when they were admitted to hospital. This included making a 'Bus Stop' at one end of the ward with comfortable chairs, a suitcase and signage. We were told that the aim was for patients who wandered to have a focus of somewhere to walk to and wait; the result had reduced patients' distress and agitation. Staff reported that money had been invested in the Emerald unit at the Royal Sussex County Hospital, which was also a ward caring for patients with dementia. Staff felt since this investment that the care in the unit was "good". However staff felt that overall insufficient funding had been allocated to ensure the safe care of patients with dementia in other areas of the hospital. The Chief Nurse told us that a Dementia Nurse Specialist was in post and was responsible for, amongst other duties, raising the awareness and management of dementia patients to staff across the Trust. This had resulted in bespoke dementia training packages and Emergency Department Dementia pathways being developed to help staff to support patients with dementia.

On Hurstpierpoint ward we found that staff took action to address patients' needs before they became frustrated and agitated. The ward manager gave examples of patients with dementia becoming anxious during the night and needing to sort through their belongings for reassurance. Staff awareness of these patterns of behaviour enabled them to support the patients to look through their possessions no matter what time of day. Staff awareness of the patterns of behaviour which contributed to patients becoming restless had reduced the

number of falls on the wards as staff acknowledged and addressed their needs before they became frustrated and agitated. The ward also offered an outreach service to support staff on other wards with elderly confused patients. This meant falls were reduced on the wards because patients' needs were addressed before they became distressed and agitated.

Patients we spoke with told us at both hospitals we visited were complimentary about the care and treatment they received. They told us the staff were "Patience itself" and that although they were always so busy they always answered the call bells as quickly as possible – although they took longer at night. They told us that they had never had problems with accessing a doctor when they needed one. One patient praised the doctors for looking into another problem while they were in the hospital. Patients told us that they felt fully involved in their care and treatment. One patient gave an example where they had been involved in arranging their discharge to a care home with staff taking on board their concerns about their previous placement. One said, "Brilliant, very kind and caring." Another said, "There have been complications but I am improving and nearly ready to go home. We asked others about their care: "They kept me informed, but the staff changeover sometimes was confusing."

We looked at a sample of nursing notes on the wards we visited and found they provided a plan of care and documented the care and treatment received. The patient records contained risk assessments and plans of care where there was an identified need such as risk of falls or wound care. A small number of care plans we looked at for example, the comfort round records were not all up to date.

We observed meal times on four wards and we found support was given to patients where it was required. The wards had a system of red trays and while we saw nursing staff were aware that this indicated a patient required assistance, this was not the case for all catering staff.

Some of the staff we spoke with at the Royal Sussex County Hospital expressed concern at a lack of cohesive working across the multi- disciplinary teams (MDT) which included medical, nursing, physiotherapy and occupational therapists and other Allied Healthcare Professionals (AHP). While systems worked well in some areas, there were others where this was of particular concern, for example, in situations where patients had complex needs and required input from a range of medical and surgical specialties. Staff told us they felt patients' needs were not always prioritised appropriately due to a lack of communication and planning between the clinical teams. In other instances, there were concerns that discharge of vulnerable patients was focused on the patient being medically fit but did not adequately take into account their ability to manage other aspects of their care safely at home.

In other areas such as the Royal Alexandra Children's Hospital and Princess Royal Hospital staff told us that the multidisciplinary teams worked well together to provide support for the patient's journey. At the Princess Royal Hospital Physiotherapy services were provided seven days a week with Occupational Therapy services being available on the wards from Monday to Friday to support patients throughout their care. Multidisciplinary ward rounds were also in place ensuring all relevant professionals were involved in decisions of care provided to patients. Staff told us there were sometimes gaps in all disciplines attending the MDT. For example it was difficult to get social workers and the speech and language therapists (SALT) to attend the ward meetings. However staff told us that the physiotherapists always provided good cover and although there had been a lack of occupational therapists over the past year this was now starting to improve.

We visited the maternity services provided at the Royal Sussex County Hospital. We spoke

with four women who were either attending the antenatal clinic or had recently given birth in the hospital. The patients we spoke with told us that they felt safe and well cared for throughout their pregnancy and birth. We found that although the facilities in the unit were cramped, the midwifery unit provided safe and effective care for women during pregnancy and childbirth. Feedback from women using the service was positive. They told us staff were caring and helpful although they were always very busy. One woman told us "The staff are excellent – it's just there are not enough of them". Staff working in the midwifery unit told us that the service was well led at ward level and overall the culture for treating women and children in the hospital had improved. The maternity service had robust systems in place to engage with local women in order to deliver the type of maternity service they needed and wanted. We saw that after birth women were kept safe by routine monitoring of their condition. The Trust used the Obstetric Early Warning System (OEWS) which identified when a woman may be at risk from complications of childbirth by monitoring their vital signs such as their temperature and pulse.

We were contacted by two members of staff who raised concerns that they felt that there was poor communication amongst the Consultant staff group within the Obstetrics and Gynaecology division. Both staff members said that the Consultants could be "Obstructive" when changes to the service were proposed. We understand from the Trust that an external consultancy will be working with this team.

We spoke with the women and children's governance lead who told us how she worked closely with the staff and other agencies to ensure vulnerable women were identified and given the necessary support through their pregnancy, birth and ensured this was followed up when they returned home. Staff we spoke with were confident about their role in safeguarding vulnerable women and were able to describe the actions they would take if they suspected abuse was taking place.

