Brighton & Hove City Council

Health Overview & Scrutiny Committee

Date: **26 January 2022**

Time: **4.00pm**

Venue **Council Chamber, Hove Town Hall**

Members: **Councillors:** Moonan (Chair), Deane (Group Spokesperson), McNair (Group Spokesperson), Brennan, Grimshaw, John, Lewry, Meadows, West and Wilkinson
Invitees: Frances McCabe (Healthwatch), Caroline Ridley (CVS Rep), Michael Whitty (Older People's Council)

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16 APOLOGIES AND DECLARATIONS OF INTEREST

17 MINUTES — **7 - 16**

To consider the minutes of the last meeting held on the 24th November 2021 (copy attached)

18 CHAIRS COMMUNICATIONS

19 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 12th January 2022;
(b) **Written Questions:** to receive any questions submitted by the due date of 12 noon on the 21st January 2022;
(c) **Deputations:** to receive any deputations submitted by the due date of 12 noon on the 21st January 2022.

20 ITEMS REFERRED FROM COUNCIL

21 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.

22 CARE QUALITY COMMISSION INSPECTION REPORT: UNIVERSITY HOSPITALS SUSSEX MATERNITY AND SURGERY SERVICES AT THE ROYAL SUSSEX COUNTY HOSPITAL — **17 - 68**

Report of the Executive Lead, Strategy, Governance & Law (copy attached)

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

23 YOUNG PEOPLE'S MENTAL HEALTH SERVICES — **69 - 112**

Report of the Executive Lead, Strategy, Governance & Law (copy attached).

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

24 COVID UPDATE PRESENTATION

Presentation from Public Health, Adult Social Care and NHS Commissioners on the latest situation regarding the Covid emergency (verbal).

25 HOSC WORK PLAN **113 - 114**

To consider and discuss the Health Overview & Scrutiny Committee 2022/23 Work Plan (copy attached).

Date of Publication - Tuesday, 18 January 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 24 NOVEMBER 2021

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Moonan (Chair)

Also in attendance: Councillor Deane (Group Spokesperson), McNair (Group Spokesperson), Brennan, Grimshaw, John, Lewry and West

Other Members present: Frances McCabe (Healthwatch)

PART ONE

8 PROCEDURAL BUSINESS

8.1 Apologies were received from Cllrs Wilkinson and Meadows.

8.2 There were no declarations of interest.

8.3 There were no substitutes.

8.4 **RESOLVED –** that the press & public be not excluded from the meeting.

9 MINUTES

9.1 The draft minutes of the 14 July 2021 committee meeting were agreed.

10 CHAIR'S COMMUNICATIONS

10.1 This meeting of HOSC should have taken place on 13th October. Unfortunately we had to postpone the original meeting because the Council Chamber was unavailable due to another meeting taking much longer than anticipated.

The agenda for today's meeting is largely the same as for the October meeting. However, one item has dropped off: this is the report on plans to re-commission Sussex Sexual Abuse Referral Centres (SARC). I've taken this report off because NHSE commissioners have informed me that they have temporarily halted their plans to re-design services, and will seek to extend contracts with the current SARC providers for another 18 months. When revised long term plans for SARC services do become available, they will be brought to the HOSC for consideration.

An item that is featured today, but that wasn't on the original agenda is Cllr Grimshaw's question about Child & Adolescent Services for children with autism. This is an important issue, and one we will explore in more depth with commissioners and providers of children's mental health services at our January 2022 HOSC meeting.

Re-scheduling a meeting at relatively short notice inevitably causes inconvenience for members and officers from the council and NHS partners. I'd like to thank everyone who had to make adjustments so they could attend today's meeting. Unfortunately, some NHS colleagues have urgent meetings that overlap with the HOSC and won't be able to join this meeting until 5pm. Depending on how swiftly we move through the agenda, I may need to call a brief pause in the meeting to accommodate this.

Finally, Covid infection rates remain worryingly high, both locally and nationally. Covid boosters are now available for over 50s, health & social care workers and those with underlying health conditions. If you're eligible and it's been 6 months since your 2nd jab you can book your booster online on the national booking system or by calling 119. Walk-in boosters are also currently available every day for those that are eligible from the vaccination centre at Churchill Square. Please check www.sussexhealthandcare.uk/get-my-jab

It's also not too late to get your first or second dose. Vaccinations can be booked or walk-in locations are available every day across the city.

11 PUBLIC INVOLVEMENT

11.1 Mr Ken Kirk asked the following question:

"Worries about NHS under an ICS are ….

1. Rationing of care - owing to specified financial limit, care will be limited, possibly denied, quality downgraded;
2. More privatisation without transparency, see HSSF's list of mainly private companies https://www.england.nhs.uk/hssf/supplier-lists/#shared-or-integrated-care-records
3. Private executives in decision-making positions, despite Bill amendments, can be on place-based committees, IC Partnerships;
4. Patients at risk – removes need for discharge assessment;
5. Deregulation of professions – down-skilling of medical care and 'race to the bottom' on pay/T&Cs.

Some councils have issued demands (a) – spending determined in partnership with LAs, guaranteed full access to services etc.

What action should you take to defend our health services?"

a. See Appendix of https://councillors.knowsley.gov.uk/documents/s71697/HWBB%20SP.pdf?StyleType=standard&StyleSize=none

11.2 The Chair responded:

There are several parts to this question, which raises a number of serious concerns about the current NHS reforms. I am not an expert on the Bill but I have spoken to many system leader locally and done a lot of reading and I can see both advantages and disadvantages in the government proposals.

