Brighton & Hove City Council

Health Overview & Scrutiny Committee

Date:	**19 October 2022**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall**
Members:	**Councillors:** Moonan (Chair), West (Group Spokesperson), Barnett, Brennan, Grimshaw, John, Lewry, O'Quinn and Rainey **Co-optees:** Geoffrey Bowden (Healthwatch Brighton & Hove), Michael Whitty (Older People's Council), Nora Mzaoui (Community & Voluntary Sector representative)
Contact:	**Giles Rossington** Senior Policy, Partnerships & Scrutiny Officer 01273 295514 giles.rossington@brighton-hove.gov.uk

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AGENDA

PART ONE **Page**

10 APOLOGIES AND DECLARATIONS OF INTEREST

11 MINUTES **7 - 16**

To consider the minutes of the last meeting held on the 13th July 2022 (copy atatched).

12 CHAIRS COMMUNICATIONS

13 PUBLIC INVOLVEMENT

To consider the following matters raised by members of the public:

(a) **Petitions:** to receive any petitions from by members of the public by the due date (10 Working Days before);
(b) **Written Questions:** to receive any questions submitted by the due date of 12 noon on the (insert date);
(c) **Deputations:** to receive any deputations submitted by the due date of 12 noon on the (insert date).

14 ITEMS REFERRED FROM COUNCIL

15 MEMBER INVOLVEMENT

To consider the following matters raised by councillors:

(a) **Petitions:** to receive any petitions submitted by Members by the due date (10 Working Days);
(b) **Written Questions:** to consider any written questions;
(c) **Letters:** to consider any letters;
(d) **Notices of Motion:** to consider any Notices of Motion submitted by Members.

16 CARE QUALITY COMMISSION INSPECTION REPORT ON MATERNITY AND SURGICAL SERVICES AT THE ROYAL SUSSEX COUNTY HOSPITAL: UPDATE **17 - 88**

Report of the Executive Director, Governance, People & Resources (copy attached).

Contact Officer: *Giles Rossington* *Tel: 01273 295514*
Ward Affected: *All Wards*

17 CARE QUALITY COMMISSION INSPECTION REPORT: ACCIDENT & EMERGENCY AT THE ROYAL SUSSEX COUNTY HOSPITAL **89 - 92**

Report of the Executive Director, Governance, People & Resources (copy

attached).

Contact Officer: *Giles Rossington* *Tel: 01273 295514*
Ward Affected: *All Wards*

18 3TS REDEVELOPMENT OF THE ROYAL SUSSEX COUNTY HOSPITAL **93 - 112**

Report of the Executive Director, Governance, People & Resources (copy attached).

Contact Officer: *Giles Rossington* *Tel: 01273 295514*
Ward Affected: *All Wards*

Date of Publication - Tuesday, 11 October 2022

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FURTHER INFORMATION
For further details and general enquiries about this meeting contact Giles Rossington, (01273 295514, email giles.rossington@brighton-hove.gov.uk) or email democratic.services@brighton-hove.gov.uk

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BRIGHTON & HOVE CITY COUNCIL

HEALTH OVERVIEW & SCRUTINY COMMITTEE

4.00pm 13 JULY 2022

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Moonan (Chair)

Also in attendance: Councillor West (Group Spokesperson), Grimshaw, John, Peltzer Dunn, Evans and McNair

Other Members present: Geoffrey Bowden (Healthwatch), Michael Whitty (Older People's Council)

PART ONE

1 APOLOGIES AND DECLARATIONS OF INTEREST

1.1 Apologies were received from Cllrs Rainey, Barnett, O'Quinn, Lewry and Brennan.

1.2 Cllr Evans attended as substitute for Cllr O'Quinn;
Cllr McNair attended as substitute for Cllr Barnett.

1.3 There were no declarations of interest.

1.4 RESOLVED – that the press and public be not excluded from the meeting.

2 MINUTES

2.1 RESOLVED – that the minutes of the 13 April 2022 meeting be agreed as an accurate record.

3 CHAIRS COMMUNICATIONS

3.1 The Chair gave the following communications:

I had hoped that University Hospitals Sussex would be able to join us at this meeting to update the committee on the improvements they have made following the CQC report on surgery and maternity services in January 2022 which found both to be inadequate. However, UHSussex have informed me that they were reinspected by the CQC in April and anticipate that this report will be published around the end of July. Until the reinspection report is published, UHSussex feel there would be limited point in scrutinising their improvement planning as they would be

unable to reference the views of their external regulator. I have therefore agreed that we will take an update on this at the next HOSC meeting.

I also have some communications on Covid, on avian flu, and on the heatwave:

Masks reintroduced in health and care settings due to rising COVID-19 cases
Unfortunately, the number of positive COVID-19 cases and the number of hospital admissions with COVID-19 is rising.
Last week NHS Sussex reintroduced mask wearing in all clinical healthcare settings to prevent the spread and protect those who are most vulnerable. This applies to patients, visitors and staff, including at GP practices, consulting rooms, outpatient departments, clinics and wards.
We now recommend that visitors and staff in all care settings should wear masks. This includes care homes, supported living, home care and offices in care settings.
Masks will be made available for visitors to use, and exemptions will be respected.

COVID-19 vaccinations
The COVID-19 vaccination centre at Churchill Square has now closed but vaccinations remain available at mobile sites in the city for people aged 16+. Many of these are now regular slots – including at Hove Tesco on a Wednesday, Hove Polyclinic on a Thursday and St Peter's Church on a Friday. Other locations vary each week.
For children aged 5-15, appointments are available to book at the racecourse through the national booking system.
For the latest information, please check the new Sussex Health and Care website.

Bird Flu
Sadly, cases of bird flu have been found in the city and are spreading in our wild bird populations – particularly gulls. The risk to humans is very low, but please do not touch any dead or sick birds that you find and keep any pets away.
If you find a dead bird on public land, please report it to Cityclean for them to safely clear it.
And if you find it on private land, including in your garden please let DEFRA know.
If you find a sick bird, please don't try to handle it. You should contact the RSPCA for advice.

Level 3 heat-health alert
A level 3 heat-health alert is currently in place in the South East until Friday. With such hot weather expected for a prolonged period of time please check in on elderly or vulnerable friends or neighbours to make sure they are keeping cool and hydrated, and watch out for signs of heat stroke. Encourage them to stay in the shade, close curtains, drink plenty of fluids, and check that any medicines are being stored at the correct temperature.

4 PUBLIC INVOLVEMENT

4.1 There were no public questions.

5 ITEMS REFERRED FROM COUNCIL

5.1 There were no items referred from Council.

6 MEMBER INVOLVEMENT

6.1 There was a member question from Cllr Evans:

I ask the committee to note that cervical screening rates have dropped in Brighton and Hove to one of the lower rates in England, that is 64% of eligible women in 2021. The national average being closer to 70% and the government target being 80% of women.

I ask the chair if she is willing to bring a report to the next committee to allow HOSC to scrutinise cervical screening services in the city. I also ask her to consider including other gender related screening programmes such as breast screening if rates are similarly poor. I would particularly ask that this report includes public health awareness and education programmes, and the accessibility and suitability of the programme for hard to reach and minority groups.

6.2 The Chair thanked Cllr Evans for her question and agreed to ask for a paper to come to the next committee meeting. The Chair told members that she would meet with council Public Health officers in the next few weeks to seek advice on the scope of any item, and would then invite NHS England commissioners to attend the October 2022 HOSC meeting.

6.3 Cllr Evans asked a supplementary question, requesting that data on equalities be included in the October report. The Chair agreed that she would ask for equalities and geographical data to be included in any report.

6.4 Cllr West requested that the report should cover all gender-specific cancer screening: e.g. male as well as female cancers. The Chair responded that she would discuss this with public health colleagues.

7 SOUTHERN WATER INVESTMENT: RESPONSE TO NOTICE OF MOTION

7.1 The Chair told members that this item had been referred to the HOSC by the Environment, Transport & Sustainability Committee. The HOSC had been asked to invite the Southern Water CEO to a meeting. The CEO accepted this invitation, but had subsequently retired and the new CEO was unable to make the July meeting date. Southern Water were instead represented by Dr Nick Mills, Head of the Storm Overflow Taskforce. The Chair reminded committee members that they should restrict their questioning to the health and wellbeing implications of storm overflow.

7.2 Dr Mills gave apologies for his colleague Dr Toby Willison, who had been due to attend the meeting, but who had been called to an emergency in the Isle of Sheppey.

7.3 Dr Mills explained that the local sewer system takes both sewage and rainwater, discharging into the sea after treatment. There is sufficient storage capacity to manage most rainfall, but in very heavy rain sewers can fill with water to the degree that they would overflow causing flooding if there was not emergency discharge of the untreated contents into the sea. There is an online system to register these discharges. Southern Water is also piloting the use of ‘clever buoys’ which measure water quality in real time.

Southern Water has ambitious plans to reduce these emergency overflows by 80% by 2030. Traditionally, the water industry has tended to think in terms of creating major infrastructure: for example, building additional storage tanks or dedicated rainwater sewers. However, this kind of infrastructure is exceptionally, and often prohibitively, expensive to build, especially in urban areas. Another option is to optimise existing infrastructure, for example ensuring that highway gullies operate effectively (this is the responsibility of the Highways Authority rather than of water companies). A third option is source control: that is, to reduce the amount of rainwater that flows into sewers in the first place. Source control measures include rain-gardens, green roofs and domestic water-butts, all of which collect rainwater rather than having it run-off into sewers.

There is an important role for Planning here: e.g. to ensure that small developments and domestic extensions have source control conditions attached. It is also important to note that the amount of rainwater flowing directly into sewers has increased in recent years due in part to actions which have reduced urban resilience: e.g. people paving over front gardens for driveways. Major change is required if source control is to be effective: for example around 40% of surface water would need to be removed to reduce storm overflows by 80%.

7.4 In response to a question from Cllr Peltzer-Dunn on the effectiveness of the Brighton & Hove seafront storm-drain, Dr Mills told members that the drain has led to fewer and less impactful discharges. However, major infrastructure works like this will never entirely solve the problem and are also extremely expensive.

7.5 Cllr Grimshaw asked what warnings were given to people going to beaches about discharges into the sea. Dr Mills responded by noting that the 95% of storm discharge is rainwater, with only around 5% untreated sewage. In addition, discharges occur at least 2km out to sea. Furthermore, most storms and hence most incidents of discharge occur in the winter, when people are less likely to be in the sea. The threat to human and marine life is consequently low. In fact discharge into rivers poses more of a threat, although it is not the only threat to inland water quality (agricultural run-off poses a significant risk). It must also be recognised that in the short-term, the only alternative to discharge is to permit flooding. In the longer term, Southern Water is committed to investing to reduce discharge. People can find info here Beachbuoy (southernwater.co.uk) which provides and interactive map and email notification of discharges, and more could be done in terms of beach signage (e.g. having a QR code on signs that would link to the app). This would be a local authority responsibility.

7.6 The Chair asked a question about the health risks of flood discharge into the sea. Dr Mills responded that there is a risk from bacteria and pathogens in untreated discharge. However, dog faeces on the beach and bird droppings also pose potential risks, and in fact beaches in the UK are cleaner than they have ever been, now meeting EU and WHO minimum standards.

7.7 Cllr West noted that, if discharges did not pose a health risk, he thought it unlikely that Southern water would be committing £2 billion to reducing their incidence. Cllr West also asked how confident Southern Water was in achieving its 80% overflow reduction target, given the effects of climate change, particularly in terms of the increasing frequency and severity of storms throughout the year and especially in summer. In addition, Cllr West noted that even if an 80% reduction in discharges was achieved, this would leave 20% of discharges in place,

with a detrimental impact on the environment and on people's health. Members of the Council's Environment, Transport & Sustainability Committee (ETS) and signatories to a recent petition had demanded that a plan be put in place to reduce storm overflows to zero. Cllr West added that it was disappointing that the CEO of Southern Water had been unable to attend the meeting. He should be invited to a future committee meeting and encouraged to meet with the Leader of the City Council to plan how to keep beaches safe. Cllr West also asked what incentives would be offered by Southern Water to encourage source control. Dr Mills responded that moving to nearer 100% reduction in discharges would be prohibitively expensive, potentially costing around £600 billion (nationally). It is not really feasible to eliminate all discharge, particularly for the biggest storms, and there are other areas that Southern Water needs to invest in also: e.g. mitigating against increasing water scarcity. In terms of future-proofing against climate change, source control remains the best option.

7.8 In response to a question from Cllr John on DEFRA targets, Dr Mills told the committee that this was complex, but essentially DEFRA was demanding no more than 10 discharges per year and no harm caused by discharges. This is compatible with Southern Water's plans for 80% reduction by 2030. A draft investment plan will be published in autumn 2022, with a final submission of plans to OFWAT in 2023.

7.9 In response to a question from Geoffrey Bowden on fines, Dr Mills told the committee that Southern Water had paid a considerable amount in fines for non-permitted discharges from 2010-2015. However, there was a change of management in 2017 and there have been no subsequent fines. The income from fines goes directly to the Treasury.

7.10 In answer to a question from Cllr McNair on flooding in Patcham and what more could be done to tackle blocked gullies and drains, Dr Mills responded that these are the responsibility of the Highways Authority rather than Southern Water.

7.11 Cllr Evans asked whether the culture at Southern Water had changed. Dr Mills responded that the illegal discharges into waterways between 2010 and 2015 were shocking, but the culture had changed significantly in recent years, driven by a new executive team.

7.12 In response to a question from Cllr Evans on the number of discharges off Saltdean this year, Dr Mills told members that he did not have this information to hand. However, it was important to understand that currently, the choice is between discharging storm overflow into the sea or allowing flooding; there is no other option in the absence of additional infrastructure or better mitigation via source control.

7.13 In response to a query from the Chair asking where the intelligent buoys would be piloted, the committee was informed that the pilot sites were in Kent and at Hayling Island.

7.14 The Chair asked a question about who is ultimately accountable for discharge. Dr Mills responded that water companies will inevitably be held accountable as they are private companies and can raise capital for infrastructure investment. However, some of the measures that could be taken to reduce the incidence of discharges are the responsibility of the Environment Agency or of local authorities.

7.15 Cllr John noted that she would like the Southern Water CEO to attend a future meeting, and looked forward to more interaction with Southern Water at the HOSC or other council committees. Dr Mills responded that he was sure the CEO would be happy to talk to council committees: the company is committed to positive joint working with the local authority.

7.16 **RESOLVED –** that the report on Southern Water investment be noted.

8 TRANS HEALTH SERVICES

8.1 This item was presented by Lola Banjoko (Executive Managing Director, Brighton & Hove, NHS Sussex); Helen Davies (Clinical Director, Trans Healthcare); Nicky Cambridge (Head of Equality, Diversity & Inclusion); and Hugo Luck (Director, Primary Care). Before handing over to the presenters, the Chair reminded the committee that this report had been requested by Cllrs Clare and Powell, who had written to the April 2022 HOSC. The Chair also noted that the commissioning of Trans healthcare services is complex, with specialist services and services for children and young people currently commissioned at a regional or national level by NHS England. In order to make scrutiny manageable, the Chair had decided to take two reports on Trans Health: the first, at this committee meeting, to focus on locally commissioned services for adults; and the second, to follow at the October 2022 meeting, to focus on NHSE-commissioned services for young people and for adults.

8.2 Lola Banjoko told members that the Trans community experiences significant inequalities, which have been made worse by Covid. These include problems accessing services, receiving treatment, and experiencing discrimination. A Trans Healthcare Improvement Board has been established with representation from primary care, public health, NHSE, University Hospitals Sussex, LGBT Switchboard and the Clare Project. The Board has objectives to reduce health inequalities, to improve comms & engagement, to improve staff training, and to foster better integration between services.

8.3 Hugo Luck informed the committee of the launch of a locally commissioned service (LCS) for Trans people, which would include hormone therapy and an annual review of physical, mental and sexual health. 54 GP practices across Sussex have already signed-up to this service (11 of them in Brighton & Hove). This is a good rate of take-up, and it may be that some practices will take on LCS functions for neighbouring practices.

8.4 Helen Davies explained to members that NHSE runs seven Gender Identity Clinics (GIC) across England. There are very long waits following referral to these clinics, with a 240% increase in GIC referrals over the past five years. A GIC for Sussex is currently under tender. As this is a live process, only very limited information about the service can be shared publicly. Ms Davies added that Brighton & Hove has traditionally had a large Trans population. In recent years there has also been an expansion in the population of Trans people living in East Sussex. Commissioners are committed to working with the Trans community across Sussex in terms of designing and delivering services.

8.5 Nicky Cambridge told members that the NHS has a long history of working with LBG and Trans organisations across the city. Commissioners fund and support organisations

for Trans people and have involved community representatives in the planning of new services.