Cleanliness and infection control

People should be cared for in a clean environment and protected from the risk of infection

Summary

Many staff that we spoke with at the Royal Sussex County Hospital commented that they felt cleaning was not up to standard in some parts of the hospital and this was a theme at nearly all of the staff focus groups we held. Staff were concerned that many of the cleaning staff did not have sufficient equipment such as cloths. Many of the clinical staff told us that they lacked confidence in the overall competency of the cleaning contractor.

In the A&E at the Royal Sussex County Hospital we saw there were cleaning checklists on notice boards that had not been completed by the cleaning team since September 2013. The newly appointed matron in the department had identified through her audits that the cleanliness had lapsed over the past month. This had been highlighted and was being monitored. The Maternity and Cardiology wards we visited during the listening events were visibly clean.

At the Princess Royal Hospital we saw there were hand gel stations throughout the hospital with reminders for staff and visitors to use them to prevent cross infection. During our visit we observed staff using the hand gel before and after attending to patients. The wards we visited were visibly clean. We noted that Ardingly Ward was cluttered due to lack of storage space. However the staff had developed systems of infection control to ensure that the environment and equipment were kept clean to prevent cross infection. The ward manager told us the floors, furniture and fittings were cleaned daily and the staff allocated to each bay were responsible for ensuring the standard of cleanliness was maintained. We spoke to staff working in the bays who were clear about their responsibilities for maintaining the environment and keeping any equipment clean and ready to be used.

The cleaning contract was run by an external cleaning contractor and had been in place since December 2012. We were told of concerns with the external cleaning contractors arrangements for audit and monitoring of the cleaning in the Royal Sussex County Hospital. Where ward cleaning audits were undertaken jointly with the ward manager and the contractors supervisor, there was a concern that the scores did not reflect the standard of cleaning observed in the audit. We were told that it appeared the external cleaning contractor had underestimated the scale of the challenge in maintaining the estate and the Trust Facilities team were commencing joint working on the monitoring of cleaning and a new matron post to support cleaning had been established. The weekly Infection Control meetings were attended by the Chief Executive, Medical Director and Chief Nurse from the Trust and the Chief Operating Officer for the external cleaning contractor with any issues raised at these being included in the infection control reports to the Trust Board.

Safety and suitability of premises

People should be cared for in safe and accessible surroundings that support their health and welfare

Summary

The Chief Executive told us about the '3T's' rebuilding project for the Trust: Teaching, Tertiary and Trauma care, which encompassed expansion of trauma services and centralisation of other specialties for neurosurgery on the Royal Sussex County Hospital site. The plans were before the Treasury for approval of the Outline Business Case. Although the majority of the planning for a new estate had been completed, the approval to start demolition, refurbishment and rebuilding had not commenced. The Chief Executive advised that patient care was influenced by a "difficult estate". For example, from the A&E to the Barry Building a journey could take as long as 35 minutes and there were times when the trip between the two buildings could not be attempted because of high winds which affected both patient and staff safety and comfort.

At the time of our visit there were high winds and rain, the impact of which was described to us by staff in the A&E and the Chief Executive as the walk way had to be closed overnight and had impacted on patients not being able to be transferred to wards on the Royal Sussex Hospital site. Staff told us many patients were frail elderly and there were instances where they had to be wheeled in cold wind and rain, in some areas other inpatient beds needed to be moved to get through. Staff stated they felt there was no upkeep on the Barry building and that their perception of the Trust's response in the interim was not to spend money on it in order to save funds and simply wait for the new buildings.

We pathway tracked some patient journeys from the A&E to various areas in the hospital. A few transfers were short and simple, but others were elongated, convoluted, exposed the patient to excessive amounts of disclosure to the general public walking along corridors and walkways and covered some rough terrain which was not designed for transferring patients on stretchers. In one part of the hospital, the floor vinyl was old and torn, and yellow hazard tape had been used to secure it back down. Further along from this, the vinyl was warped with pockets in it, which presented a potential trip hazard for staff, relatives and others and a bumpy ride for people on stretchers or wheelchairs.

All staff we spoke with were aware of the plan for redevelopment of some areas of the Trust had been submitted to the Treasury where it was awaiting final approval. Staff were concerned that although they had heard and contributed to the "3T's" planning, work had not started on knocking down the buildings that needed demolition and they were already suffering as a result. The new building would take a long time and patients would continue to suffer until it was ready for use. In response to our observations, the Trust told us they were awaiting Treasury funding approval and that the relocation of some departments to the recently refurbished St Marys Hall had begun.

In expressing their view staff told us they thought that the Trust listened to them about their concerns regarding the environment they worked in but that often the resulting action was not put in place. Staff gave us examples of the poor state of the environment that some of them had to work in. An example was in radiotherapy where patients were sent outside of Sussex for some treatment. This was because the LINACS machine was closed for

essential maintenance and so patients were starting treatment elsewhere rather than delaying or cancelling treatment. This lack of space in the building for such a facility was recognised as a potential risk to patients by the Chief Operating Officer. There is a plan developed to increase capacity locally and as part of our network in Eastbourne and Chichester.

Staff highlighted the South Point building as a concern due to the environment which was poor and cold with mould on the walls. They told us they felt the Trust did not promote their health and welfare because of the poorly maintained premises. One department with poor fabric was the Occupational Health department which had been waiting for two years for essential maintenance to be carried out. Staff felt it did not give a good impression when people come to the department for help and support. The Occupational Health department is moving to St Marys Hall. Other examples of walls which ran with water when it rained had not been rectified and a staff member who was working out of the storeroom on a ward due to lack of office space.

We visited Baily ward where the balcony room was used as a single patient bed space. However the female bay was adjoining this and all the patients from the bay walked through the balcony room to use the shower and toilets. This meant patients dignity and privacy and infection control measures would be compromised. We noted on Baily Ward that a clinical room was not kept securely locked which posed a risk that the draws containing syringes and cupboards containing medication were open and accessible to visitors and patients.

At the Princess Royal Hospital we noted reception and waiting areas were clean and attractive with appropriate seating, a clock and range of magazines. Corridors were mainly clear, with access and emergency routes clearly signposted. All fire exits were clear and visible. However on most of the wards there was little storage space for essential equipment. We saw that equipment was stored in the corridors both inside and outside the wards. We were told the hospital did not have an equipment library. This is a central area for the storage of equipment used across several wards and departments and gives staff quick access to equipment they need. On Ardingly ward there was no day room space so patients did not have the opportunity to spend time away from their bedside. The ward had one assisted bath which was not working. Staff told us that although showers were available they had not been able to give patients baths for over two weeks. This had been raised with the maintenance team.

On the maternity unit at Royal Sussex County Hospital we saw that women and their new born babies were protected through the use of a keypad entry system. However we noted that the wards were cramped and cluttered due to a lack of space as there was building work to provide en-suite bathrooms.

Staffing

There should be enough members of staff to keep people safe and meet their health and welfare needs

Summary

The theme from the staff groups we facilitated across the Trust was that recruitment processes were not efficient or helpful to managers in ensuring their wards and departments were able to recruit in a timely way. Particular concerns were the amount of 'hoops' that had to be worked through such as agreement to replace staff being required from more senior managers and then agreement from a panel that recruitment could go ahead. Many examples were given of nursing and medical staff being interviewed but then not actually being appointed, with the main reason being a delay in confirming appointment. Staff felt this led to people thinking they were not wanted and applying for other jobs. Managers felt that many good staff were lost through the delays in the process and meanwhile they remained reliant on bank and agency staff to ensure staffing levels were maintained. Staff described the turnover rate of staff at the Trust as high, saying there were around 50 new staff each month that attended the Trust induction. Others said that exit interviews of staff who were leaving had ceased "about a year ago" and the Trust was unable to ascertain the reasons for people leaving.

The Trust monitored the effectiveness of the Human Resources (HR) department with Key Performance Indicators (KPIs) for recruitment which were reported monthly to the Trust Board. We were told by HR staff that the objective was to complete recruitment of new staff in 12 weeks from the request to appoint date once they had been interviewed. The HR KPI report for November 2013 stated the overall staff numbers for the Trust was 6995 with 6150 in post and 523 vacancies across the Trust. We noted that in October 2013 the KPI for the Trust to issue an offer letter within 48 hours was set at 78% against a target of 95%. It was confirmed that an applicant tracking system had been approved and should help in the future in speeding up the process and monitoring.

Staff in the A&E at both hospitals we visited were concerned that the use of bank and agency staff had an impact on patient safety. We were told of an occasion when a patient in the resuscitation area was being looked after by an agency nurse. The patient required defibrillation and close observation for an episode of tachycardia (high heart rate). The agency nurse did not understand her responsibilities and was apparently worried about being left in the Resuscitation area during this time.

At the Royal Sussex County Hospital A&E we were told there had been a high turnover of senior nurses and the department had lacked leadership and that the department was also frequently understaffed. The manager explained that she had permission to over-recruit and there were plans in place for the introduction of further staff over the next 12 months which included "drip feeding in" new inductees so that they did not all commence at once. The manager told us in order to ensure patients were safe they overstaffed the department with nurses and healthcare assistants despite this being outside of their budget. On the day of the visit, the early shift was supposed to have eight Registered Nurses on duty, but two were off sick. The Matron was working clinically providing patient care and one other senior nurse (an experienced nurse practitioner (ENP)) was working to cover the shift vacancy,

whilst trying to cover the minor injury department as well. This impacted on the length of time patients had to wait to be seen in Minors. Her concern was that whilst she tried to enable A&E to manage their load during staff shortages, her personal performance suffered as a result.

Information supplied by the Trust demonstrated the reliance on bank and agency staff. At November 2013 the calculation of bank and agency staff as whole time equivalent staff across the Trust was 415 for bank and 107 for agency. This was predominantly for nursing staff where the ongoing vacancy rate was around 10% for the year. The Chief Nurse told us that their vision was to fully recruit into the substantive vacancies and to reduce the reliance on bank and agency staff. This had meant the Trust was required to review the rates of pay for bank staff as it had been identified that there was a significant discrepancy between the rates of pay for bank staff versus substantive staff. For example, the Chief Nurse informed us that some health care assistants were able to earn more per hour working bank shifts compared to a qualified registered nurse who was working in a substantive position.

We heard of concerns that the levels of staffing on some wards and in some departments. Staff said it was difficult to retain new nurses for much more than a year and this resulted in nurses being promoted when they hadn't been qualified for long. The impact was then felt by these staff as they were under pressure to 'step up' before they had gained sufficient experience which may have an impact on patient safety. On some wards where managers reported high use of bank and agency staff we found that some documentation, for example the comfort round records were not all up to date.