8.6 Ms Davies acknowledged that there were challenges: Trans people experience really significant health inequalities; there is a pressing need to reduce waiting times; and also to improve data on Trans people and their needs (the inclusion of Trans questions in the 2021 census should help). Ms Banjoko added that the next steps include: opening the Sussex GIC; establishing a baseline dataset of Trans needs; strengthening links with local universities; and developing services that feel integrated from a patient perspective.

8.7 In response to a question from the Chair on the typical patient journey, Ms Davies told members that most people's destination is not surgery; it is key that there are good local services in primary care and timely referral into the GIC, with appropriate support to help patients manage waiting times.

8.8 In response to a question from Cllr John on timelines for the new services, Ms Banjoko offered to provide more information on the GIC at the October 2022 HOSC meeting. Mr Luck added that the offer of training for GPs will be assessed at six months. There is no real expectation or requirement that all GPs will undertake the training as 100% adherence is very rare, and only some GPs in a practice will typically undertake training. Practices offering the LCS will need to show that they have an effective offer to their Trans patients, particularly in terms of annual reviews.

8.9 Responding to a query from Cllr John on engagement and data, Ms Cambridge told the committee that there is lots of engagement happening now, and that it is absolutely vital to the success of services that the community feels engaged. There has been good involvement in and feedback on the LCS model. In terms of data, detailed information from the 2021 census will be published in the autumn and this will give us the first real data on the size of the Sussex Trans population. Ms Banjoko added that public health teams would be analysing the census data and using it to update their JSNAs.

8.10 In response to a question from Cllr Evans on Trans people and cancer, Ms Davies told members that the issue here was primarily around ensuring that people received the screening appropriate to their previous identities. There is a risk that people will be missed in screening calls.

8.11 In answer to a query from Cllr Evans about staff training, Ms Davies responded that it is important that all staff understand that transphobic attitudes are unacceptable. However, different types of staff require different levels of training in Trans health issues, so there is no one-size-fits-all programme.

8.12 Cllr Grimshaw asked what was expected from the census date. Ms Banjoko replied that combining the census data with existing information from JSNA, the ONS etc. will enable a richer understanding of the scale of need. However, specialist capacity will remain limited, so work may need to focus on how best to support specialist services.

8.13 The Chair asked about the what the commissioning philosophy is for Trans health, given the potential for the NHS to medicalise services when people may have a greater need

for support. Mr Luck acknowledged this risk, and told members that the basic philosophy is that Trans people should have the same healthcare experience as everyone else.

8.14 Geoffrey Bowden told the committee that Healthwatch had worked with LGBT Switchboard on survey work with the Trans community. It was clear from this that there are still big challenges in terms of communication and engagement. However, it is good to see that the original scrutiny panel report is still relevant and that its recommendations are still being taken forward. The Chair agreed that it had been a long journey, but that there is clearly lots of positivity.

8.15 The Chair thanked all the presenters for their input and said she was looking forward to the report on NHSE commissioned services at the October HOSC meeting.

8.16 RESOLVED – that the report be noted.

9 HEALTHWATCH BRIGHTON & HOVE ANNUAL REPORT

9.1 This item was presented by Geoffrey Bowden, Interim Chair of Healthwatch Brighton & Hove. Mr Bowden began by paying tribute to Frances McCabe, who had chaired Healthwatch for many years. Fran will be greatly missed, although she is now working as a Governor at University Hospitals Sussex, leading and patient and public engagement work. Members expressed thanks to Fran for all her work over the years, including her contributions to the HOSC.

9.2 Mr Bowden told members that Healthwatch operates with funding of £197K from the city council (this comes from a Government grant), employing five permanent staff members, and more than 70 volunteers. In the past year, Healthwatch has published more than 20 reports. Instances where Healthwatch has had a real impact include a report on the Coldean GP surgery: the practice felt it had to reduce sessions, but after a report from Healthwatch, commissioners found additional funding to maintain opening hours. Healthwatch Brighton & Hove has also been recognised nationally for its work with patients post-discharge (HOPS), although sadly Healthwatch has not been recommissioned to continue this excellent work.

9.3 Looking forward, Healthwatch remains concerned about the provision of primary care in the city and will monitor this closely. Healthwatch will also be working closely with the emerging Integrated Care System (ICS); Healthwatch is represented on ICS bodies, but will robustly maintain its independence from the system.

9.4 Various committee members congratulated Healthwatch on the work undertaken in the past year.

9.5 The Chair asked Mr Bowden how the HOSC could support the work of Healthwatch. Mr Bowden responded that Healthwatch was not seeking additional core funding, although inflation and the fact that funding has not been increased, have created pressures. However, Healthwatch is keen to explore opportunities to take on specific commissions (e.g. the HOPS post-discharge work), and would encourage the HOSC to lobby on behalf of Healthwatch for such work, particularly given Healthwatch's excellent record of delivery.

9.6 Cllr Grimshaw asked whether Healthwatch might be interested in looking at the high number of deaths of homeless people in the city. Mr Bowden responded that Healthwatch is aware of and concerned by this issue, and would welcome the opportunity to undertake commissioned work in this area.

9.7 Cllr Peltzer-Dunn noted the work that Healthwatch had done around A&E services. Whilst A&E staff are excellent, aspects of A&E are unacceptable, including the physical state of the waiting area; and crucially the information given to people while they are awaiting treatment. It would be much better for the hospital to be honest with patients about likely waiting times than to display waiting time information that is wildly inaccurate. Mr Bowden responded, saying that Emergency Department staff have been working very hard for a very long time. Staffing is a massive problem, with the department regularly understaffed or staffed in part by non-A&E workers. In consequence, morale is very low. Healthwatch recently engaged with the Care Quality Commission around their inspection of A&E services, flagging a number of concerns. There is no easy fix to the problems at A&E, although additional staffing, reducing inappropriate presentations, and increasing GP and community pharmacy capacity would all help. The Chair noted that the HOSC would definitely want to consider the CQC report on A&E services at the Royal Sussex County Hospital when it becomes available, and would work closely with Healthwatch on this.

9.8 Cllr Peltzer-Dunn proposed that the report recommendation should be amended to “note and acclaim the work of Healthwatch” to reflect the value that the HOSC attaches to the work that has been undertaken over the past year. This was unanimously agreed by members.

9.9 RESOLVED – that the report be noted and that the HOSC acclaims the work of Healthwatch Brighton & Hove over the past year.

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of

Brighton & Hove City Council

Health Overview & Scrutiny Committee

Agenda Item [Insert]

Subject: **Care Quality Commission Inspection of Maternity and Surgery Services at the Royal Sussex County Hospital: Update**

Date of meeting: **19 October 2022**

Report of: **Executive Director, Governance, People & Finance**

Contact Officer: **Name: Giles Rossington**
Tel: 01273 295514
Email: giles.rossington@brighton-hove.gov.uk

Ward(s) affected: **All**

For general release

1. Purpose of the report and policy context

1.1 This report provides an update on the improvements made to maternity and surgical services at the Royal Sussex County Hospital (RSCH) following a Care Quality Commission inspection report published in December 2021, and a subsequent reinspection report published July 2022.

1.2 Information provided by University Hospital Sussex NHS Foundation Trust (UHSussex), is included as Appendix 1 to this report.

2. Recommendations

2.1 That Committee is asked to note the contents of this report on improvement planning at the Royal Sussex County Hospital with regard to maternity and surgery services.

3. Context and background information

3.1 The Care Quality Commission (CQC) is the national NHS regulator/inspector. The CQC conducted an unannounced inspection of maternity and surgery services at UHSussex hospitals in September/October 2021, publishing its inspection report in December 2021. The CQC downgraded its ratings of services at all UHSussex hospitals, but of particular concern was the RSCH, where surgery and maternity services were downgraded from ‘good’ to ‘inadequate’.

3.2 The Trust undertook a range of urgent actions in response to the CQC’s findings. These were outlined to the HOSC at its 26 January 2022 meeting. The Trust also put together a longer term action plan, with input and monitoring from health & care system partners.

3.3 RSCH surgery and maternity services were reinspected by the CQC in April 2022. The CQC did not update its ratings of these services, but did publish a

detailed report on its findings:
https://api.cqc.org.uk/public/v1/reports/c55b73a3-3d17-4e31-833e-59556e80cc95?20220729070335

3.3.1 **Maternity.** The CQC found significant improvements across maternity services, with more comprehensive staff training, improvements in recruitment, better record-keeping, enhanced incident-reporting, more responsive leadership, and a happier workforce. The CQC did require the Trust to make some further improvements to the checking of clinical equipment, to elements of patient records, and to maintaining appropriate temperatures in environments where medicines are stored.

3.3.2 **Surgery.** The CQC found some improvements in surgery: e.g. in terms of better infection prevention processes; improved training completion; better reporting of safety incidents. However, the CQC also found that problems remained in a number of areas, including the cancellation of planned surgery, recruitment of suitably skilled nursing and support staff (e.g. theatre nurses), leadership, and staff morale. The CQC noted that their re-inspection followed a challenging winter, due to a combination of Covid infections and the usual seasonal pressures. The Trust was confident that some of its performance was a consequence of these pressures, and that things would improve as pressures eased. The CQC required urgent improvement in a number of areas: better monitoring of the risk to patients when surgery is cancelled; ensure the timely completion of mandatory training; ensure that appropriately qualified staff are employed in theatre and recovery; ensure that patients requiring surgery do not experience harmful delays; improve the patient-flow through the hospital; ensure that the hospital has sufficient high dependency/intensive care capacity; ensure that there are enough staff to keep patients safe.

3.4 Details of the actions being taken by UHSussex in response to the CQC's reinspection report findings are included in Appendix 1 to this report.

3.5 The April 2022 CQC visit also included inspection of A&E services. The CQC's findings are detailed in a separate report to the HOSC.

4. Analysis and consideration of alternative options

4.1 Not applicable to this report for noting.

5. Community engagement and consultation

5.1 Not applicable to this report for noting.

6. Conclusion

6.1 Members are asked to note progress in UHSussex improvements in surgery and maternity services at RSCH, and the findings of the April 2022 CQC reinspection of these services.

7. Financial implications

7.1 None to this report to note.

Name of finance officer consulted: Date consulted (dd/mm/yy):

8. Legal implications

8.1 No legal implications identified to this report.

Name of lawyer consulted: Date consulted (dd/mm/yy):

9. Equalities implications

9.1 Not directly for this report to note.

10. Sustainability implications

10.1 Not directly for this report to note.

Supporting Documentation

1. Appendices

1. Information provided by University Hospitals Sussex.
2. CQC Inspection Report of RSCH Surgery and Maternity April 2022

University Hospitals Sussex
NHS Foundation Trust

CQC findings, feedback and our response

BHCC Health Overview and Scrutiny Committee

19 October 2022

Dr George Findlay, Chief Executive

Dr Maggie Davies, Chief Nursing and Midwifery Officer

Today’s agenda

University Hospitals Sussex NHS Foundation Trust

- Background
- Overview of current CQC ratings by hospital
- A more detailed look at
  - Maternity
  - Surgery at RSCH
  - Upper Gastro-Intestinal (GI) cancer surgery at RSCH
  - Urgent and Emergency Care at RSCH
- Summary
- Q&A

22

Background

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University Hospitals Sussex NHS Foundation Trust (UHSussex) was created on 1 April 2021 through the merger of Western Sussex Hospitals and Brighton and Sussex University Hospitals trusts

- UHSussex operates seven hospitals in Sussex, including the Royal Sussex County Hospital (RSCH) in Brighton and the main district general hospitals in Haywards Heath, Chichester and Worthing
- In September 2021, inspectors from the Care Quality Commission (CQC) visited the new Trust to inspect all UHSussex maternity services as well as the surgery service provided at RSCH in Brighton
- A number of issues were raised and improvements sought from the Trust
- In April 2022, the CQC reinspected these services and carried out an unannounced inspection of urgent and emergency care at the RSCH
- In July 2022, the CQC's findings were published, to be discussed today

Overview of CQC ratings

University Hospitals Sussex NHS Foundation Trust

Following their inspections, the CQC downgraded three services and made a number of recommendations for improvements

Maternity

Maternity services at Worthing Hospital, Princess Royal in Haywards Heath and St Richard's in Chichester downgraded to 'Requires Improvement' and at RSCH in Brighton to 'Inadequate'

Surgery

Surgery services at RSCH were rated 'Inadequate'

Urgent and Emergency

Urgent and emergency services at RSCH were rated 'Requires Improvement'

Princess Royal CQC ratings

University Hospitals Sussex NHS Foundation Trust

Princess Royal Hospital

Overall: Good

Ratings for specific services

Medical care (including older people's care)	8 January 2019	Good
Services for children & young people	8 August 2014	Good
Critical care	8 January 2019	Good
End of life care	10 August 2017	Good
Maternity	10 December 2021	Requires improvement
Outpatients	8 January 2019	Requires improvement
Surgery	8 January 2019	Good
Urgent and emergency services	8 January 2019	Good

25

St Richard's CQC ratings

University Hospitals Sussex NHS Foundation Trust

St Richard's Hospital

Overall: Outstanding

Medical care (including older people's care)	20 April 2016	Outstanding
Services for children & young people	20 April 2016	Outstanding
Critical care	22 October 2019	Outstanding
End of life care	20 April 2016	Outstanding
Maternity	10 December 2021	Requires improvement
Outpatients	22 October 2019	Good
Surgery	20 April 2016	Good
Urgent and emergency services	20 April 2016	Outstanding

Worthing Hospital CQC ratings

University Hospitals Sussex NHS Foundation Trust

Worthing Hospital

Overall: Outstanding

Medical care (including older people's care)	20 April 2016	Outstanding
Services for children & young people	20 April 2016	Outstanding
Critical care	22 October 2019	Outstanding
End of life care	20 April 2016	Outstanding
Maternity	10 December 2021	Requires improvement
Outpatients	22 October 2019	Good
Surgery	20 April 2016	Good
Urgent and emergency services	20 April 2016	Outstanding

RSCH CQC ratings

University Hospitals Sussex NHS Foundation Trust

Royal Sussex County Hospital

Overall: Good

Ratings for specific services

Medical care (including older people's care)	8 January 2019	Good
Services for children & young people	10 August 2017	Outstanding
Critical care	8 January 2019	Good
End of life care	10 August 2017	Good
Maternity	10 December 2021	Inadequate
Outpatients	8 January 2019	Requires improvement
Surgery	10 December 2021	Inadequate
Urgent and emergency services	8 January 2019	Good

Requires improvement

Comments on current CQC ratings

University Hospitals Sussex NHS Foundation Trust

We welcome the CQC's inspection of our services and are pleased with the improvements they identified between their first and second visits

- We are confident maternity services are on their way to previous ratings when they are next formally inspected but recognise that we still have further to go in maternity, as well as for surgery and emergency care at RSCH
- We understand the reasons for the downgrade in the rating of urgent and emergency services at RSCH. It is also important to recognise that these are primarily related to issues such as environment and pressures on staffing and demand rather than the efforts of our staff
- The pressures on the NHS are felt across all our services and our people continually step-up to meet the challenges and make sure patients get good care
- We are particularly pleased that the inspectors recognised the dedication of staff and praised colleagues for the care they provide in every service

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Maternity

Dr Maggie Davies
Chief Nursing and Midwifery Officer

Maternity – a more detailed look

University Hospitals Sussex NHS Foundation Trust

Significant improvements in staffing and standards of care have been demonstrated in our maternity services

In addition to follow-up visits by the CQC, we have also welcomed NHS England Ockenden review-visits that have each returned excellent feedback.

31

CQC inspectors of maternity said:

"During this re-inspection we met a happier and more motivated workforce. There was recognition that significant improvements to the culture had occurred and they felt hopeful this would continue going forward. No staff reported any bullying behaviour to us during the inspection."

Maternity improvements noted

University Hospitals Sussex NHS Foundation Trust

The inspectors noted a number of significant improvements

Staffing and culture

- Staffing has improved (though still challenged at Princess Royal and Brighton)
- 31.14 wte midwives have joined our maternity service since January 2022
- New director of midwifery recruited April 2022
- “Most staff felt supported, listened to, and felt able to raise concerns” – CQC inspectors noted
- Low and falling staff-turnover and sickness rates
- Weekly listening events have enabled staff to talk through challenges they face

Improvements noted cont.