There were concerns that the Occupational therapy teams were not sufficiently resourced with staff giving us examples such as staff on maternity leave not being covered. There was also a concern that the level of skill and expertise in some senior posts was not sufficient to support discharge planning adequately. Pharmacy staff reported that the 'winter pressures' affected their department as the service was needed seven days a week. At Princess Royal Hospital staff told us told us that since September 2013 regular training sessions had been factored into the ward staffing rota but due to staffing pressures this had not yet occurred. The lack of staff cover meant that training opportunities were lost.

Concerns around consultant medical staff were brought to our attention on Ardingly Ward where we found there was one full time and one part time medical consultant. On the week of our visit the senior registrar was on night duty, the part time consultant was available on the Tuesday and Thursdays and the full time consultant was not available for part of the week. This meant that on Monday and Wednesday there was no day time medical consultant cover in the hospital. Staff told us that lack of forward planning had an impact. For example, when a consultant was off sick or on annual leave there was not always a plan in place to provide cover by a locum doctor. They gave examples where the medical clinicians had not arranged cover for their leave and where this had been escalated to senior managers. One staff member told us "There are too few doctors looking after too many patients". They told us that patients admitted over the weekend would not be seen by a consultant until the Monday ward round as there was not seven day consultant cover. This meant there were often delays in decision making which slowed up patient planning, treatment and discharge.

Other Consultants that we spoke told us about the high number of patients that had to be seen at each ward round. One doctor told us that morning they were due to see over 41 patients. They told us it was difficult to maintain a safe service when senior medical cover was so stretched. Additional concerns were around the impact of centralising the management of medical secretaries at Princess Royal Hospital which had resulted in the

consultants doing a lot of their administration work themselves as it was deemed to be quicker.

Patients we spoke with on Ardingly ward told us they generally felt safe and well cared for but the nurses were always very busy and they sometimes had to wait for assistance especially at night. The duty rotas showed that during the day there were eight staff on duty and five at night. We were told that an extra qualified member of night staff had been requested a year ago and they had been told recently that it was likely the Trust Board would approve this. However on the day of our visit the ward was still working with three rather than four qualified staff at night. Staff told us it was difficult to answer the call bells quickly enough when there was not enough staff on duty. On the day of our visit the ward was working short of two health care assistants and although senior ward staff were working on the floor staff were pressured to maintain safe levels of effective care for patients. One staff member told us the lack of staff had a big impact especially when a patient needed one to one support due to their condition. Other wards felt better supported in increasing staff numbers and told us the Matron had presented a business case which had been approved and recruitment had been initiated.

We spoke with ward managers who told us that although they were supposed to be supernumerary to manage the day to day running of the ward and monitor the audits and action plans they often worked on the ward as part of the nursing numbers due to staff shortages. They told us that although they enjoyed administering direct care to patients it meant there was insufficient time to undertake their management responsibilities and these were often done in their own time. The Trust have informed us that Supernumerary Band 7s are being appointed from April 2014 on all wards. Other concerns were the increasing levels of dependency and acuity of patients which were not matched by increases in staffing numbers. Some staff told us that in order to maintain safe staffing levels they often went without breaks and stayed late. We found that although there were systems in place to manage risk in the hospital, these were often compromised due to lack of staff.

At our previous visit we identified that maintaining safe staffing levels was a concern on the maternity unit at the Princess Royal Hospital. Senior staff working on the wards told us that the Trust Board had approved an increase in the staffing levels. However during this visit we found that although there had been some progress in staffing the unit staff told us they still worked longer hours than they were paid for, didn't have time to take proper breaks and that managers were used on the ward to give direct care to patients. They told us that staff were often moved to cover other wards and that bank staff were used a lot. Senior managers told us that the staffing had improved since last year following a shift by shift audit. They told us they were now working to ensure that each shift had an appropriate skill mix as this remained an issue. Patients told us that although they couldn't fault the staff they simply did not have enough time to always meet their needs in a timely fashion.

Supporting workers

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Summary

Staff we spoke with at the Princess Royal Hospital told us about recent training they had undertaken such as the annual mandatory training and additional training such as conflict resolution, stroke and end of life care. We spoke with Health Care Assistants (HCA) who told us how the Trust had supported them in gaining vocational qualifications. One HCA told us how they were being supported to undertake registered nurse training. Medical staff also spoke positively about their training saying it was always planned and they were able to attend. All of them said they would come and work again at the hospital and recommend it.

Staff told us they were supported through training and appraisals. They told us that although they did not get sufficient time for regular clinical supervision the ward manager was always available and the staff worked well as a team to support each other. We heard that there was a rolling programme for the appraisals and over 80% of staff had completed their appraisals to date. We spoke with newly qualified staff who told us that there was always someone they could ask for advice. One nurse told us they had a good induction by the Trust and felt supported in their preceptorship. They said "The senior staff always take the time to explain things, if I have a problem I know I can always speak to [the ward manager]". They gave an example where they had looked after a patient and they had concerns about their condition. They raised this with the ward manager who arranged with the doctor for additional blood tests to be done. They felt listened to and valued as a new member of the ward team.

At the Royal Sussex County Hospital we heard mixed views about training. Some staff were positive about mandatory updates and told us they had an e-mail alert to tell them when something was due. Staff who worked in departments such as physiotherapy and radiology ensured time for training was planned and booked. It was recognised that for ward-based staff this was not so easy and often staff were called back to the wards or their attendance at training was cancelled due to staff shortages. In the A&E staff felt they had effective leadership to support staff with adequate training. Staff said they had received mandatory training, and there were opportunities for continuing professional development for nurses to enhance their skills such as developing advanced emergency care nurse practitioner roles. They felt despite the fact the hospital had university status and trained medical and nursing students, that training for substantive staff members was poor and little effort was made to keep their knowledge and skills up to date.

Health care assistants were able to take observations in 7A as part of their role scope being extended. The practice educator helped to enable the health care assistants with their skills and competencies to do this role. We asked for a copy of the training matrix for this ward which contained lots of gaps and red risk ratings where HCAs and RGNs had not completed mandatory training. The training register showed that 60% of care staff had received some form of performance appraisal in the last 12 months. Staff reported that they had to come in on their days off to have mandatory training topics completed. There was evidence of regular teaching sessions for junior doctors. This included a protected two-hour weekly

teaching session. Every doctor we spoke with was supported by a clinical supervisor. Some Doctors confirmed to us they felt well supported and were able to approach their seniors if they had any concerns.

We reviewed the Trust report for June – September 2013 which were used to monitor the number of staff who were required to undertake some of the mandatory training topics such as infection control, fire safety, conflict resolution and paediatric life support. For fire safety there were 6827 staff across the Trust that were required to have the training with 3107 who were rated as requiring training.

For clinical staff such as nurses, doctors and AHPs figures for infection control were: 2607 staff required training, 1873 staff had received recent training and 532 staff were due for refresher training within three months.

For non-clinical staff, infection control training showed: 494 staff required training, 1212 staff had recently received training and 108 staff required refresher training within three months.

For paediatric life support training which applied to a smaller number of specialist staff, data showed that of the 633 staff, 384 staff were not in possession of a valid training certificate and required refresher training. Only 212 staff had attended recent training in paediatric life support.

In July 2013 a paper was presented to the Board which set out the plans for staff training to meet the requirements. The actions included use of a blended approach to learning using a range of delivery methods a full review of what constituted statutory and mandatory training and emphasised the need for managers to ensure staff had the time for training.

Staff we spoke with across the Trust gave a mixed view of supervision and appraisal with some reporting supervision was not regular and some had received no supervision or appraisal. They told us there was a mentor and preceptorship role which worked well. Preceptorship is a key aspect of supporting student nurses and sufficient numbers are required to enable adequate support for the student nurses to be assessed and progress in their training. Staff told us that on some wards there was a shortage of staff who could be a preceptor and this may have an impact on student nurse placements. One reason was the difficulty to attend the relevant study days as when there are staff shortages they can't attend or get pulled back to the wards.

Staff stated that whilst some performance appraisals were completed, they felt that there was insufficient training for managers to effectively carry out appraisals to ensure a consistent approach to the process. Another staff member stated that an "open door" approach to staff appraisals had been adopted and that there was a "new form". They felt there had been a larger uptake of the new appraisal system when compared with the previous version.

Staff commented that the appraisal system did not identify emerging themes or risks across the Trust or within specific departments. For example, staff commented that there was a culture "lacking of praise, recognition and reward". Staff felt they were not encouraged to use their initiative to solve problems.

The Human Resources data for December 2013 demonstrated that appraisal rates for the last year had a range of 23% in April 2013 to 52 % in December 2013. While this showed a steady increase there were areas with higher rates of appraisal such as: 81% of staff in the estates department, 54% in medical directorate, 58% nursing and Operational staff and 60% in surgical directorate. The Trust had taken action to increase the level of appraisals and had

recently launched a new simplified version of the appraisal document which was in use. Monitoring of compliance and the number of appraisals undertaken was sent to all managers. While the Trust has implemented actions there remain significant numbers of staff who have not received appraisal.

Our visit was focused on listening to staff and hearing their experiences of how the Trust supported them to raise concerns coupled with the character of the relationships between different groups of staff and the Trust management. During the period leading up to our visit we had been made aware of concerns regarding bullying and harassment and racism within the Trust. The concerns centred on the relationships within and between different departments and groups of staff.

One theme of concern pertained to black and minority ethnic staff (BME). Staff from across the Trust told us of instances of bullying and harassment and racial disputes within four divisions of the hospital. The Executive team and the Safety Ombudsman concurred that there had been, and still were, some examples of this which had been longstanding and others more recent. The specific issues raised varied from the contractual conditions of BME middle grade doctors, lack of training opportunities, little confidence in the independence of external investigations, glass ceilings on promotion, racist taunts, bullying and more general racial discrimination.

We received variable feedback from staff members regarding the support provided by their direct line managers. Staff that we spoke with told us they were generally well supported by their direct managers, and that there were some 'fantastic, dedicated and committed' staff working at the Trust.

Staff that we spoke with in the A&E departments were positive about the leadership which they said motivated the team. They told us there was an open culture where they could raise concerns and these would be acted on. They felt empowered by the recent changes to the senior management structure and felt that the department had improved. However, some staff raised significant concerns that the professional relationship with their line manager or peers had become ineffectual and staff considered that this had the potential to have a negative impact on the patient's experience. We found that the staff involved had felt their only option was to raise their concerns by using the Trust's internal whistle-blowing process. We discussed with the Trust the actions that had already been taken to address the individual concerns that had been raised.