University Hospitals Sussex NHS Foundation Trust

Systems and processes

- Introduction of Birmingham Symptom Specific Obstetric Triage Tool to manage risk on all sites
- Maternity Obstetric Early Warning Score (MEOWS) widely used and compliant
- Maternity Information system in place in Brighton and Haywards Heath and launching in Worthing and Chichester in Q1 2023
- Clinical guidelines are up-to-date
- Incidents are managed effectively
- Risk register reviewed and updated
- No ‘never events’
- Introduction of Patient First ‘lean’ improvement approach to maternity service

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RSCH Surgery

RSCH Surgery – a more detailed look

University Hospitals Sussex NHS Foundation Trust

We have increased staffing levels, reinforced minimum safety standards and reduced the number of patients waiting for operations – but we know more improvements are required

CQC inspectors of surgery at RSCH said:

"Leaders were passionate about the service and worked to try to deliver good outcomes for patients despite the challenges the department faced"

Additional actions include

- External review by Professor Peter Dawson commenced 6 July
- Cultural deep-dive undertaken by consultancy Edgcumbe
- Chief Medical Officer chairing a new oversight group on training and education
- Weekly CQC reporting to track incident management

RSCH surgery – improvements noted

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The CQC inspectors noted a number of improvements

- Staff use control measures to protect patients, themselves and others from infection and said they have recently been reminded about this
- Only three vacancies – trust has recruited 26 new staff in the department
- Improved incident management - staff recognised and reported incidents and near misses and lessons were learned and shared

The service has also

- Set up an Emergency Care Forum
- Set up risk assessments for delays to emergency surgery
- Achieved 90% statutory and mandatory training rates for staff
- Created all day governance meetings
- Introduced skills assessments and weekly 30-minute training sessions

RSCH surgery – theatres

University Hospitals Sussex NHS Foundation Trust

Following the CQC visit, we launched a Theatre Improvement Programme to better understand and address challenges

- The programme uses the feedback from the CQC and from colleagues shared during listening events held after the inspection
- The improvement programme has focused on
  - Workforce
  - Training
  - Infection Prevention and Control standards
  - Management of safety incidents
  - Leadership and culture

37

RSCH Upper GI cancer surgery update

University Hospitals Sussex NHS Foundation Trust

The CQC made an unannounced inspection of the specialist Upper Gastro-Intestinal cancer surgery service at RSCH in August 2022 and subsequently instructed that planned surgery should be suspended

- The number of patients cared for by the service is very small (around four to six a month) and so while the potential impact on individuals is significant, thankfully the number of people affected is currently low.
- All patients due for oesophago-gastric resection surgery have been re-booked into Royal Surrey in Guildford, in line with their existing treatment dates to minimise the impact on their treatment and patients are being engaged with to help them through the change in pathway.
- This work has been supported by the Surrey and Sussex Cancer Alliance.
- We are also working with the CQC and our partners to agree next steps for the specialist oesophago-gastric cancer service at RSCH.

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RSCH Urgent and Emergency Care

RSCH Urgent and Emergency – CQC rating

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

RSCH Urgent and Emergency developments

University Hospitals Sussex NHS Foundation Trust

We have opened a new Urgent Treatment Centre in Brighton to reduce pressure on the constrained Emergency Department and introduced new ‘fit to sit’ areas for patients who do not need the use of a bed

41

We have secured investment for a business case to develop plans to improve the layout and functionality of the Emergency Department, once new space is freed up by services moving into our new £500 million hospital building in 2023

RSCH Urgent and Emergency - improvements noted by CQC

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The inspectors praised care in a number of areas

- Staff provided safe emergency care and treatment, enough food and drink and pain relief
- Staff could call for support from doctors and other disciplines and diagnostic services 24/7
- Staff treated patients with compassion and kindness and provided emotional support
- Staff felt respected, supported and valued by immediate leaders.
- Staff were committed to continually learning and improving services
- Staff expressed that their ideas were listened to and acted upon
- Service collaborates with external NHS providers to support safe care and improvements
- Staff knew how to protect patients from abuse
- All areas were clean and had suitable furnishings
- Staff responded quickly to patient calls for assistance
- Staff completed risk assessments for each patient swiftly
- Staffing is improving
- Staff kept detailed records of patients' care and treatment

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Summary and Q&A

Summary

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Significant improvements have been made and acknowledged by the CQC but we know we still have outstanding 'must do' actions in all services, including:

Maternity

- The service must monitor regular checks on life-saving equipment (must do – all sites)
- Ensure maternity triage ratings are recorded in electronic patient record (must do – RSCH)
- Improve staffing (must do – Princess Royal and Brighton)

Surgery

- Mandatory training is still below target, despite improvements
- Ongoing delays and cancellations remain a concern
- Low staffing levels led to staff speaking about exhaustion and feeing pressured

Urgent and emergency

- Requires improvement for safety and responsiveness
- Mandatory training and appraisal rates are too low
- Too many patients stay longer than four hours before leaving and 12 hours before admission

Thank you

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Q&A

- Dr George Findlay, Chief Executive Officer
- Dr Maggie Davies, Chief Nursing and Midwifery Officer

45

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Royal Sussex County Hospital

Inspection report

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Brighton
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Date of inspection visit: 26 and 27 April 2022
Date of publication: 29/07/2022

Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Royal Sussex County Hospital

Inspected but not rated

We carried out this unannounced focused follow up safety inspection of maternity services and main theatres at the Royal Sussex County Hospital who are part of the University Hospitals Sussex NHS Foundation Trust on the 26th and 27th of April 2022 because, at our last inspection on the 26 September 2021 we issued a warning notice to make sure the trust made improvements.

Summary of concerns from the warning notice:

- Lack of sufficient numbers of suitably trained staff to deliver safe services
- Unsafe storage and administration of medicines
- Unsecured and non-contemporaneous medical records
- Poor assessment and response to risk
- Poor governance processes
- Infection prevention and control standards were not consistently applied across some areas.
- The service did not have enough staff to care for patients and keep them safe.
- Staff did not have training in key skills.
- The service did not manage safety incidents well and did not always learn lessons from them.

We carried out this return inspection to review compliance to the warning notice issued on the maternity services and main theatres

This inspection has not changed the ratings of the location and our rating of surgical services remains the same.

In addition we inspected the core service of urgent and emergency care following some information of concern. We rated urgent and emergency care as requires improvement because:

- Not all staff had completed all the trust mandated training in key and essential skills. Not all staff received appraisals.
- The use of the environment did not always support keeping people safe. Patients were frequently accommodated in non-clinical areas. The use of the environment did not always enable staff to protect the privacy and dignity of patients. The environment of the short stay areas did not support effective care for patients accommodated there, which included patients with mental health illnesses. The environment posed an infection risk as it could not be cleaned effectively.
- The service was not able to plan and provide care in a way that met the needs of local people and the communities served. The needs of patients in the local community with mental health conditions were not fully met. They were accommodated for lengthy periods of time in an environment that did not fully meet their needs and by staff who may not have the skills to care for the patient.

Our findings

- There were challenges in accessing the service. Poor patient flow throughout the hospital resulted in delays in ambulance handovers. There was an increasing number of patients staying longer than four hours in the department before leaving and an increasing number of patients in the department for over 12 hours after a decision to admit them.

However,

- Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well.
- Staff provided safe emergency care and treatment and gave patients enough to eat and drink, and gave them pain relief when they needed it. Staff worked well together for the benefit of patients and key services were available seven days a week.
- Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. Consultant rotas were arranged so there was consultant cover in the department 24 hours a day seven days a week
- Staff treated patients with compassion and kindness and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Staff felt respected, supported and valued by immediate leaders. They were focused on the needs of patients receiving care.
- Staff were committed to continually learning and improving services. Staff expressed that their ideas were listened to and acted upon.
- The service had collaborated with external NHS providers to support safe care and improvements to the service and for patients. This included working with the local mental health NHS trust and the local ambulance NHS trust.

Maternity (inpatient services)

Inspected but not rated

We carried out this unannounced focused follow up safety inspection of maternity services provided by the Royal Sussex County Hospital who are part of the University Hospitals Sussex NHS Foundation Trust on the 26th of April 2022 because, at our last inspection on the 26 September 2021 we issued a warning notice to make sure the trust made improvements.

Summary of concerns from the warning notice:

- Lack of sufficient numbers of suitably trained staff to deliver safe services
- Unsafe storage and administration of medicines
- Unsecured and non-contemporaneous medical records
- Poor assessment and response to risk
- Poor governance processes

We carried out this return inspection to review compliance to the warning notice issued on the maternity services. We did not inspect any other core service. Although, we continue to monitor all other core services.

This inspection has not changed the ratings of the location overall and our rating of maternity services remains the same.

Is the service safe?

Inspected but not rated

Mandatory training

The service provided mandatory training in key skills to all staff and ensured everyone completed it.

Staff received and kept up to date with their mandatory training. At the previous inspection staff told us that although annual mandatory training was provided by the trust they could not attend because they were needed to work in clinical areas of the department. The service had a target of 90 % staff attendance at mandatory training. Records showed that average attendance for midwifery staff was 81.27% and for medical staff it was 70.28%. This was worse than the trust target of 90%.

During this re-inspection records showed staff attendance at mandatory training was between 86% and 100%. Staff who had not yet attended all the mandatory training courses had a date to attend and staff attendance rates for mandatory training will be above the trust target of 90% by the end of May 2022. Staff told us that training was provided on the site they worked at and they were released from clinical work commitments to attend the training.

Safeguarding

Staff understood how to protect women 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.

Maternity (inpatient services)

Midwifery staff received training specific for their role on how to recognise and report abuse. At the previous inspection the service had a training attendance target of 90%. Records showed 73.3% of nursing and midwifery staff had attended safeguarding training specific for their role. This was worse than the trust target of 90%.

During this re-inspection records showed staff attendance at safeguarding training was between 86% and 100%. Staff who had not yet attended all the safeguarding training courses had a date to attend and staff attendance rates for mandatory training will be above the trust target of 90% by the end of May 2022. Staff told us that training was provided on the site they worked at and they were released from clinical work commitments to attend the training.

Medical staff received training specific for their role on how to recognise and report abuse. At the previous inspection the service had a training attendance target of 90%. Records showed 45.5% of medical staff had attended safeguarding training specific for their role. This was much worse than the trust target of 90%.

During this re-inspection records showed staff attendance at safeguarding training was between 86% and 100%. Staff who had not yet attended all the safeguarding training courses had a date to attend and staff attendance rates for mandatory training will be above the trust target of 90% by the end of May 2022. Staff told us that training was provided on the site they worked at and they were released from clinical work commitments to attend the training.

Staff followed the baby abduction policy but had not undertaken recent baby abduction drills. At the previous inspection the trust had a baby abduction policy which was seven months overdue for review. During the previous inspection staff told us they had not recently undertaken baby abduction drills. Records showed that 46% of midwives had attended skills drills training in the 12 months before inspection. This was much worse than the training target of 90%.

During the re-inspection records showed medical staff attendance at drills training was 83% and midwife attendance at skills drills training was 93%. Staff who had not yet attended skills drills training had a date to attend and staff attendance rates for skills drills training will be above the trust target of 90% by the end of May 2022. The baby abduction policy had been updated to include current national guidance.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe.

Staff did not always carry out daily safety checks of specialist equipment. At the previous inspection all clinical area's records showed that specialist equipment was not checked on a daily basis.

After the previous inspection the trust provided CQC with assurance all equipment was checked in line with trust policy.

During the re-inspection records showed that improvements had been made in daily and weekly checks of emergency equipment. In the 12 weeks before inspection, all daily checks had been completed on the emergency equipment in all areas but there were some weekly checks missing. On the labour ward almost half the days in the four weeks before the re-inspection the resuscitaires on the labour ward had not been checked. On the day of the re-inspection the resuscitaires on the labour ward had not been cleaned and were dusty. This meant that lifesaving equipment could have been faulty or missing when it was needed. Staff did not have assurance that checks were being completed.

Assessing and responding to patient risk

Maternity (inpatient services)

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks but did not always record the risk in the patient notes.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. At the previous inspection staff in the maternity triage department told us they did not use a tool such as the Birmingham symptom-specific obstetric triage system (BSOTS) but relied on their clinical experience to assess women attending the department. As midwives with little clinical experience were staffing the triage department this was a significant risk for women attending.

During the re-inspection we found a national maternity triage tool had been implemented and was being used to assess all pregnant women attending the antenatal triage area who had concerns about their pregnancy. We reviewed five clinical records of women who attended maternity triage for an assessment and found the triage tool had been used for each attendance however the allocated priority of red, amber or green for each episode had not been recorded consistently in the electronic patient record.

Implementation of the national maternity triage tool ensured women were reviewed by a doctor within the timeframe needed according to the risk of the concern. The trust audited the use of the national tool monthly. Records showed 100% of women attending antenatal triage in the 12 weeks before the re-inspection had been risk assessed using the tool.

Staffing

The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels, and gave bank and agency staff a full induction.

The service did have enough midwifery staff to keep women and babies safe. At the previous inspection all staff we spoke with told us that low numbers of staff made them feel unsafe.

During the re-inspection staffing numbers had improved but on many shifts they did not have the planned number of staff. Staff were less worried about low staffing and felt the numbers of staff on duty had improved safety. Women in labour had one to one care from a midwife 98% of the time. The labour ward had a senior midwife who was not counted in the staff numbers 98% of the time. Antenatal triage had a dedicated midwife 90% of the time and calls were diverted to the labour ward at other times.

Managers calculated and reviewed the number and grade of staff needed for each shift in accordance with national guidance. Each area had a rota of staff planned a month in advance and included midwives, nursery nurses and midwifery care assistants.

The ward manager could adjust staffing levels daily according to the needs of women. The department had twice daily staffing huddles at 9 am and 3pm with Matrons and discussed the staffing levels in one to one care for women in labour, a supernumerary midwife and telephone triage dedicated midwife. Staff were allocated to areas according to need.

The service had reducing vacancy rates, turnover rates, sickness rates and use of bank nurses. Since the previous inspection the trust had worked hard to recruit new staff and retain current staff. Twenty-one midwives had joined the team and the trust projected that they would be fully staffed by October 2022. Current staff were paid enhanced bank rates to cover shifts but did not feel any pressure to work extra shifts unless they wanted to.

Maternity (inpatient services)

Records

Staff kept detailed records of women's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Women's notes were comprehensive, and all staff could access them easily. At the previous inspection the majority of women's notes were stored on an electronic patient record and the rest were paper notes. Each healthcare professional who had contact with the women recorded their care in the electronic patient record.

Since the previous inspection all women's notes were electronic and the WIFI had been upgraded so women's electronic patient records could be accessed anywhere in the hospital.

Records were stored securely. At the previous inspection in all clinical areas we visited the women had a secondary set of paper notes which contained details of their inpatient care episode. These were stored in notes trollies with electronic digital combination locks. All of the note's trollies were unlocked on the day of inspection. This meant the notes could be accessed by people without the authority to do so.

During the re-inspection there were less paper records as the electronic patient record was fully implemented. In each area any paper record was stored in a locked notes trolley. This meant only authorised staff could access the paper notes.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff generally stored and managed medicines and prescribing documents in line with the provider's policy. At the previous inspection there were gaps in the medicine fridge temperature checks and one gap in the controlled drug checking record. During this re-inspection the checking records were fully completed.

Staff checked the ambient temperature of the clinical room where intravenous fluids and medicines were stored in line with trust policy.

Incidents

The service managed safety incidents well. Managers shared lessons learned with the whole team and the wider service.

Staff raised concerns, reported incidents and near misses in line with trust policy. At the previous inspection staff told us they often did not have time during the shift to report incidents and only reported what they considered to be a serious incident after their shift had finished. This meant all reportable incidents were not being regularly reported. Staff told us they had been instructed to stop reporting low staffing as an incident as it was a known risk. Incidents were not reviewed and closed in a timely way and there were 279 open incidents at the time of the last inspection. During the re-inspection records showed there were no overdue serious investigations, 5 overdue low harm incident investigations and 1 overdue moderate harm investigation. There were 31 open incidents.

During the re-inspection staff told us they reported incidents in line with the trust policy. In the six months before the re-inspection the maternity staff reported 435 incidents of varying risk.

Maternity (inpatient services)

Managers shared learning with their staff about never events that happened elsewhere. Staff received feedback from investigation of incidents, both internal and external to the service. At the previous inspection staff told us that due to a shortage of staff they had not been meeting to discuss learning from never events occurring elsewhere within the trust. This meant staff did not have an opportunity to learn and change their practice or improve the service through learning. Staff were aware of a system called 'message of the week'. However, staff told us they were too busy to read this message, and no one asked could recall a recent safety message that had been shared.

During this re-inspection we saw governance notice boards in all areas which included learning from incidents and investigations. Staff told us that themes from learning following incidents were shared at the handover in between shifts.

Learning from recent incidents was included an education session on day three of the mandatory training and included investigations from previous year, along with learning and safety actions.

Is the service effective?

Inspected but not rated

Competent staff

The service made sure staff were competent for their roles. Managers did appraise staff's work performance to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. At the previous inspection staff told us they had been unable to practice live drills, pool evacuation and Cardiotocography (CTG) training recently as they were so short of staff. The service had a training attendance target of 90%. Records showed that 51% of midwives had attended CTG training in the 12 months before inspection. Records showed that 46% of midwives had attended skills drills training in the 12 months before inspection. This was much worse than the training target of 90%.

During this re-inspection records showed medical staff attendance at skills drills training was 83% and midwife attendance at skills drills training was 93%. Staff who had not yet attended skills drills training had a date to attend and staff attendance rates for skills drills training with be above the trust target of 90% by the end of May 2022. Staff told us that training was provided on the site they worked at and they were released from clinical work commitments to attend the training.