Some members of the AHP staff raised concerns about the different values and behaviours between the consultants and other staff at the Trust. They felt there was poor inter-professional working with consultants and that "they don't want to meet and work with the AHPs in some areas." Other staff told us they were frightened to stick their head "above the parapet" in support of colleagues for fear of what would happen if they did. The staff felt they had seen and experienced many instances of where this had occurred and therefore knew what the repercussions would be. In some areas issues at strategic level within the Trust between the consultant bodies had led to anger and frustration at ward level.

Staff that contacted us via the e-mail account we had set up, raised very specific allegations regarding the power imbalance between different ethnicities across the Trust. We were also told it was difficult "to get rid of" poor performing staff and that senior management did not address root causes or support those that raised a grievance. Senior staff told us that the Trust's clinical strategy and culture needed "sorting out". We were told how the matrons and staff were "So frustrated with the lack of progress". For example, staff told us that although there had been some improvement, strong leadership was needed to take forward the Women and Children's team within the Trust. As part of the Trust work on Foundation for

Success there is a value and behaviours group which is one of the ways in which they are taking this work forward.

Some staff felt they were undervalued and not listened to with some BME staff reporting that they were too scared to raise concerns openly for fear of repercussion. Under a previous Chief Executive the Trust had recognised institutionalised racism and had set up a BME network. This led to the implementation of a programme called 'Commitment to change' known as C2C. This provided training to improve understanding and to protect staff and patients from racism. The C2C was supported by a network of leads in wards and departments. We heard there were communication problems with people from culturally and linguistically diverse groups. Many staff employed by the cleaning contractor did not have English as their first language and this at times caused distress for them and patients in understanding their role and interacting.

 We were told that there was a lack of BME staff in senior positions which people described as 'the glass ceiling'. They felt despite the Trust recognising the need to support BME staff this had not resulted in any significant number of promotions at the higher senior level. As part of this listening event we met with representatives from the Trust's BME network. This was a further opportunity for us to hear first-hand the concerns that staff had on how the culture impacted on their ability to promote cohesive working between all levels in the Trust.

Following the two day listening events in December 2013 the Chair of CQC met with BME groups within the hospital in January 2014 to hear first-hand their experience, which echoed what we heard during the initial listening event. Due to the serious nature of the concerns that were shared with us, we have had regular dialogue with the Trust to ensure that the potential impact to patient safety and welfare is appropriately managed.

The Chief Executive was candid in making available a recent report from an advisory external organisation into one team. The review centred on team work and relationships exploring professional, racial and cultural aspects of these which had led to a dysfunctional team with the potential to impact on patient safety. It was confirmed that the Trust was taking steps to address the findings of the report and was using an external company that specialised in development and performance improvement of medical teams and healthcare management. As the report had been completed in November 2013 actions were at an early stage. We heard that the Chief Executive recognised there was a lot of work to do and that he was committed to improving the culture within the Trust setting this out in the 'Foundations to Success' document which set out the vision for the Trust recognising the challenges and steps required. As part of this he had also set up a 'behaviours and values' programme which consultant staff were aware.

We heard from the Executive Team about how the Trust supported staff to raise concerns in a number of ways in line with the whistleblowing policy which we were told was being revised at the time of our visit. Staff were being encouraged to participate in the development of the new policy with the Director of HR setting up focus groups in January 2014. The policy was supplemented by a leaflet which would be accessible to staff and contained information how to raise concerns internally and externally and the protection afforded to whistle blowers under The Public Disclosure Interest Act.

However, we heard that there were some instances where bullying was a concern and that some of these situations had the potential to impact on patient safety. Staff told us through the confidential email mailbox that they did not always feel supported when they raised concerns about the behaviour and/or practice of some colleagues. Three members of staff told us that when they had raised concerns they felt they had subsequently been directly or in-directly discriminated against and had not always been protected by the Trust's

whistleblowing policy or through the legal requirements of the Public Interest Disclosure Act 1998.

As part of the arrangements to support staff to raise concerns the Trust had a Safety Ombudsman: a dedicated person staff could approach with their concerns. We spoke with the Safety Ombudsman and they described the role as being accessible to staff, patients and relatives across the Trust. When information was presented to them they adhered to principles of confidentiality and only disclosed names with permission to do so. They described the importance of the Trust being open to concerns and that this had improved but their role was important for those who felt unable to report in other ways. We were told that many issues were resolved at local level with the Ombudsman having a good relationship with ward managers. If concerns were of a more serious nature, with a potential impact on patient safety these would be escalated to the matron or Associate Chief Nurses.

The Ombudsman reported to the Chief Executive, met with the Chief Nurse, and had, in the past presented written reports to the Executive Quality and Safety Committee and the divisional Quality and Safety groups. There was a concern that recently these had been a verbal update. Their view was that a review of these arrangements was needed to support the role and ensure robust feedback and confirmation of investigations and actions. The Chief Executive told us an advisory group to support the Ombudsman role and ensure the processing and monitoring of concerns raised was being planned as part of the review of the Trust whistle blowing policy.

Staff were asked if they knew what the role of the Safety Ombudsman was. They said the role was for "whistle-blowing" and "to raise issues". However staff said when they had used the Safety Ombudsman they were unaware of the outcomes as they never heard back what happened with the issues they had reported. They felt the governance of the Trust meant the person could not work or have an impact independently ("on their own"). Staff told us individual cases were often easier to report than groups or trends in poor care.

We heard that the Chief Executive had been visible in the Trust and staff felt he was approachable and had an "ability to immediately understand things we tell him." The Chief Nurse was also recognised as being visible. However there was some concern that some of the other senior nurses were not so visible and a lot of their communication to staff was via e-mail which some staff felt was not a good method for managing teams.

Assessing and monitoring the quality of service provision

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Summary

In line with national incident reporting systems the Trust reported patient incidents at ward or department level using the 'Datix' system, any incidents graded moderate or above were then reported to the National Reporting and Learning Service (NRLS). Those graded as a serious incident such as pressure ulcers, outbreaks of infection or if a patient had suffered a high level of harm were reported to the regional NHS unit. Outcomes of these investigations were reviewed and closed on the authorisation of the NHS unit. We reviewed data on incidents reported which demonstrated that medical specialities and obstetrics and gynaecology were the clinical areas that reported the most incidents. Trusts are expected to report relevant incidents in a timely way once the internal investigations have been completed. To further explore this we reviewed the incident reports for the some of the areas we visited including Cardiology and Digestive Diseases specialties. We reviewed the incidents reported from June 2013 to November 2013. The incidents covered a range of areas from falls, to medication, issues with equipment and treatment. Information was recorded with details of the incident, whether harm was caused and a summary of action taken to prevent future occurrence. There were a number of incidents categorised as moderate which did not appear on the NRLS report but had been identified some months earlier in June and July 2013. The NRLS is a national learning process and failure to report incidents may impact on lessons for patient safety not being more widely disseminated in the NHS. 98.4% of the incidents reported on Datix in 2013 were uploaded to the NRLS by the Trust. The grading of clinical incidents is finalised when the investigation is completed. The Trust apply the NPSA guidance when grading severity. The Trust are currently reviewing the system.

Staff we spoke with at focus groups and in all the wards we visited told us there was a good focus on patient safety and that reporting of incidents was encouraged. They said they would have no problem with reporting any incident if they had a concern. They told us that their immediate managers were approachable and felt certain that appropriate action would be taken. Access to the Datix system, which is the computer based incident reporting system, was described as good by all grades of staff and we saw evidence of this in information provided by the Trust. Some more junior members of staff, such as student nurses described how they were encouraged to contribute any important aspects of an incident report; this ensured that the member of staff making the report was able to include all relevant details. One Health Care Assistant (HCA) told us of an incident where they had noticed a patient had unexplained bruising and they reported this to the nurse in charge.

Staff we spoke with told us of some examples where concerns had been raised and investigated however a number of staff expressed a view that actions had not been sufficient. The Trust had an investigation team who undertook investigations into serious incidents. The process included a weekly incident review meeting where all new incidents classified as moderate or above are discussed. Themes that emerged from investigation were often related to communication, clinical care and staff attitude. Resources for

investigation were felt to be sufficient with recommendations and themes being reported to the Divisions each month with an action log being reviewed at each meeting until all aspects had been resolved. The Executive team informed us that the Trust had a number of systems in place to enable them to learn from incidents and accidents. These included "After Action Reviews (AAR)" and "Root Cause Analysis (RCA)". However, there was a view from staff that the Trust was not very good at learning from incidents despite clinical staff being involved in the investigations and that it was not clear how the Divisions acted upon themes that arose. The investigation and complaints team described the Trust as taking concerns seriously and that staff were encouraged to report but sometimes the appropriate route was not always used. An example of an incident that reoccurred was described which had resulted in robust systems being put in place to prevent future harm to patients.

On a number of occasions staff told us that they didn't always get feedback when they reported incidents, which meant they didn't know what action had been taken to resolve the issues. Staff told us that the processes for learning from incidents were not as robust as it could be. For example they told us that they learnt about incidents occurring in other areas of the hospital 'through the grapevine' or if they had time to print off the monthly newsletter called 'Patients First'. They told us that meetings called 'Staff Stories' were held which included a 'Patient's Story'. They told us that these meetings could be better planned in order that more staff could attend.

We were told that the WHO checklist used in the operating theatres was audited, but staff were not sure if any results were fed back to theatre staff to address any gaps or identified issues.

The Trust informed us that they had a number of systems in place to help them learn from incidents and accidents. For example, A Chief of Safety role had been in place since 2008; the individual held responsibility for management of the Head of Patient Experience and Complaints and the Safety team. The Chief of Safety confirmed that weekly incident review meetings took place and were well supported by the consultant staff, with open discussions being fed back to the wards and departments. However, we received information from two members of staff who raised concerns that the Obstetrics and Gynaecology Consultants were not always engaged in internal investigations relating to complaints or incidents and that the consultants were not accepting of outcomes which may help to enhance the patient experience.

The Chief of Safety worked with the Head of Nursing-Patient Safety and Quality but this person did not attend the weekly incident review meetings. All divisions are covered at this meeting. The review group made decisions on the level of seriousness of an incident and had, at times identified a lack of understanding of what constituted a serious incident which could lead to under reporting.

Senior staff we spoke with confirmed they attended clinical governance meetings where incidents were discussed. The objective of the Chief of Safety was to improve the Trusts and Divisional Quality and Safety meetings to ensure that data on complaints, incident and performance were reviewed.