Managers gave all new staff a full induction tailored to their role before they started work. At the previous inspection staff told us it was not always possible to complete a full supernumerary induction due to the shortage of staff. The inspection team were given examples of staff of all grades who worked as part of the team before their induction programme had been completed.

During this re-inspection newly recruited staff spoke positively about their induction and we observed a new member of staff being orientated to the ward area and required tasks.

Managers ensured staff attended team meetings or had access to full notes when they could not attend. At the previous inspection when staff meetings took place, minutes were recorded and shared with staff who could not attend due to staffing shortages.

During this re-inspection staff told us they received minutes of meetings via email and they were also displayed in the staff room.

At the last inspection staff told us there were few opportunities to complete additional training.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge During this re-inspection staff told us they had received an appraisal and had a personal development plan to complete additional training if needed. Records showed appraisal rates for midwives were 90% and for medical staff 96%.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the necessary experience and capacity to lead effectively and abilities to run the service. They managed the priorities and issues the service faced. They were visible and approachable.

Maternity was part of the Women and Children's Division which covered the Royal Sussex County Hospital in Brighton and the Princess Royal Hospital in Haywards Heath. The director of midwifery post was vacant at the time of inspection. The head of midwifery was cross-site and covered both the Princess Royal Hospital site and the Royal Sussex County Hospital site and in the absence of the director of midwifery post, reported directly to the Chief Nurse who represented the service at trust board level and was the maternity safety champion for the trust. There was an inpatient matron and a community matron, and a governance and safety lead who reported into the head of midwifery. Since the previous inspection a director of midwifery had been recruited. They had recently joined the trust and had a leadership responsibility for the Royal Sussex County Hospital and Princess Royal Hospital.

The Children and Women's East Divisional Board met monthly. We reviewed the minutes of the meetings held between June and September 2021. Records showed the meeting ran to a standard agenda but did not record attendance.

At the previous inspection staff told us they did not always feel supported during a shift. For example, they found some managers were not approachable and were reluctant to raise concerns with them. They would either not raise a concern or wait until an alternative manager was on duty. Staff told us their effort was not recognised or praised by managers. During this re-inspection all staff were positive about the leaders and were happy to raise concerns openly with managers.

Maternity (inpatient services)

At the previous inspection staff starting leadership roles told us they felt unsupported and did not have a clear development plan. They felt obliged to work clinically due to the shortage of midwives and were not able to focus on their leadership objectives. During this re-inspection junior leaders told us the support provided by the trust had enabled them to focus on their roles and develop their leadership skills. They felt supported and empowered to make decisions and changes within their departments.

At the previous inspection staff told us they felt pressurised by the senior leaders to work extra shifts even though they were exhausted, and this showed a lack of understanding of the current situation on the ward areas. Managers verbally acknowledged that low staffing was a problem but did not have a plan to improve the situation. During this re-inspection staff no longer felt this pressure and told us that staffing had improved.

During the re-inspection staff spoke positively about the changes the leadership team had made since the last inspection. In particular there had been regular listening events and observable changes following the feedback given.

Culture

Staff felt respected, supported and valued by leaders. The staff were focused on the needs of patients receiving care.

All staff we met during the re-inspection were welcoming, friendly and helpful. They felt pride in the peer support they provided each other and having worked together to provide the best service they could to patients in their care.

At the previous inspection staff told us of incidents of bullying and intimidation amongst their colleagues. Staff had raised concerns about the safety and culture of the service on multiple occasions and told us nothing had been done to improve the situation. Staff who had worked for the service for many years were taking early retirement or seeking employment elsewhere. Staff told us this unit ran on the loyalty and hard work of the staff and this was “coming to an end”.

The trust assured CQC the leadership and support concerns were being reviewed and monitored.

During this re-inspection we met a happier and more motivated workforce. There was recognition that significant improvements to the culture had occurred and they felt hopeful this would continue going forward. No staff reported any bullying behaviour to us during the inspection.

Management of risk, issues and performance

Leaders and teams used systems accurately to manage performance effectively. They identified and escalated all relevant risks and issues to take action to reduce their impact in a timely way.

The service had a women’s and children division specific risk register. The risk register included a description of each risk, controls in place, and a summary of actions taken. The initial and current risk rating was included and any updates since the previous review.

Maternity (inpatient services)

Risks were discussed at the monthly maternity Quality and Safety Meeting and were measured against the risk reckoner which was used by the trust to determine risk to patients, staff and the organisation. All recorded risks were reviewed by the divisional leadership team and reported by exception through the governance meeting structure. At the previous inspection staff told us not all risks were recorded as were often repeated or ongoing without resolution. During this re-inspection we reviewed the current risk register and found it was reviewed and updated on a monthy basis.

Since the previous inspection the division had developed and implemented a comprehensive action plan to address the concerns identified in the warning notice issued by the Care Quality Commission. They had worked with system partners to make the improvements needed to the maternity service.

At the previous inspection we found a number of clinical guidelines were overdue for review. This meant staff did not have access to the most up to date clinical information to care for their patients. During the re-inspection 78 guidelines had been brought up to date with three remaining in the review process. This is a significant improvement.

Areas for improvement

MUSTS

Royal Sussex County Hospital Maternity

Action the trust MUST take to comply with its legal obligations

- The trust must ensure the maternity triage RAG ratings recorded in the electronic patient record. (Regulation 12 (1) (2) (a, b))
- The trust must ensure regular checks on lifesaving equipment are undertaken. (Regulation 12: (2) (b, e)).

SHOULDS

Royal Sussex County Hospital Maternity

Action the trust SHOULD take to comply with its legal obligations

- The trust should ensure the temperature of clinical rooms where medicines and intravenous are stored is monitored daily and remains under 25 degrees centigrade (Regulation 12)

Surgery

Inspected but not rated

The rating of the service went down. We rated it as requires improvement because:

- Patients requiring emergency surgery experienced delays and cancellations placing them at risk.
- Staff without the necessary skills, competence and training were caring for patients.
- The service did not always have enough nursing and support staff with the right skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Leaders operated governance processes throughout the service, but it was unclear how effective these were. There was a lack of oversight of complications associated with delays or surgical cancellations.
- Not all staff felt respected, supported and valued. Not all staff felt the service had an open culture where they could raise concerns without fear.
- Leaders understood the priorities and issues the service faced but were not always able to manage them. Not all staff felt supported to develop their skills and take on more senior roles.
- The overall mandatory training compliance was below the trust target of 90%, for all staff groups.

However:

- Staff used control measures to protect patients, themselves and others from infection. All staff in theatres we observed wore their PPE, including masks, correctly. We also saw all staff in clinical areas were bare below the elbow.
- Managers regularly reviewed staffing levels and skill mix. There had been a reduction in vacancy levels within the department.
- The service had improved how they managed patient safety incidents. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons

Is the service safe?

Inspected but not rated

Mandatory Training

The service provided mandatory training in key skills to all staff. However, mandatory training levels were below the trust target, for most staff groups.

At our last inspection we found that the service provided nine mandatory training modules, for staff. These included manual handling, health and safety and life support. However, we found not all staff were compliant with the training.

On this inspection we found the overall training compliance had improved but was still below the trust target for completion of mandatory training of 90%.

Surgery

Data for staff working in main theatres and recovery showed an overall compliance rate for the department of 81%. Administration staff were 98% compliant; heath care support staff were 84% compliant; nursing and operating department practitioners were 88% complaint and medical staff were 70% compliant.

We also found compliance with basic life support had improved, with an overall compliance rate of 76%, which was below the trust target of 90%. Data showed that health care support staff were 65% compliant; nursing and operating department practitioners were 70% compliant and medical staff were 92% compliant.

Staff told us they were not given protected time to complete their mandatory training. This was the same as the last inspection.

Cleanliness, infection control and hygiene

Staff used control measures to protect patients, themselves and others from infection.

Staff followed infection control principles including the use of personal protective equipment (PPE). On our last inspection we found that staff did not always follow infection control principles including the use of personal protective equipment (PPE). In theatres we found, some staff were not bare below the elbows and some staff were not wearing face masks correctly. We also found not all staff challenged colleagues who were non-compliant with infection prevention and control principles.

On re-inspection we found that personal protective equipment was readily available for staff in clinical areas, to ensure their safety when performing procedures. All staff in theatres we observed wore their PPE, including masks, correctly. We also saw all staff in clinical areas were bare below the elbow. This meant staff were able to adequately ensure staff and patient safety and reduce the risk of cross infection when staff performed procedures.

Staff told us, after our last inspection, they had been reminded the importance of adhering to infection prevention and control principles.

Infection prevention and control training was part of the trusts statutory and mandatory training requirement for all staff. Data supplied to us showed that the departments overall complaint was 90% for clinical staff and 100% for non-clinical staff with this training, which was equivalent or better than the trust target of 90%.

Assessing and responding to patient risk

Patients requiring surgery experienced delays and cancellations placing them at risk. Staff without the necessary skills, competence and training were caring for patients.

Patients requiring emergency or trauma surgery that experienced delays were at risk of further complications.

At our last inspection we found patients requiring emergency or trauma surgery experienced delays to getting their surgery. In addition, we found capacity and flow issues within the hospital. Patients requiring either a high dependency, intensive care or a ward bed spent prolonged periods of time in recovery.

On this inspection, staff we spoke with told us that cancellations to surgery remained an issue. They felt there was a reluctance to cancel elective surgery to undertake or prioritise emergency and trauma surgery. The trust told us that no emergency surgery had been cancelled to meet an elective key performance indicator (KPI).

Surgery

We asked managers about cancellations of surgery, who told us this had not significantly improved and was on the risk register for the department. They told us this was due to a variety of pressures the trust was experiencing which had an impact on the capacity and flow into and out of the department. For example, winter pressure and the continued impact of the COVID 19 pandemic. As well as, a surgical ward that had been changed to a 'red' ward, for patients who had tested positive for COVID 19, which meant there was a reduction in the number of beds available to surgical patients. Managers told us this was an improving picture and felt that the number of cancellations would be reduced as the impact of winter pressures and pandemic reduced, and the surgical ward had now changed back to its original usage. In addition, managers felt that the new critical care unit currently under construction, expected to have an impact on the flow.

Medical Staff told us that the delays in surgery had resulted in additional complications for patients which they would not have experienced had they had their surgery sooner. They gave examples where had surgery had occurred outside of recommended timeframes and resulted in complications, such as patients developing sepsis, or requiring life altering surgeries. This meant that patients waiting for these surgeries were at potential risk of further complications. We were not assured that the potential risks to patients was being monitored appropriately.

Data supplied showed, between October 2021 and March 2022, a total of 1,332 patients required general emergency or emergency trauma surgery at the hospital. Of those, 954 required emergency surgery, and 378 were trauma surgery. For those requiring emergency trauma surgery we saw they experienced a wait of between zero to 10 days for their surgery, and for general emergency surgery the wait was between zero and 21 days.

During the same time period, out of the 954 patients requiring general emergency surgery, 180 patients had between one and seven postponements for their surgery, and 32 had between one and four postponements for emergency trauma surgery.

Managers told us the main reasons for cancellations were due to either staffing shortages or capacity and flow. This was the same as our previous inspection.

On our last inspection, we found the department experienced issues with flow, which meant that some patients spent prolonged periods of time in recovery whilst waiting for a bed on the ward or in critical care. We found that this meant staff cared for patients without the required skills, knowledge and competence.

On this inspection, there were no patients that had spent the night in recovery waiting for beds elsewhere in the hospital. All staff we spoke with told us this was unusual. The trust told us that patients who need a critical care bed, were added to the Intensive Care Unit (ITU) bed request book if a bed was not available in critical care they can be cared for in recovery by trained staff, supported by critical care staff and the outreach team until a bed becomes available.

Data showed between October 2021 and March 2022, a total of 261 patients spent three hours or longer waiting for either a high dependency, intensive care or ward bed. Out of the 261 patients we saw, 165 were waiting for a bed on the ward, 61 for a high dependency bed and 35 for an intensive care bed.

In addition, the trust told us, 188 patients across the same time period waited between one and two hours 59 mins in recovery. We saw the majority (137) were waiting for a ward bed, with 30 waiting for a high dependency and 21 an intensive care bed.

As well as patients spending prolonged periods of time in recovery following surgery, recovery was also used as an escalation area for patients requiring a higher level of care.

Surgery

We looked at the '*records for recovery patients needing ITU/HDU (High Dependency Unit)'*. Between 1 April and 23 April 2022, there were 16 recovery patients needing either a high dependency or intensive care bed. Out of the 16 we saw one required ventilation (mechanical support with breathing), and two required inotrope support (are medicines that change the force of the heart's contractions). Between 1 March and 31 March 2022, 31 patients were in recovery who required either a high dependency or intensive care bed. Out of the 31 we saw two patients required ventilation.

All except one member of staff we spoke on inspection told us they had not received additional training in caring for patients who required high dependency or intensive care support. One member of staff had received training, as a result of being redeployed to critical care during the pandemic. No staff told us when they care for these patients they were supported by staff from critical care or from outreach.

Data supplied to us by the trust showed that 61% (17 out of 28) of recovery staff had completed the full recovery competency training. They told us recovery competency training is a four to six-month programme and has a critical care skills focus. The evidence supplied stated that two recovery competency training programmes take place a year and that all new members of staff will have completed this training by September 2022. Six out of 28 (21%) of recovery staff had completed a full critical care training programme. This meant patients were not always cared for by staff who had the required skills, knowledge and competence.

The trust told us that two new standard operating procedures had been developed; '*critical care full capacity policy'* and '*standard process for critical care patients in recovery'*. Staff we spoke with were aware of the new standard operating procedure but felt that it was not always adhered to. We asked managers how the process was monitored or audited, and they told us it is via the numbers of patients in recovery, which had not increased.

When we looked at the risk register, we saw that delays in patients leaving recovery leading to poor patient experience was included. We did not see a risk entry for staff caring for patients without the required skills, knowledge and competence.

At the last inspection we found that compliance with World Health Organisations (WHO) '5 Steps to safer surgery' checklist in theatres was not being consistently audited to ensure compliance. Managers told us the process had been reviewed, and is now included in their smart audit app, which allows for 'real' time compliance to be monitored. As part of this process it was found that not all areas of the trust audited were the same, and a new approach to improve consistency had been rolled out across the trust. We saw that WHO checklist not completed leading to potential harm to patient, was entered onto the department risk register. We looked at the smart audit app data for four months and saw that three elements of the check list had been audited. Previously, we were told compliance with the 'debrief' part of the checklist was poor, but this was not included in the audit records supplied.

Nurse staffing

The service did not always have enough nursing and support staff with the right skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed staffing levels and skill mix.

Theatres and recovery did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. All staff in theatres and recovery spoke of poor staffing and exhaustion. This was the same as our last inspection.

Data showed within main theatres and recovery there was a vacancy of 5.74%, in March 2022. This was forecast to reduce to 2.97% by the end of April 2022. The trust supplied data that showed they had recruited 26 new staff in the department which meant there was only three vacancies outstanding. However, when we looked at the theatre meeting minutes for 19 April 2022, it showed that 11 band six jobs were currently being advertised along with a rolling advert for band fives.

In addition, the theatre meeting minutes show there has been some difficulty in covering shifts especially at night. Staff told us they felt the department had been covering the night shift at the expense of the days, this had caused the dilution of skill mix and experience to be diluted both day and night. Managers told us, they are working with staff to ensure a fair and equitable distribution of shift coverage. A new 'twilight' shift had been introduced to manage theatre lists that over run and two extra theatre teams for the busiest days.

Staff we spoke with told us the department sometimes felt unsafe due to staffing numbers, skill mix and the acuity of patients, which was the same as the previous inspection. Staff also felt new members of staff were signed off sometimes before being fully competent. Managers told us; they have had a 'really good' recruitment campaign but recognise this may not have filtered through to staff on the floor at present. This is due to the new members of staff requiring training and support and (some) are supernumerary, but this will not be 'forever'.

On the last inspection we found operating lists went ahead when staffing was below national guidelines, such as the Association of Perioperative Practice (AfPP). The trust told us that operating lists are monitored against AfPP guidelines. Staffing is discussed at the 8am safety huddle. Managers confirmed that there is discussion around the running of lists below the AfPP guidelines if it is safe to do so. If a decision was made to cancel this would be done in accordance with trust policy.

Data supplied for November 2021 and April 2022 showed that operations had been staffed and run as planned for emergency trauma operations ranged between 91.9% in March 2022 and 100% in November 2021 and February 2022.

For general emergency surgery we that showed that operations had been staffed and run as planned ranged between 68.1% in December 2021 and 93% in April 2022.

We saw that delayed emergency and cancelled elective surgery due to staffing was on the risk register. However, we did not see a risk entry for cancellations or delays for emergency surgery.

Between 1 October 2021 and 29 April 2022 there were three incidents reported due to staff shortages in theatres and recovery. This had improved from the previous inspection.

Incidents

The service had improved how they managed patient safety incidents. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service in. However, staff did not always report incidents and near missed in line with trust policy.

At our previous inspection we found the service did not manage patient safety incidents well. We found that managers did not investigate incidents and therefore lessons learned were not shared with the while team and the wider service.

At this inspection we found the management of safety incidents had improved. Safety incidents were investigated, and lessons learned shared.

Surgery

On our previous inspection we found that incidents were not always reviewed and investigated in a timely manner. There was a backlog of 128 incidents within the service that had not been reviewed and investigated by managers. On this re-inspection we found the number of incidents waiting to be investigated had improved. Currently, we found a backlog of 18 incidents waiting to be reviewed. These have been categorised as either moderate (5) or low/no harm incidents (13).

Staff received feedback from investigation of incidents, both internal and external to the service. On our re-inspection we added the morning safety huddle. We saw this included a brief of 'need to know' information or incidents that may have occurred, including those that had happened at other sites. Learning from the incidents were shared. We looked the meeting minutes for main theatres and saw that incidents were discussed.

Staff knew what incidents to report and how to report them. Staff told us they knew how to raise concerns and incidents and near misses in line with trust policy. However, some members of staff told us they did not always report incidents or request follow up information about incidents they reported at they reported feeling worried or scared to do so. This meant that a culture openness and honesty at all levels was not encouraged within the organisation.

Is the service well-led?

Inspected but not rated

Leadership

Leaders understood the priorities and issues the service faced but were not always able to manage them. Not all staff felt supported to develop their skills and take on more senior roles.

The leadership of the perioperative directorate remained the same from the previous inspection. The directorate was led by a chief of service, divisional director of operations and a divisional lead nurse (current post holder was interim). This leadership style is called a triumvirate. Since our last inspection, the senior clinical theatre manager had returned to post following secondment.

Leaders were passionate about the service and worked to try to deliver good outcomes for patients despite the challenges the department faced. The trust told us, there was a plan to refresh the surgical leadership team, which will start in July 2022. Other regulators are supporting leaders in theatres.

Staff views remained mixed regarding the visibility; how approachable trust leaders were. Some staff told us the local senior leadership team were visible and approachable, but as a department they felt there was a disconnect between the executives and frontline staff. They told us they did not see senior leaders such as the board of directors, so they were unsure if their voices or feedback was heard at that level.

Not all staff felt supported to develop their skills or take on more senior roles. Most staff spoke highly of the clinical educators in the department but expressed there was a lack of dedicated time to undertake learning. This was the same as our previous inspection. Other staff told us they wanted to 'act up' into more senior roles, although they were encouraged to this, it was ad hoc in response to staffing shortages rather than as part of a developmental role.

Culture

Surgery

Not all staff felt respected, supported and valued. Staff were focused on the needs of patients receiving care but were not always able to deliver the level of care needed. Not all staff felt the service had an open culture where they could raise concerns without fear.

At out last inspection we found there was a low morale within some groups in theatres and recovery. They did not always recognise the leadership team as dealing with their concerns around these matters. Some staff told us they were not able to speak up about concerns or issues without fear.

On this inspection, staff expressed similar concerns. They told us 'not a lot' had changed, and morale remained low. All staff told us they were proud of their teams and their colleagues, and felt that when patients were in the department, they all received 'good' care. However, all staff told us of the impact that patients having long waits for emergency surgery, cancellations, staff shortages, dilution of skill mix and caring for patients for prolonged periods in recovery was having on them and the morale.

Not all staff felt there was and open and honest culture across the whole of the department. Staff we spoke with were candid throughout our inspection about the service and the areas they felt had improved and what had not. Not all staff felt valued and respected. Some staff told us they were concerned about speaking with us, as this may reflect badly on them. We saw that staff raised these concerns at the main theatres audit meeting dated 19 February 2022, however it was unclear from the minutes what discussion or action had happened as a result of this.

They also told us they did not always raise concerns or ask for outcomes or follow ups to any they had raised due to feeling worried or scared to do so.

Managers told us following the last inspection, they had undertaken a variety of measures to address the culture. These included one to ones with staff and 'listening' events. For example, staff had expressed concerns around the fairness of shift patterns, with some staff working shift patterns for reasons that may no longer apply. A listening event had been held and they were working with staff to ensure a more fair and equitable pattern. This included developing a new rota system, starting with healthcare assistants. They told us they had addressed certain members of staff's behaviours but know there is a perception that this had not taken place, due to confidentiality, they were not able to disclose what had been done. In addition, they told us there an external review of culture had been commissioned.

Governance

Leaders operated governance processes throughout the service, but it was unclear how effective these were. There was a lack of oversight complications associated with delays or cancellations of surgeries. Staff at all levels were clear about their roles and accountabilities.

At our last inspection we found governance processes in the directorate were not always clear.

There was a process for monitoring patients waiting for surgery. There was a patient tracking list that monitored patients daily who are waiting for surgery. The trust told us the patients experiencing the longest waits were in trauma, ear, nose and throat, colorectal, ophthalmic and gynaecological surgery. The trust had a surgical senate which prioritised patients according to capacity. Leaders told us patients could be moved to any of the three other sites within the trust or outsourced to local private providers. The surgical senate reviewed patients a quarter ahead so currently the senate was reviewing patients who will breach in quarter two. We were told that there were no patients waiting longer than 104 weeks, unless by patient choice.

Surgery

There was a lack of oversight of complications associated with delays or cancellations of emergency surgery. We asked managers where clinical harm reviews associated with cancellations of surgery were held and any concerns discussed. They told us this would be within the specialty division governance or mortality and morbidity meetings.

However, medical staff we spoke with told us that the governance around clinical harm reviews was not robust, with meetings often cancelled. As a result of the frequent cancellations they told us the meetings were not always well attended. An example given that at a recent governance meeting there were over 20 clinical harm reviews to discuss, but they had been told that they should pick only three. This meant there was a lack of oversight to identify if either a single delay or a sequence of delays may have resulted in further complications to the patient.

We requested three mortality and morbidity meeting minutes for different surgical specialities. The trust gave us the quality, safety and patient experience minutes for anaesthetics and ear, nose and throat and the clinical governance minutes for trauma and orthopaedic meetings. All meeting minutes sent to us were dated March 2022. Clinical harm or 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.

From review we found that the meeting minutes lacked detail and did not give managers and staff the ability to learn from the service performance. We saw there was evidence of individual cases discussed along with outcomes and any learning. However, we did not see discussion associated with cancellations, and potential complications associated with this or delayed or postponed surgery. In addition, the meeting minutes lacked a record of attendees, therefore, it was unclear how well attended the meeting were

We requested the last three minutes for main theatres. The trust gave us two minutes of main theatres audit meeting dated 19 January and 16 February 2022, and theatre unit meeting minutes dated 19 April 2022. From review, we found that the meeting minutes lacked detail and did not give managers and staff the ability to learn from the service performance. For example, we saw that risks and incidents were discussed, however, it was unclear when some concerns were raised what the outcome of the discussion was. This meant it was not clear how effective these minutes were at keeping staff informed, especially those who were not able to attend the meetings. In addition, the meeting minutes lacked a record of attendees, therefore, it was unclear how well attended the meeting were.

We looked at three quality, safety and patient experience minutes for anaesthetics for January, February and March 2022. We saw they all followed a similar agenda, with discussion around risks, and incidents and any learning identified, or actions need had a person assigned to them. However, the meeting minutes lacked a record of attendees, therefore, it was unclear how well attended the meeting were.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

The trust must monitor the risk of harm and outcomes for patients who experience cancellations of surgery. Regulation 12 (2) (a) (b)

Surgery

The service must ensure staff complete their mandatory training and each module meets their compliance targets. Regulation 12 (2) (c)

The service must ensure that staff working in theatres and recovery have the qualifications, competence, skills and experience to keep patients safe. Regulation 12 (2) (c)

The service must ensure that patients receive surgery when they need it and do not experience delays, placing patients at risk of deterioration and harm. Regulation 12 (2) (a) and Regulation 12 (2) (b)

The service must ensure it improves flow in the hospital and theatres to reduce the time patients spend in the recovery unit waiting for a bed in the hospital. Regulation 12 (1)

The service must ensure it has suitable facilities to care for patients requiring high dependency or intensive care. Regulation 12 (2) (b)

The service must ensure that there is enough staff with the right skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Regulation 18 (1)

Action the service SHOULD take to improve:

The service should ensure it provides continuous professional development to all staff. Regulation 18 (2) (b)

The trust should monitor the governance processes of all surgical disciplines to ensure they are able to asses, monitor and improve the quality and safety of the service. Regulation 17 (2) (a)

The service should ensure all parts of the with World Health Organisations (WHO) ‘5 Steps to safer surgery’ checklist process are adhered and monitored to ensure compliance. Regulation 17 (2) (f)

There service should consider a staffing levels and skill mix review to ensure it is able to adapt and respond to the changing needs and circumstances of the people using the service. Regulation 18 (1)

Urgent and emergency services

Requires Improvement 

Not all staff had completed all the trust mandated training in key and essential skills. Not all staff received appraisals.

The use of the environment did not always support keeping people safe. Patients were frequently accommodated in non-clinical areas. The use of the environment did not always enable staff to protect the privacy and dignity of patients. The environment of the short stay areas did not support effective care for patients accommodated there, which included patients with mental health illnesses. The environment posed an infection risk as it could not be cleaned effectively.

The service was not able to plan and provide care in a way that met the needs of local people and the communities served. The needs of patients in the local community with mental health conditions were not fully met. They were accommodated for lengthy periods of time in an environment that did not fully meet their needs and by staff who may not have the skills to care for the patient.

There were challenges in accessing the service. Poor patient flow throughout the hospital resulted in delays in ambulance handovers. There was an increasing number of patients staying longer than four hours in the department before leaving and an increasing number of patients in the department for over 12 hours after a decision to admit them.

However,

Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well.

Staff provided safe emergency care and treatment and gave patients enough to eat and drink, and gave them pain relief when they needed it. Staff worked well together for the benefit of patients and key services were available seven days a week.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. Consultant rotas were arranged so there was consultant cover in the department 24 hours a day seven days a week

Staff treated patients with compassion and kindness and helped them understand their conditions. They provided emotional support to patients, families and carers.

Staff felt respected, supported and valued by immediate leaders. They were focused on the needs of patients receiving care.

Staff were committed to continually learning and improving services. Staff expressed that their ideas were listened to and acted upon.

The service had collaborated with external NHS providers to support safe care and improvements to the service and for patients. This included working with the local mental health NHS trust and the local ambulance NHS trust.

Urgent and emergency services

Is the service safe?

Requires Improvement 

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills. However, this did not include the highest level of life support training and the service did not make sure everyone completed the required mandatory training.

Nursing staff were not up to date with their mandatory training. The trust set a target of 90% compliance with mandatory training. Records showed this target was not met. For nursing staff across the emergency department, the 90% compliance rate had only been met for five of the ten required training topics.

Medical staff were not up to date with their mandatory training. Records showed the target of 90% compliance was not met. For medical staff across the emergency department, the 90% compliance rate had only been met for one of the thirteen required training topics.

The mandatory training did not fully meet the needs of patients and staff. Records showed that mandatory training covered a wide range of essential safety topics. However, the training only included basic life support training. There was no evidence provided to demonstrate staff had completed any higher levels of life support training. This was not in line with national guidelines for example, the Royal College of Emergency Medicine (RCEM). Across all staff groups (nurses, support staff and medical staff) overall compliance with completing adult basic life support training was 65% and completion of paediatric basic life support training was 52%.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers knew that staff completion of mandatory training did not meet the trust target. However, they said staff were now given time to complete their mandatory training and staff confirmed this in conversations.

Safeguarding

Staff understood how to protect patients from abuse. However, not all staff had received training on how to recognise and report abuse.

Not all nursing and medical staff completed training specific for their role on how to recognise and report abuse. Records demonstrated that all nursing staff and medical staff were required to complete safeguarding adults' level 2 training and safeguarding children level 3 training, which met national guidance. However, records showed that only 83% of all staff required to complete level 2 adult safeguarding training had completed it. Records also showed that only 66% of all staff required to complete level 3 children's safeguarding training had completed it.

Staff could give some examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff described caring for patients with protected characteristics and how to keep them safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff described what a safeguarding concern was and how to make a referral. The service had a safeguarding lead based in the emergency department for support and advice. Staff accessed safeguarding adult and children's policies on the trusts intranet to give them guidance about safeguarding processes.

Cleanliness, infection control and hygiene

The service controlled infection risk. Staff used equipment and control measures to protect patients, themselves and others from infection. However, due to overcrowding of the environment, staff experienced challenges with cleaning the department.

All areas were clean and had suitable furnishings which were visibly clean and well-maintained. Cleaning staff were visible in all areas.

Cleaning records were up-to-date and showed that all areas were cleaned regularly. Cleaning staff followed a set schedule to ensure all areas of the environment were cleaned. Records showed most areas were cleaned according to the schedule. However, staff did describe challenges with cleaning due to the regular overcrowding of the unit. They described how they worked flexibly to clean areas as patients vacated them.

The emergency department was separated into red and green areas. This allowed for separation of patients who had COVID-19 or had signs and symptoms of Covid-19 from other patients. As part of the segregation of the two areas, there was a tarpaulin covering an opening in a wall in the entrance route to the 'red' area of the department. Staff said the tarpaulin had been in place for nearly two years. It was not clear how this was effectively cleaned, and staff did not know whether the use of the tarpaulin had been assessed for potential risk to safety of patients. Information provided by the service did not demonstrate how effective cleaning of this tarpaulin had been considered. Since the inspection the tarpaulin had been removed.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were all bare below the elbow and during the inspection all grades of staff cleaned their hands before and after patient interactions. There were clinical handwashing sinks and posters reminding staff of the World Health Organisation's guidance five moments of hand hygiene.

Environment and equipment

The use of the environment did not always support keeping people safe. However, the design and maintenance of facilities, premises and equipment supported safety of patients. Staff were trained to use equipment. Staff managed clinical waste well.

The use of the environment did not always support safe care or treatment. Patients were commonly accommodated in non-designated patient areas. The standard operating procedure for patients placed in the corridor detailed that, "the holding of patients in areas not intended for patient care needs to be seen by the department and wider trust as an extraordinary event rather than business as usual." However, patients were routinely accommodated in non-designated patient areas. In the majors area of the department, it was normal practice for patients to be accommodated on trolleys in the corridor and in front of patient cubicles. On the day of inspection at 10.15am and 12 noon there were 12 patients accommodated across the corridor and in front of patient cubicles. Data provided by the service showed that between 01 February and 16 April 2022, patients were accommodated in the corridor every day. There were only two days where

there were periods when less than 11 patients were accommodated in the corridor. On 67 days of this period there were over 18 patients accommodated in the corridor. Patients accommodated and cared for in non-designated patient areas were at increased risk of poor care and avoidable harm. This was because it was difficult for staff to monitor patients and to carry out clinical assessments and interventions.

Not all patients could reach call bells. Patients accommodated in escalation areas, such as the corridor in the major's area, did not have access to call bells to request assistance. However, staff responded quickly to patients calling out for assistance.

Staff carried out daily safety checks of specialist equipment. Records showed staff checked daily that emergency equipment was available and in working order.

The service did not have suitable facilities to meet the needs of patients' families. There was one relative's room in an adapted patient cubicle and was in the busy noisy area of the major's part of the department. Although staff had decorated and furnished the room to make it comfortable for relatives, staff felt it was not in a suitable environment to break bad news to relatives.

The service had enough suitable equipment to help them to safely care for patients. Staff could access all the equipment they needed to provide care. Availability and servicing of the equipment was monitored and coordinated by a team of equipment technicians. Staff said they completed training in the use of equipment.

Children routinely presented at the separate children's emergency department at the co-located Royal Alexandra Children's Hospital. However, in the event of major trauma children were treatment in the resuscitation room in the adult emergency department. This was because there was easier and prompt access to diagnostic imaging equipment, such as CT scanners. There was equipment in the resuscitation room to safely provide treatment for children. The children's emergency equipment was subject to the same daily safety checks as the adult equipment.

Staff disposed of clinical waste safely. Waste was separated and stored securely before being disposed of safely. Sharps boxes were assembled, used and disposed of correctly.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the National Early Warning Score (NEWS2) to identify patients at risk of deterioration. They completed scores correctly. When a concerning score was calculated the patient was escalated for medical review.

Staff completed risk assessments for each patient on arrival using a recognised tool. Staff used a nationally recognised tool to triage patients on presentation to the department. This enabled staff to direct patients to the most appropriate area of the department to meet their treatment needs and supported prompt commencement of tests and treatment. This also identified whether patients had any specific risk issues, such as possible sepsis. Records reviewed showed staff followed national guidance in their assessment and management of these risks.