All of the wards we visited participated in the Patient Safety Thermometer metrics. These required staff to collect regular information on hospital acquired pressure ulcers, in-patient falls, hospital acquired venous thromboembolism, and urinary catheter associated infections. Most wards used a system of safety crosses to demonstrate the level of compliance with these areas and displayed their results which enabled staff and visitors to

see how the ward was performing against the safety criteria. Some staff were concerned that although the data was reported they did not get any feedback about it which made it difficult to maintain enthusiasm for the process, also plans to implement action was difficult due to lack of time. On Ardingly ward we saw information and data on the care that patients received following a stroke was displayed outside the ward.

Monitoring of patient falls was a priority for the Trust. We were told that when a fall occurred, the detail from the incident report was captured centrally so that analysis of any themes was easy to review and enabled lessons learnt to be shared. A target was set for the number of falls for a ward which varied dependant on the history of falls. The time since the last fall was displayed as part of the safety metrics. We looked at the records and audits of the department's incidents, complaints and near misses. We found that there had been a large number of reported falls; however these had decreased over the past three months. Staff said that most falls in the Emergency Department were patients that were inebriated and increased staff numbers within the Emergency Department had been effective in reducing the falls rate.

The Chief Nurse told us about the 'Working Ward Wednesday' when matrons in the hospital had a day working on the wards. At lunchtime they would all meet and share what they had observed and any positive practice or issues. These would be discussed to enable sharing and learning with action plans then being developed.

On ward 7A the cardiac surgery ward, we saw that the ward used Metavision, an electronic clinical documentation system. Staff told us they were struggling with incorrect information on the system pertaining to medication ordering, delivery and recording. This was due to the fact that whole system had crashed within the last five days. This had been fixed at the time by one of the doctors who was a 'super user' for the system but despite the system being rebooted and functioning again, the patient records contained information that could not be removed. We asked for the Trust contingency plan for when Metavision went offline. We were told if one patient bed was affected the patient would be moved to another bay which had the documentation system working. If the whole system went offline, staff would revert to paper documentation. There was no contingency plan with links to the IT team on how to manage such a crisis and reliance appeared to be with individual staff members who had an interest in the system being responsible for it running again. This was a risk for patients who may be subject to incorrect care or poor recording of observations and conditions when the system was offline and waiting for clinicians to repair its functionality.

Members of the Executive team we spoke with were open in telling us about a number of external reports and investigations that had taken place during the year.

We had previously been aware of a review in the A&E department by the Emergency Care Support Team (ECIST) which had raised concerns and had prompted an inspection by CQC in April 2013. The Chief Operating Officer told us that the report had raised many issues and measures were being taken to address these. The Trust Board received regular updates from the Emergency and Unscheduled Care – Right Care, Right Place, First Time - Implementation Plan. The November 2013 update reported that overall there had been a sustained improvement in waiting times in A&E since April and zero breaches of the 12 hour standard (no patient to wait more than 12 hours from decision to admit to admission). Performance against the 4 hour standard was achieved in September but not in August and October. The Trust recognised the continued need to work with the Clinical Commissioning Groups (CCGs) and partners to reduce the overall number of A&E attendances.

The Chief Executive told us about the Trust site developments linked to the "3T's" project

which was still before the Treasury for final approval and funding. It was evident that some staff did not feel engaged with the vision for the future and had concerns as to how the plans would affect the current services that they provided. They felt the demands on the current service were increasing but resources were not increasing alongside. It was difficult to engage with the vision when there was no extra capacity and people were working hard to meet the current demands. They told us they did not know what the Trust's strategy was and what services they aimed to provide. We were told of the Trust's 3T's initiative, where the aim was to provide Teaching, Tertiary and Trauma care. However staff felt that the focus on plans to build on the Brighton hospital site had meant that plans for the other essential services at the Princess Royal Hospital had been put on hold.

One area of concern we had been alerted to prior to our visit was the Cardiac unit. We spoke with the Chief Executive before and during our visit, who advised that some concerns had been raised internally during the summer of 2013. As a result the Trust had requested a review of the Cardiac surgery service by the Royal College of Surgeons (RCS), which took place in September 2013. The Trust shared the report findings with us alongside their response and targeted action plan to address the recommendations and ensure patient safety. We asked some staff if they were aware of the RCS review and recommendations. While some of the staff that we spoke with were able to describe some of the recommendations that had been put in place others expressed anxiety that the Trust was not addressing all of the concerns raised. The Trust confirmed that the recommendations and Trust action plan had been shared with lead staff at the time of our visit and was being disseminated to all staff in the service.

We also received some information of concern regarding The Digestive Diseases Unit during and after our listening events in December 2013.

We have shared the information for the Cardiac and Digestive Diseases Units raised with us with the Chief Executive. Investigations into these concerns are confirmed as being actioned and the findings will be shared with us to provide assurance that patient care, treatment and welfare is protected from the risk of preventable harm.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)

Consent to care and treatment - Outcome 2 (Regulation 18)

Care and welfare of people who use services - Outcome 4 (Regulation 9)

Meeting Nutritional Needs - Outcome 5 (Regulation 14)

Cooperating with other providers - Outcome 6 (Regulation 24)

Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)

Cleanliness and infection control - Outcome 8 (Regulation 12)

Management of medicines - Outcome 9 (Regulation 13)

Safety and suitability of premises - Outcome 10 (Regulation 15)

Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)

Requirements relating to workers - Outcome 12 (Regulation 21)

Staffing - Outcome 13 (Regulation 22)

Supporting Staff - Outcome 14 (Regulation 23)

Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)

Complaints - Outcome 17 (Regulation 19)

Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Contact us

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