Urgent and emergency services

The service had 24-hour access to mental health liaison and specialist mental health support. A mental health liaison team located at the hospital but provided by a different NHS trust was available 24 hours, seven days a week to support the care and treatment of patients with mental health illnesses. The trust also contracted security staff, who they said had relevant training in conflict management and restraint techniques, to safely support patients demonstrating challenging behaviours due to their mental health conditions.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. With the support and guidance of the mental health liaison team staff carried out assessments of patients who presented as at risk of safe harm or suicide. The assessment set out clear guidance about the actions staff needed to take, dependent on the presentation of the patient, to protect them from harm.

Shift changes and handovers included all necessary key information to keep patients safe. Staff used an electronic handover process to ensure all staff had essential information about patients' conditions and treatments. The handover process also included any other information that may affect the safety of patients. This included staffing issues, patient flow and any equipment issues.

Nurse staffing

The service experienced challenges in ensuring there were enough nursing and support staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service experienced challenges in ensuring there were enough nursing and support staff to keep patients safe. Staff said it had been normal for there to be gaps on staff rotas daily across the emergency department and that it was a regular occurrence for staff to finish shifts late. However, following a successful recruitment programme, staff numbers had improved. Staff said that whereas previously there had been up to 11 agency or bank nursing staff on each shift, that number had now reduced to two or three.

To safely meet the needs of patients with mental health illness accommodated in the short stay areas of the department the service requested agency registered mental health nurses. However, these shifts were not always filled, and the emergency department nursing staff managed these patients with the support and guidance from the mental health liaison team. This included, when needed, health care assistants with some additional training to carry out one to one supervision of patients with mental health illnesses.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. The department manager could adjust staffing levels daily according to the needs of patients. Patient acuity and staffing across the hospital was reviewed daily by senior leaders and the department. To support safe staffing numbers, staff were moved from other areas of the trust to work in the department. For example, on the day of inspection a member of staff from the paediatric emergency department and a member of staff from one of the trust's other emergency departments had been moved to work in the department.

The service had reviewed nurse staffing levels against the Royal College of Emergency Medicine (RCEM) guidelines and identified where they were not meeting the current guidelines. This included the number of agency nursing staff used each shift, numbers of nurses working in the resuscitation room and lack of dedicated portering staff for the department. At the time of the inspection the service was in discussion regarding a business case to increase the nursing establishment to meet the RCEM guidelines.

Managers made sure all bank and agency staff had a full induction and understood the service. During the inspection staff described how they orientated temporary members of staff to ensure patients were kept safe.

The department did not employ registered children's nurses. Children routinely presented at the separate children's emergency department at the co-located Royal Alexandra Children's Hospital. However, in the event of major trauma children were treatment in the resuscitation room in the adult emergency department. In these circumstances staff from the children's emergency department attended to provide the specialist children's treatment.

Medical staffing

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

The service had enough medical staff to keep patients safe. The department had consultant presence 24 hours a day, which was better than the Royal College of Emergency Medicine guidelines. However, staff said that consultants regularly had to back fill junior doctors' gaps on rotas to ensure medical staff matched the planned number.

Managers requested locums when they needed additional medical staff and locums had a full induction to the service before they started work. However, staff expressed that locum medical staff were sometimes hard to source. They expressed a concern that locum medical staff were paid more to work at emergency departments elsewhere in the trust. This deterred them from working at Royal Sussex County Hospital.

The department did not employ paediatricians. In the event of major trauma when children were treatment in the resuscitation room in the adult emergency department, paediatricians from the children's emergency department attended to provide the specialist children's medical treatment

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, easily available to all staff providing care, but not always stored securely.

Patient notes were comprehensive, and all staff could access them easily. Patient notes were mostly paper based and completed thoroughly. To reduce risk of patients accommodated in the corridor receiving substandard care, the service monitored completion of nursing records in this area every day. Patients' paper records were held in notes trolleys. Notes trolleys were always accessible to staff. Where patients' records, such as test results and tracking how long the patient was in the department were held electronically, computers were accessible to all staff working in the department.

Records were not always stored securely. Electronic records could only be accessed by staff who were authorised to access the trust computer system. Paper records were held in notes trolleys, these were not locked as staff needed to access them frequently and was deemed to be less of a risk to patient safety than having the notes trolley locked. However, the service had not formally assessed the risk of the notes trolley not being locked.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. They followed current national practice to check patients had the correct medicines. Medicines records were complete and contained details on dose and when patients received them.

Staff reviewed each patient's medicines regularly. The department had a trial of pharmacy staff working in the department. The pharmacy staff checked to ensure patients remained on medicines they were taking before admission to hospital and time essential medicines were prescribed and administered appropriately.

Staff completed medicines records accurately and kept them up to date. Records detailed doses prescribed and administered.

Staff stored and managed all medicines and prescribing documents safely. All medicines were stored safely in locked cabinets.

A recently introduced electronic auditing tool showed that for February, March and April 2022 medicines were stored securely and at the recommended temperatures.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents, but there was no structured approach to share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy via an electronic reporting system. Staff said they were encouraged to report incidents and near misses.

The service had no never events in the department. However, managers had shared information and learning with their staff about never events that happened elsewhere.

Staff understood the duty of candour. They said they gave patients and families a full explanation if things went wrong.

There was no structured process for learning from incidents to make improvements to patient care. Themes of the week as result of incidents across the trust were shared by senior leaders. This was not done at a local level within the urgent and emergency care services. Leaders of the department said they had identified there was an unstructured approach to learning from incidents across the urgent and emergency services which needed to be improved. However, there was some evidence of learning from incidents. A falls project was reviewing and acting to improve falls prevention and post falls actions after identifying a theme of patient falls in the department.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. A member of the nurse leadership team reviewed all reported incidents, investigated those that were not serious incidents and, following trust policy, referred serious incidents to the serious incident review group for investigation.

Urgent and emergency services

Is the service effective?

Good ➔➔

Our rating of effective remained the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff had quick access to laminated cards in the department that gave detail about treatment for all common emergencies. The National Institute for Health and Care Excellence (NICE) and trust guidelines were available on the trust intranet. Staff said guidance was easy to access, comprehensive and clear to follow.

Clinical practice reflected guidance and best practice. Key issues in patient care were handed over and acted upon. Senior clinical staff gave clear direction and support to junior staff and ensured patients received care and treatment based on national guidance.

Staff protected the rights of patients subject to the Mental Health Act 1983. The mental health liaison team supported staff to protect the rights of patients detained under the Mental Health Act.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients were regularly offered hot drinks and snacks. Volunteer staff had been recruited to support this service. They checked with nursing staff which patients were not able to eat and drink, prior to serving drinks and snacks. Patients said they were offered drinks and snacks. Patients accommodated in the short stay areas, were offered three hot meals a day. Fresh water was available from water dispensers in all areas of the emergency department.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately.

Staff monitored pain level of patients and recorded the information. Pain scores were recorded in most patient notes. Staff used pictorial aids to assess the pain of patients who were not able to verbally communicate.

Urgent and emergency services

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. This included Royal College of Emergency Medicine audits for infection prevention and control, consultant sign off, mental health self-harm and cognitive impairment in older people and the Trauma Audit and Research Network audits

Outcomes for patients were positive, and mostly met expectations, such as national standards. Performance in the 2022 Trauma Audit and Research Network audit were mostly similar to other organisations. Median time from arrival to receive a CT head scan for patients with a severe head injury was 42 minutes. This met the recommended time scale of one hour. Between 1 January 2019 and 31 December 2021 90% of patients with cardiothoracic injuries were treated by a consultant. This was in line with national guidance and better than the average national performance. The average time for patients with severe injuries to limbs and pelvis to go to theatres (18 hours), was similar to the average national performance.

Managers and staff carried out some repeated audits to check improvement over time. The service had introduced an electronic auditing tool to assess the performance of the service. This was in its infancy and currently only audited essential safety standards, but there was a plan to extend this audit tool. For the three months this tool had been used, it showed 100% compliance with the essential minimum standards being assessed. This included auditing whether emergency equipment was checked, medicine storage was safe and whether cleaning materials and substances hazardous to health were stored correctly.

Competent staff

The service made sure staff were competent for their roles. Managers provided staff with support to develop. However, managers did not always appraise staff's work performance.

Staff were experienced, qualified and mostly had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. Staff said the trust induction programme was detailed and comprehensive and provided all the information and support they needed to do their jobs.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. The trust policy required staff to receive yearly appraisals. At the time of inspection only 70% of the nursing staff had received an appraisal in the last 12 months. However, leaders had a plan to ensure all staff had received an appraisal in the next three months.

The practice educators supported the learning and development needs of staff. The service had three practice educators who supported all staff with their development. Staff spoke positively about the support the practice educators gave them with their development.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. However, leaders had recognised that staff had reduced access to learning and development during the Covid-19 pandemic and were taking action to address that. Practice educators had an action plan they were following to meet the training needs of staff.

Urgent and emergency services

Staff received specialist training for their role. Nursing staff completed emergency care competency assessments. However, staff compliance with competencies was not currently monitored. The service had identified this as a concern and was reintroducing monitoring of staff compliance. Practice educators were rolling out a teaching programme for the multidisciplinary team. Medical staff had dedicated time allocated to them for training. Some staff said they would welcome additional training about meeting patients' mental health needs as they did not feel fully equipped to care for patients with mental health conditions accommodated in the department.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers working in the department said they completed relevant training, which included training in essential safety topics and training relevant to the support they gave to the department to patients.

Multidisciplinary working

Doctors, nurses and other healthcare professionals mostly worked together as a team to benefit patients. They supported each other to provide good care.

Throughout the inspection we saw multidisciplinary team working in all areas. Clinical staff said nurses, doctors and allied health professionals worked well together within medicine and felt part of the team.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There were regular multidisciplinary meetings during the day where doctors, nurses and allied health professionals discussed patient care and treatment plans. Staff described effective working relationships with most services in the hospital. However, they described challenges with general surgical teams' engagement with the department which sometimes resulted in delays in patient reviews and plans for treatment.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. The mental health liaison service, provided by another NHS trust, was embedded into the working of the department. Staff said the mental health liaison team was responsive and always available to support patients with mental ill health.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. Consultant rotas were arranged so there was consultant cover in the department 24 hours a day seven days a week. Out of hours interventional radiology was available for patients who presented with an emergency. The trust provided diagnostic radiology such as scans or x-rays 24 hours a day, seven days a week.

Health Promotion

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

The service had relevant information promoting healthy lifestyles. Leaflets about self-support for healthy lifestyles and certain medical conditions and lifestyles were available for patients. Some staff were not sure if this information could be provided in alternative languages.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Urgent and emergency services

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff could clearly describe the correct process for establishing the capacity of patients to make decisions about their care.

Staff understood the use of Deprivation of Liberty Safeguards. Discussion with staff demonstrated they had a good understanding about the use of Deprivation of Liberty Safeguards, and when and how they should apply for a Deprivation of Liberty Safeguard for a patient.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, and they knew who to contact for advice. The mental health liaison team guided the emergency department staff about consent and decision making for patients detained under the Mental Health Act.

Is the service caring?

Good 

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

Compassionate care

Staff treated patients with compassion and kindness and took account of their individual needs. However, staff could not always protect the dignity and privacy of patients.

Staff were responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff responded in a reasonable time to call bells or when called. Not all patients had access to call bells, but those who we talked to said that staff came quickly when called. Patients informed us that they felt staff were doing their best to help them, despite the pressures they were under.

Patients said staff treated them well and with kindness. Out of 18 patients,17 said they had experienced good care and compassion during their time in the department, despite the long waiting times. Patients described the staff as being patient, friendly, caring, and considerate to their needs and wishes. Members of staff were observed introducing themselves by name, speaking with patients in a respectful manner and asking each patient if they needed a drink.

Urgent and emergency services

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff were observed giving sensitive one to one care to patients needing additional support. One to one care was given to those with mental health needs, dementia, and those with high falls risk. There were three side rooms available to patients who needed a quieter space. Staff had access to a dementia box and fiddle blankets if needed to support patients with additional needs.

Patient's privacy and dignity were not always respected. The design of the department meant that discussions between the medical staff and patients were not always confidential and discreet. Other patients could see and hear discussions between patients and the medical staff due to insufficient space within the department. Due to patients being treated and waiting in the corridors of the department, their dignity was compromised.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Out of 18 patients,17 told us they felt supported and fully informed about their treatment. They felt able to ask questions about the care they were receiving.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Relatives called and booked a time to visit their relatives to support them. Staff made allowances for patients with additional needs, who needed their relatives to accompany them for longer periods of time. Volunteers helped with non-clinical roles. We observed a volunteer helping a patient to contact their relatives and spending time with a patient who needed emotional support.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. A member of staff told us of training that she had received about delivering bad news. We observed members of staff discussing bad news with a patient in a compassionate manner, giving time for the patient to ask questions and ensured they were fully informed of all options.

Although staff supported patients who became distressed in an open environment, the design and layout of the department meant that their privacy and dignity could not always be respected. During the inspection, one patient became distressed and staff acted quickly to support them. Staff told us that the Mental Health room was not used very often, as it was out of the way.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. All patients that we spoke to felt involved in their treatment plans and were able to ask questions. Relatives told us that they felt involved and fully informed in the treatment plans of their loved ones.

Staff talked to patients in a way they could understand, using communication aids where necessary. If required, a translator service was used for patients who need it. Staff were able to give examples of occasions when this was used.

Urgent and emergency services

Is the service responsive?

Requires Improvement 

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

Service delivery to meet the needs of local people

The service was not able to plan and provide care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The planning and organisation of the service did not fully meet the needs of the local population. The needs of patients in the local community with mental health conditions were not fully met. The local population had a known significant number of people with mental health conditions. Due to the national shortage of mental health inpatient beds, patients presenting to the emergency department with a mental health crisis frequently were accommodated in the short stay area of the department for several days and in some cases for up to two or three weeks. Although some action had been taken to meet the needs of these patients, such as the provision of a mental health liaison service and employment of agency registered mental health nurses, the service was not planned to meet the ongoing needs of these patients.

The service had escalated their concerns and sought assistance from the integrated care system. They had escalated that the emergency department was not the right place to meet the clinical needs of this patient group and that challenges about lack of mental health inpatient beds could not be addressed by the acute trust.

However, there were some examples of the service acting to meet the needs of the local population. Patients arriving by ambulance were triaged by emergency department staff to identify which area of the department they needed treating in. Patients presenting to the emergency department independently were reviewed by a navigator nurse and directed to the most appropriate service in the emergency department for their presenting condition. This included the use of the recently opened urgent treatment centre where patients were seen and treated by either an emergency nurse practitioner or a GP.

The short stay areas of the urgent and emergency care service accommodated mental health patients waiting for mental health inpatients beds. Data provided by the trust showed that the average length of stay for these patients was 52 hours, though staff said some mental health patients experienced stays of up to three weeks.

There was a dedicated mental health room for the assessment of mental health patients. Staff said this room was predominantly used as a place of safety (section 136 suite) for patients in a mental health crisis by the police using their emergency powers under section 136 of the Mental Health Act when there was no other availability of section 136 suites. Staff said this room was rarely used for assessment of other mental health patients, as it was felt it was too out of the way and not always the best environment to assess a patient if they were not demonstrating harmful behaviours.

Staff could access emergency mental health support seven days a week for patients with mental health problems, learning disabilities and dementia. There was a mental health liaison service provided by another NHS trust. Staff form the team reviewed any mental health patients in the department daily. Staff had access to a dementia nurse and to a learning disability liaison service to give support and guidance with the care of patients.

Urgent and emergency services

Meeting people's individual needs

Not all facilities and premises were appropriate for the services being delivered. Patients individual needs and preferences were not fully considered and met. However, staff made some reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The environment did not allow staff to fully meet patients' individual needs. There was one cubicle in the majors area allocated for consultation with 'corridor' patients. Patients were wheeled in and out of this cubicle for consultations and examinations. This cubicle was also the only cubicle available for patients to have personal care needs attended to. Staff spoke about frequent occurrences when patients' personal needs could not be met, because the one cubicle allocated for this purpose was occupied. Staff said this resulted in some patients being incontinent of urine or faeces.

The department was not designed to meet the needs of patients living with dementia. The environment throughout the emergency department was not dementia friendly. However, staff did have access to the support of a dementia nurse and access to equipment such as sensory blankets to offer meaningful activity and decrease agitation and anxiety levels of patients living with dementia.

There was no natural daylight in the short stay areas. Staff expressed concern about mental health patients being accommodated in this area. They expressed concern that the lack of daylight and the low ceilings which gave an oppressive feeling to the unit did not help patients mental health. There were hand washing basins in the toilet areas, but no shower facilities. The service said patients could access shower facilities on a neighbouring ward if they wished. Staff supported patients living with mental health problems to receive care to meet their needs. Staff and patients had access to a mental health liaison service that was provided by another NHS trust. Patients with mental health conditions accommodated in the short stay areas whist waiting for a mental health in patient bed were reviewed daily by the mental health liaison team. The management of their conditions was shared by the emergency department medical staff and the mental health liaison team. Staff said a member of the team bought some activities, such art and craft materials, and printed out activities such as sudoku and cross words to provide some activities for patients. However, patients did not have access to radio or televisions in this area.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Some staff gave examples where they had made reasonable adaptions in communicating with patients who were lip readers. Staff removed their face mask so the patient could lip read and understand what was being discussed with them.

The service did not have information leaflets available in languages spoken by the patients and local community. Information leaflets for patients were only in English and staff were unsure how these could be provided in alternative languages.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff could access translation services which included British Sign Language.

Access and flow

People were not always able to access care and treatment in a timely way and in the right setting.

Urgent and emergency services

Facilities and premises did not meet the needs of the number of patients attending the department. Demand for services frequently outstripped the availability of appropriate clinical spaces to assess, treat and care for patients. Patients were frequently cared for in non-clinical spaces and there were regular occurrences of patients being held in ambulances outside the department due to lack of capacity to accommodate them.

Patients experienced delays in accessing emergency services, but mostly received treatment within agreed timeframes and national targets. There were regular occurrences of patients being held in ambulances outside the department due to lack of capacity to accommodate them. Between April 2021 and March 2022, 9.4% of ambulance handovers at Royal Sussex County Hospital took over 60 minutes and this was higher than at any other hospital attended by the local NHS ambulance trust.

Patients frequently had to stay longer in the department than they needed to. 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. Between February and May 2022, the department failed to meet this standard with between 46% and 56% of patients spending less than four hours in the department. However, this was lower (better) than the England average of 72% for this period.

Across all the trust's emergency departments the trust's monthly percentage of patients waiting more than four hours from the decision to admit was getting worse (April 2021 less than 10%, March 2022 35%), but was below the England average. The figure for patients waiting more than four hours from the decision to admit for Royal Sussex County Hospital for the period February 2022 to May 2022 was between 46% and 56%.

Across all the trust's emergency departments the number of patients waiting over 12 hours for admission after the decision to admit had got worse. It had deteriorated from no patients in February 2021 to 772 patients waiting for over 12 hours in March 2022. We did not have figures for patient experience at Royal Sussex County Hospital. However, on the day of inspection we identified a minimum of five patients who had waited more than 12 hours from the decision to admit to being admitted. One patient had been waiting over 20 hours to be admitted.

There was a number of patients leaving the service before being seen for treatments. Across all the trust's emergency departments the number of patients leaving the department before being seen between April 2021 and March 2022 ranged from 4% to 7%. This was worse than the national average.

However, the service had acted to make some improvements to the flow of patients through the emergency department. An urgent care treatment centre had recently been opened. Patients were triaged on arrival to the department, and if their conditions were suitable, they were directed to the urgent treatment centre to be seen by either a GP or an emergency nurse practitioner. *O*n average, 31% of attendances at Royal Sussex County Hospital emergency department were streamed to primary care, from mid-January to mid-May 2022. This was higher (better) than the England average of 16.8%.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The hospital website gave clear directions abut who to raise a concern or complaint. However, there was no information displayed in patient areas in the department.

Urgent and emergency services

Staff understood the policy on complaints and knew how to handle them. Staff had access to the trust's complaints policy and process to prompt them to manage complaints.

Managers investigated complaints, identified themes and learning was used to improve the service. Staff described themes form complaints, such as communication and pain management and described the actions being followed to make improvements in these areas.

Is the service well-led?

Good  

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The emergency department was part of the acute floor directorate which was led by multi professional triumvirate which included an operational manager, medical consultant and directorate lead nurse.

Department staff said they were well supported by their immediate managers who understood and managed issues the department faced. We observed good leadership in the department with leaders giving clear directions and support to junior colleagues However, staff expressed that trust senior leaders did not always fully understand the challenges, issues and risks to the service.

Staff were encouraged and supported to develop their skills and take on more senior roles. The trust had leadership programmes and the department supported staff to develop. This included band 7 staff development by taking on rotating lead roles for sepsis, recruitment, incidents and governance and safeguarding.

Vision and Strategy

Staff did not have confidence in how the trust vision and strategy supported the development of the emergency department.

The trust had vision of excellent care, every time, with the overarching purpose of the patient being first. This was supported by the trust's values and strategic themes. Staff across the emergency department knew about the vison and strategy. However, they felt it was remote to the current experience for patient's receiving care and treatment in the department. They demonstrated in their conversation their commitment to the vision but expressed frustration at not being able to deliver the vision. They expressed a lack of belief, considering the challenges experienced by the emergency department, that trust leaders were demonstrating their commitment to the vision.

Culture

Urgent and emergency services

Staff felt respected, supported and valued by their immediate leaders. Staff were focused on the needs of patients receiving care. The service provided opportunities for career development.

Staff felt valued and supported by their immediate managers and spoke highly of their jobs. They said there was good teamwork and peer support. Several staff said engagement and communication was the best they had experienced in their careers. Staff gave examples where their immediate leaders positively considered their wellbeing.

The service provided opportunities for career development. All staff spoke highly of the educational team. Senior nurses were given opportunity to develop by taking on lead roles such as recruitment and governance.

Staff and their leaders were focused on the needs of patients receiving care. This was demonstrated by the service carrying out additional tests, such as blood tests when patients were initially triaged from ambulances, to reduce risk of harm to patients from delays of accessing the service and the use of volunteers to ensure patients received food and drinks. However, some staff felt the senior leadership of the trust did not fully understand the challenges the department faced daily.

Some staff expressed emergency department staff across all the trusts emergency departments were not treated equally by the trust. This related to inequity of locum staff payments across the trust's emergency departments.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were governance structures within the trust with representation from all disciplines. The acute floor meetings fed into the medicine division meetings which followed the trust wide governance structure to report to the executive board. Meeting records evidenced collaboration with the NHS ambulance trust with monitoring, managing and reducing ambulance waiting times at the hospital.

There was a clear governance structure within the acute floor. Monthly meetings took place at all levels to discuss key risk and performance issues. Meeting minutes for the acute floor directorate meetings showed them to run to a set agenda and were clearly recorded. Actions could be tracked, and an action log showed they had been completed. However, not all meetings were recorded. Essential messages from these meetings were conveyed to staff through email correspondence.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Risks were recorded at department, division and trust level. Most staff identified their top risks as the negative impact on wellbeing confidentiality and dignity the environment had on the patients. Review of the department's risk register echoed staff view of risks. The top risks recorded concerned the practice of corridor care, staffing and assault/aggression to staff.

Staff used an electronic auditing programme to monitor minimum safety standards and compliance with trust policy, such as medicine management, safe storage of records, equipment and cleaning processes and equipment. Records provided by the service for the months of March and April 2022 showed the department had scored 100% in all areas assessed. However, the service did not provide any information about how they used audit results to improve outcomes for people using the service.

The service had business continuity plans, which included action cards for staff to follow in the event of situations such as loss of power, lack of staff and failure of equipment.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected, analysed, managed and used information to support its activities, using secure electronic systems with security safeguards. The trust's website provided annual quality performance reports and board reports which included data about performance. This gave patients and members of the public a range of information about the safety and governance of the hospital. Senior leaders had confidence that data was accurate and reliable.

The department had computer terminals to allow staff to access electronic records, test results and trust policies and procedures. All staff had individual log on passwords and all terminals were locked when not in use.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Leaders encouraged staff to share ideas for improvement. Staff said they were encouraged to suggest ideas for improvement, and they would be actioned where practicable.

The service had collaborated with external NHS providers to support safe care and improvements to the service and for patients. This included working with the local mental health NHS trust and the local ambulance NHS trust.

There was no forum currently that the service used to formally engage with patients, equality groups or public and local organisations.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

Urgent and emergency services

Staff were committed to continually learning and improving services. Staff expressed that their ideas were listened to and acted upon where practicable. This included a simple laminated card located next to telephones giving the detail staff needed to share when making an emergency call for a deteriorating patient. Areas for improvement were identified from incidents and issues, such as a falls project and the development of a bespoke nursing document for the short stay areas to address nutrition, hydration and skin integrity for patients who were accommodated over 24 hours.

Areas for improvement

MUSTS

Royal Sussex County Hospital Urgent and Emergency Care

The trust must ensure that action is taken to improve the environment of the emergency department to ensure it is suitable for its use and protects patients' privacy and dignity. (Regulation 15)

The trust must ensure that all areas of the department can be cleaned effectively. (Regulation 12)

The trust must ensure that staff complete appropriate lifesaving training. (Regulation 12)

The trust must ensure that staff complete required safeguarding training. (Regulation 12)

The trust must ensure all patients are cared for in designated patient areas. (Regulation 12)

The trust must make sure patients with mental health illnesses accommodated in the emergency department receive care and treatment from staff who have the relevant skills and experience. (Regulation 12)

SHOULDS

Royal Sussex County Hospital Emergency and Urgent Care

The trust should ensure that staff compliance with mandatory training meets the trust target. (Regulation 12(2)

The trust should ensure that completion of staff appraisals meets the trust target. (Regulation 18(2)

The trust should ensure the practice of open notes trolleys in the department does not pose a risk to patient confidentiality. (Regulation 17)

The trust should consider improving the environment to meet the needs of people living with dementia.

The trust should consider introducing a structured approach to share learning form incidents.

The trust should consider improving the facilities for relatives.

Our inspection team

The team that inspected the service comprised of three CQC lead inspectors and three specialist advisors. The inspection team was overseen by Carolyn Jenkinson Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Surgical procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures	S12 Notice of Decision to impose a condition of registration

Health Overview & Scrutiny Committee

Agenda Item 17

Subject: **Care Quality Commission Inspection Report on Urgent & Emergency Services at the Royal Sussex County Hospital**

Date of meeting: **19 October 2022**

Report of: **Executive Director, Governance, People & Resources**

Contact Officer: **Name: Giles Rossington**
Tel: 01273 295514
Email: giles.rossington@brighton-hove.gov.uk

Ward(s) affected: **All**

For general release

1. Purpose of the report and policy context

1.1 This report presents information (including material submitted by University Hospitals Sussex NHS Foundation Trust: UHSussex) on the recent Care Quality Commission (CQC) inspection of Urgent & Emergency services at the Royal Sussex County Hospital (RSCH), and on UHSussex actions in response to the inspection report requirements and recommendations.

2. Recommendations

2.1 That Committee notes the contents of this report on the CQC inspection of Urgent & Emergency services at the Royal Sussex County Hospital.

3. Context and background information

3.1 The Care Quality Commission (CQC) is the national independent regulator and inspector of NHS services. In April 2022, the CQC undertook an inspection of Urgent & Emergency services at the Royal Sussex County Hospital, Brighton (RSCH). The CQ published an inspection report in July 2022. The inspection report published by the CQC includes information on both the inspection of RSCH Urgent & Emergency services and the reinspection of RSCH surgery and maternity services (the inspection report as included as an appendix to the HOSC item on the maternity and surgery reinspection rather than being included as an appendix to both reports).

3.2 The CQC identified a number of problems in urgent & emergency services, including:

- Not all staff completing mandatory training/appraisal
- Patients being regularly accommodated in non-clinical areas unsuitable for clinical care, particularly in terms of providing an

appropriate environment for people with mental health problems, and an environment that could be effectively cleansed to minimise infection risk.
- The Needs of people with mental health problems were not fully met, with vulnerable people accommodated for lengthy periods of time in an environment that did not fully meet their needs, and supported by staff without a specialist understand of mental health.
- Delays in access, with poor patient-flow through the hospital causing ambulance handover delays. The Trust regularly exceeded the four and 12 hour emergency care waiting targets.

3.3 Despite these problems, the CQC identified good practice across urgent & emergency services. This included:

- Good risk-assessment and medicines-management and safety incidents managed well despite the pressures the department was under.
- Emergency care was safe, with patients given food and drink and pain medication where appropriate. Staff worked together well in difficult circumstances.
- 24/7 specialist support was on hand including specialist mental health support.
- Staff consistently treated patients with compassion and kindness.
- Staff felt valued, supported and listened to by their immediate leaders.
- The Trust has good relations with external NHS partners, including the local ambulance and mental health trusts.

3.4 As a consequence of its findings, the CQC downgraded RSCH urgent & emergency care from ‘good’ to ‘requires improvement’, although elements of the rating, including the quality of leadership remain as ‘good’. The CQC also required some improvements to be implemented urgently. These include:

- Improve the emergency department environment to ensure that all patients have their privacy and dignity respected.
- Ensure that all areas of the emergency department can be thoroughly cleaned.
- Ensure that all staff complete the appropriate life-saving and safeguarding training.
- Ensure that all patients are cared for within designated patient areas.
- Ensure that all patients with mental health problems are cared for by staff with relevant skills and experience.

3.5 Information on the Trust’s response to the above requirements, and its general plans for improving urgent and emergency care are included in Appendix 1 to this report.

4. Analysis and consideration of alternative options

4.1 Not relevant to this report for noting.

5. Community engagement and consultation

5.1 Not relevant to this report for noting.

6. Conclusion

6.1 Members are asked to note information concerning the recent CQC inspection of urgent & emergency services at RSCH and the Trust's plans to improve services in response to the CQC's findings.

7. Financial implications

7.1 None identified for this report to note.

8. Legal implications

8.1 No legal implications identified in this report.

Name of lawyer consulted: Elizabeth Culbert Date consulted 01.10.22

9. Equalities implications

9.1 None directly for this report to note. Members may be interested in exploring how the Trust ensures that urgent and emergency services can be accessed by people from protected groups, perhaps particularly people with mental health problems.

10. Sustainability implications

10.1 No direct implications identified.

Supporting Documentation

Appendices

Please note that the appendix to item 16 (CQC Inspection of maternity and surgery at RSCH) provides information on both item 16 and item 17: CQC inspection of urgent & emergency services at RSCH.

Brighton & Hove City Council

Health Overview & Scrutiny Committee

Agenda Item 18

Subject: **3Ts Redevelopment of the Royal Sussex County Hospital**

Date of meeting: **19 October 2022**

Report of: **Executive Director, Governance, People & Resources**

Contact Officer: **Name: Giles Rossington**
Tel: 01273 295514
Email: giles.rossington@brighton-hove.gov.uk

Ward(s) affected: **All**

For general release

1. Purpose of the report and policy context

1.1 This report provides an update on the redevelopment of the Royal Sussex County Hospital (3Ts). Information on the 3Ts development, provided by University Hospitals Sussex NHS Foundation Trust, is included as Appendix 1.

2. Recommendations

2.1 That Committee notes the information included in this report on the progress of the 3Ts redevelopment.

3. Context and background information

3.1 The Royal Sussex County Hospital (RSCH) is the main general hospital for Brighton & Hove residents, and for significant numbers of people living in East and West Sussex. RSCH also provides more specialist (tertiary) services across Sussex and the South East of England. The RSCH is managed by University Hospitals Sussex NHS Foundation Trust (UHSussex), which also manages hospitals in Hayward's Heath, Worthing and Chichester.

3.2 The RSCH is located on Eastern Road in Brighton. The site consists of a variety of buildings of different ages, and it had long been recognised that some of the estate was no longer fit for purpose – particularly the buildings at the front of the hospital, some of which dated from the 1820s. A significant redevelopment of the RSCH had been mooted for a number of years, and funding was eventually secured for a major transformation of the site which began in 2016. This was a C £500 million project, funded directly by the Treasury (rather than from NHS capital funding), representing one of the most significant hospital developments in England in recent years.

3.3 The redevelopment is called ‘3Ts’: trauma, teaching and tertiary care, and the project supports ed the RSCH as a regional Major Trauma Centre, enhances undergraduate and graduate teaching capacity, and improves specialist services such as critical care, cancer care and neurosciences. However, 3Ts is not just about specialist services: the initiative will see substantial improvements to more than 40 RSCH wards and departments and will significantly enhance patient experiences of the hospital.

3.4 As the 3Ts project nears completion, the Chair has asked UHSussex to present an update on the development. Members may be particularly interested in:

- The date(s) when various aspects of 3Ts will be completed and new facilities are open to patients.
- How the 3Ts redevelopment will offer better tertiary/specialist services for people across Sussex and the South East.
- How the 3Ts development will impact on Brighton & Hove residents requiring standard acute hospital services.
- How 3Ts will help UHSussex recruit and retain a high quality workforce.
- How 3Ts will help the local health and care system manage system pressures, particularly in terms of pressures on the A&E department and on waiting times for elective procedures.

4. Analysis and consideration of alternative options

4.1 Not applicable to this report for noting.

5. Community engagement and consultation

5.1 Not applicable to this report for noting.

6. Conclusion

6.1 Members are asked to note the progress of the 3Ts development

7. Financial implications

7.1 None to this report for noting.

8. Legal implications

8.1 No legal implications have been identified.

Name of lawyer consulted: Elizabeth Culbert Date consulted 01.10.22

9. Equalities implications

9.1 None directly to this report for noting. Members may be interested to explore with UHSussex how the needs of protected groups have been accounted for in terms of the design and delivery of 3Ts.

10. Sustainability implications

10.1 None directly to this report for noting. Members may be interested to explore with UHSussex, what the environmental impact of 3Ts is likely to be: e.g. in terms of the sustainability of new estates and how the redevelopment is supporting sustainability improvements on the wider hospital site.

Supporting Documentation

1. Appendices

1. Information provided by UHSussex

University Hospitals Sussex
NHS Foundation Trust

3Ts Hospital Development

BHCC Health Overview and Scrutiny Committee

19 October 2022

Karen Geoghegan, Chief Financial Officer
Peter Larsen-Disney, Clinical Director for 3Ts Programme

A new hospital in the heart of Kemptown

3Ts - introduction

The Full Business Case for the provision of new acute hospital estate at the Royal Sussex County Hospital, Brighton was approved in 2015 and supports delivery of a new regional **Teaching, Trauma and Tertiary Care (3Ts) Centre to support patients across all of Sussex.**

- The Programme is in 3 distinct phases: Stage1, 2 and 3
- The total capital cost is 0.£7bn across all 3 stages
- Provides 100 more beds on Brighton site
- Laing O'Rourke are the appointed contractor for all 3 stages of the build programme
- 3Ts is part of the 40 Hospitals programme, now overseen by the New Hospitals Programme team

Redeveloping the hospital estate

- Pre-Stage 1: decant and site diversions
- **Stage 1** – Replacement of Barry Building, enhance Major Trauma Centre facilities for Sussex incl critical care and helideck
- **Stage 2** – Replacement and expansion of Cancer Centre for Sussex
- **Stage 3** – Site-wide Logistics Centre

Building commenced

Stage 2 Cancer Centre opens

2015 | 2016 | 2023 | 2025 | 2026

Full business case approved

Stage 1 opens for patients

Stage 3 Logistics Centre opens

Stage 1 – four phases to completion

University Hospitals Sussex NHS Foundation Trust

Nov 22	Nov 22 – Jan 23	Feb 23 – March 23	March 23 – Aug 23
Capital Development	**Pre-Occupation**	**Move**	**Decommissioning / 100-day plan**
Handover 22 November Snagging and defects corrected Safety checks	13-week programme Equipping and stocking Staff familiarisation and training	3.5 week moving programme Safety checks	Decommissioning of buildings to enable Stage 2 subject to approvals Realising the benefits of Stage 1

Stage 1 - Facts and Figures

University Hospitals Sussex NHS Foundation Trust

More than one million patients, visitors and staff will be passing through the hospital's new Main Entrance and Welcome Space every year

- The Welcome Space is more than twenty times bigger than the current main entrance of the hospital.
- Stage 1 has an internal floor area of 62,375m2 – that's four times the size of the Royal Alexandra Children's Hospital
- 32 wards and departments that provide direct patient care will move into Stage 1
- Every year, more than 100,000 patients will receive care in the new building.
- There are 11 storeys above ground and two basement levels, including a car park for patients and visitors

Main reception desk in the Welcome Space

Stage 1 - Benefits

Better for inpatients

- Five times more space around each bed
- 65% single ensuite rooms
- Remainder are in 4-bed bays
- Most rooms have stunning sea views
- More clinic space enables more ward-based treatments
- New lounges and private space for patients and visitors

Better for outpatients and visitors

- Clinics located on the lower floors to improve access
- Larger and more comfortable waiting areas
- Privacy and dignity improvements
- Improved retail and catering facilities
- Improved access from underground car park
- New bus stop and pedestrian crossing near entrance
- Direct links to Thomas Kemp Tower on levels 5, 6 and 7

Medical ward four bed bay

Fracture clinic reception

Stage 1 - Benefits

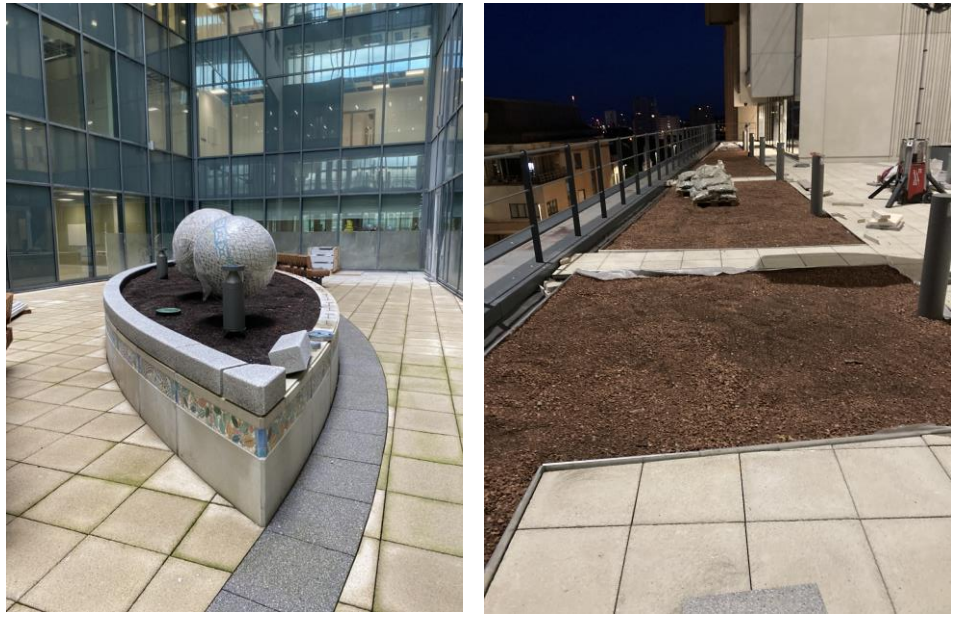
Better for staff

- Many new career pathways and opportunities
- More than 125 new jobs in Facilities and Estates, including house-keeping, porters and estates
- New roles for nurses, healthcare assistants and allied health professionals such as physios, radiographers and dietitians
- Improved staff welfare facilities such as changing rooms, lockers and showers
- Dedicated meeting and teaching suite

Critical Care staff review patient equipment

Better for the environment

- Planting 29 trees and 1400 shrubs and perennials
- Seeding 450m2 to grass and wildflowers
- Installing more efficient boilers for the Thomas Kemp Tower, Millennium Wing and A&E Building

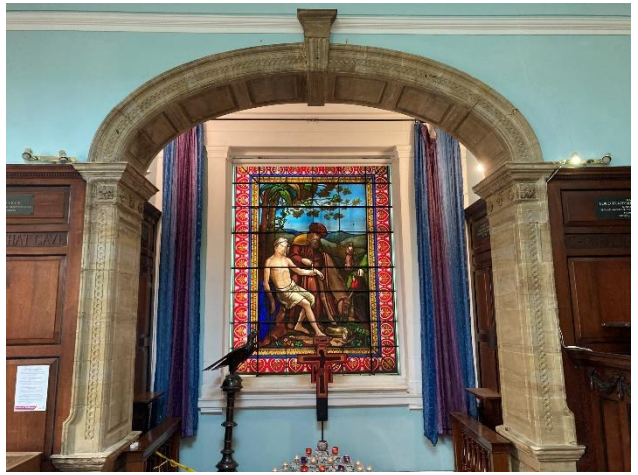


Green spaces on Levels 1 and 4

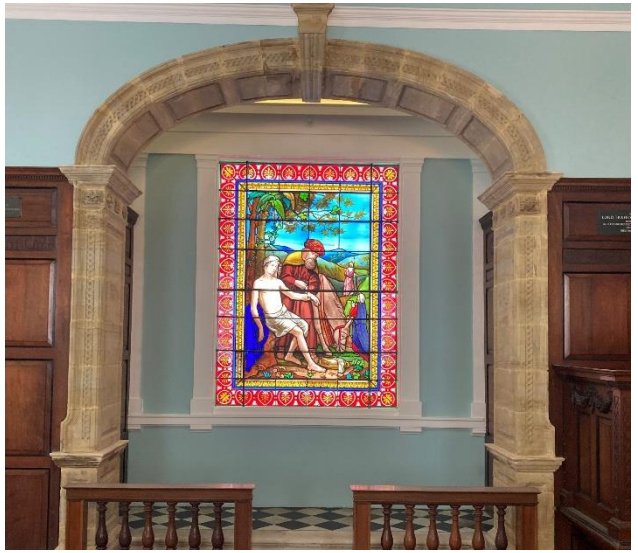
A new building that preserves the best of the old

University Hospitals Sussex NHS Foundation Trust

- Preserving links to the 194-year history of the hospital is an important part of the 3Ts Redevelopment
- This is typified by the completed relocation of the 165-year-old Chapel from the Barry Building (the oldest acute ward building in the NHS) to its new home in the Stage 1 Building
- Every brick, panel, brace and windowpane was recorded, numbered, stored off site and then reinstalled in the Chapel's new home in Stage 1
- It is at the end of the Welcome Space on Level 1 and easily accessible to everyone
- Along with the Sanctuary on Level 6, it will be available for services as well as welfare and social events, meetings, and to play a part in the heritage story of the hospital

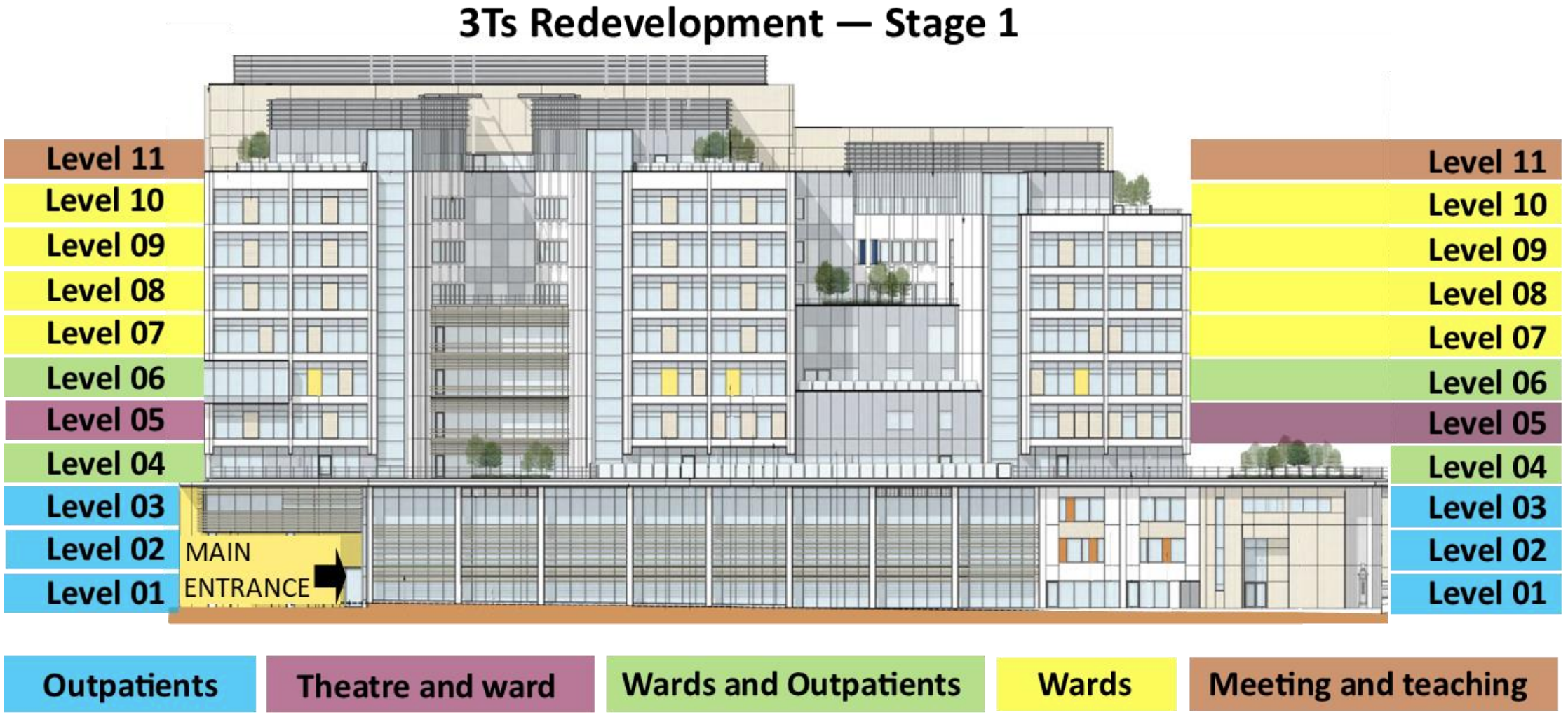


2020 in the Barry Building



Chapel relocated in 2022

Stage 1 – clinical focus by floor



Clinical facts and figures

NHS
University Hospitals Sussex

Inpatient facilities

- 7 inpatient wards
- 256 inpatient beds
- 65% single rooms with their own bathrooms
- Large 4-bed bays
- Treatment rooms

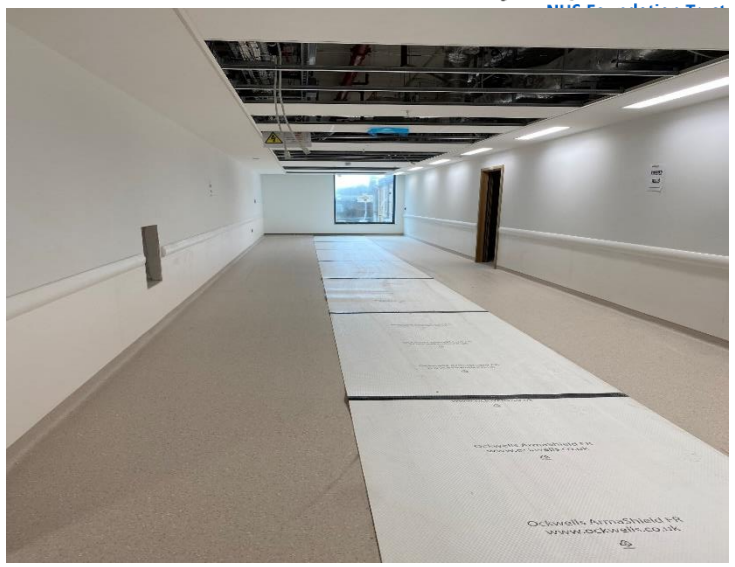
Outpatients

- 7 outpatient departments
- Inpatient rehabilitation gym

Theatres

- 4 operating theatres
- 3 interventional radiology suites

Medical ward reception area



Inpatient transfer corridor

Single en-suite room

Maxillo-facial dentistry room

Clinical facts and figures

University Hospitals Sussex NHS Foundation Trust

Critical Care

- 31 critical care beds
- Co-location of critical care services

Diagnostic Radiology

- 3 MRI scanners – including intra-operative MRI
- 2 CT scanners
- 3 X-Ray/fluoroscopy rooms
- 2 Ultrasound rooms

Nuclear Medicine

- 1 x PET Scanner
- 2 x SPECT CT scanner
- 1 x heart scanner

Neurosurgery intraoperative MRI

Critical Care ward station (west)

Critical Care bay with pendants fitted

Clinical Benefits

University Hospitals Sussex NHS Foundation Trust

New models of care and clinical pathways;

- Expanded acute floor with direct links to Emergency Department
- New Short Stay Medicine Ward adjacent to Emergency Department
- New respiratory ward to manage patients with complex respiratory disease
- New care of the elderly ward including a dementia unit and an acute frailty unit
- Planned Investigation Unit enables patients requiring complex investigations to be treated as day cases
- Improved facilities for patients with complex strokes
- Helideck will reduce patient transfer times to the Major Trauma Centre
- Reduced patient transfers through co-location of clinical services

Current Discharge Lounge

New Discharge Lounge

3Ts Communication and Engagement

University Hospitals Sussex NHS Foundation Trust

Hospital Liaison Group meetings

- Regular meetings since 2009
- Open to anyone living or running a business within ¼ of a mile of RSCH
- Focuses on the 3Ts Redevelopment and other operational matters
- Use of social media and distribution lists with local groups and residents

Share A Name initiative

- Patients, members of the public and staff were invited to suggest a name for the Stage 1 Building
- 690 names were received
- The Board will choose the final name from a short list of suggestions

Rolling programme of onsite visits

- Members of HOSC will be invited before the end of the year

Next Steps

University Hospitals Sussex NHS Foundation Trust

Developing opportunities

- Bringing together clinical services into the Stage 1 building frees up clinical space for other developments and improvements across the whole of the University Hospitals Sussex
- Develop estates masterplan for the Royal County Hospital site to take advantage of capacity unlocked by Stage 1 that will help us improve a range of other services for patients
- Scoping and planning work for improvements to the Emergency Department at Brighton are already underway
- Planning for new Cancer Centre (Stage 2) is underway
- Opening of the new helideck on Thomas Kemp Tower in 2023 will improve care for major trauma patients
- Collaboration with Brighton and Sussex Medical School and other partners to expand teaching and training opportunities

111

Thank you

University Hospitals Sussex NHS Foundation Trust

Q&A

Karen Geoghegan, Chief Financial Officer

Peter Larsen-Disney, Clinical Director for 3Ts Programme