Regarding financial limits, this has always been the case. CCGs have had spending caps from their inception and sadly rationing of NHS care, in different guises, has been here for many decades. We spend far less a proportion of GDP on health care than most advanced economies and get great value for money. But the real solution is to properly fund the NHS, and I might add social care.

The lack of transparency in procurement is defiantly of concern and I agree it could lead to more and more major contract going to private providers with little openness. It might also lead to more contracts going to NHS providers and the voluntary sector, but this remains to be seen and will require close scrutiny.

Private providers on NHS boards is, I agree, also a cause for concern. But I would say that this is not the only potential conflict of interest in the new Board structure as major NHS providers are also represented on Boards, as is primary care. The potential benefit here is the removal of the internal market which costs so much time and money, and in its place having greater partnership working and commissioning across the whole patient journey, which will lead to better patient outcomes and more cost effective services. The risk is that vested interests have influence on millions of pounds of public money with no improvement in care and privatisation by stealth.
On your concern around discharge assessment, I would say that this has been local practice for a while as you can provide a much better assessment of care needs when someone is back in their own home or care home, than in a hospital bed. Once someone is medically fit to leave hospital it is definitely the best thing to get them out as soon as possible. But discharge to assess only works if there are the right patient pathways in place, adequate step-down services, social workers to carry out the assessment, and providers to cover the new care packages. It is vital the whole system works together with the patient at the centre, which has not always been the case around hospital discharge. When someone vulnerable leaves hospital they need a soft landing as it is only the beginning of recovery.

Finally, you raise a concern about deskilling the workforce and this is another area of the Bill that has caused widespread concern. Closer partnership working with the VCS shouldn't equate to the same service for less money!

You conclude Mr Kirk by asking what HOSC can do about this and the short answer is very little in terms of the primary legislation. There is only passing mention of HOSC in the guidance, but we will continue to work with organisations such as Heath Watch and scrutinise wherever we can.

11.3 Mr Kirk asked a supplementary question, requesting the Chair's views on the establishment of a Sussex Integrated Care Board (ICB) which would potentially have private sector representatives, but only one local authority representative; on the risks of post-discharge assessment leaving vulnerable people without the care they needed; and on new NHS budgeting arrangements which would leave NHS provider Trusts rationing services because they would be unable to run deficits as they can currently.

11.4 The Chair asked NHS and social care colleagues if they wished to respond to these questions. Rob Persey, BHCC Executive Director, Health & Adult Social Care, noted that the Directors of Adult Social Care from all three Sussex upper-tier local authorities would in fact have seats on the ICB. In terms of discharge prior to social care assessment, Discharge to Assess schemes have been in place for several years now and offer better and more holistic assessment of people's care needs than assessment in hospital. The Chair told Mr Kirk that she would be happy to meet him outside the meeting to discuss in more depth the points he raised and to explore ways in which the HOSC might scrutinise these issues.

12 MEMBER INVOLVEMENT

12.1 There was a member question from Cllr Grimshaw: "Mascot has brought the issue of its complaint to Sussex Partnership NHS Foundation Trust (SPFT) to me and asked me to raise at the HOSC."

12.2 In response, the Chair noted that a joint response from SPFT, NHS commissioners and BHCC Families, Children & Schools was included in the committee papers. There is a scheduled item at the January 2022 HOSC meeting on young people mental health, and officers will ensure that this includes information on services for young people with autism.

13 PRESENTATION, HASC COMMISSIONING STRATEGY

13.1 This item was introduced by Rob Persey, BHCC Executive Director, Health & Adult Social Care (HASC). Mr Persey told the committee that a draft Commissioning Strategy had been presented to the Health & Wellbeing Board in 2020. Completion of the Strategy had not progressed as planned, as officers had been required to focus on responding to the Covid emergency. However, the principles of the draft Strategy are being used to inform commissioning – e.g.:

- Partnership & collaboration
- Prevention & empowerment
- Person-centred and outcome focused
- Co-production with service users
- Value for money
- Valuing the workforce.

13.2 Since 2020 the context within which social care commissioning has operated has changed significantly, due to the pandemic, to increased workforce pressures, and to the establishment of an Integrated Care System (ICS), due to go live in April 2022.

13.3 Major commissioning activity in 2022/23 will include:

- Domiciliary Care contract
- Residential/Nursing Care contracts
- Supported Living/Community Support/Day Services contracts
- Community Equipment Service contract

- Knoll House.

13.4 Currently, local authorities across the South East are working to develop a co-ordinated Market Position Statement. The Brighton & Hove HASC Commissioning Strategy will need to reflect, and must therefore follow, the publication of this Statement.

13.5 Fran McCabe asked whether thought had been given to designing seamless services around service users, rather than commissioning discrete services that people had to navigate between. Mr Persey acknowledged the value of this holistic approach and noted that aspects of this type of care were already being commissioned. For example, where people have a temporary placement in a care home setting and then return to their own homes, some care homes have been commissioned for their staff to provide initial homecare support in order to ensure continuity of care. Moving to more holistic commissioning models is complicated by the need to deliver all statutory services and to maintain a sustainable local care market, but commissioners are committed to working with service users and experts by experience to deliver person-centred services.

13.6 Ms McCabe noted that more imaginative models of working might have workforce benefits also. Mr Persey agreed, and told members that a health & care system workforce strategy was being developed at ICS level. This includes identifying new roles that the system requires, looking across health and care services; and also seeking to optimise the capacity of the whole system workforce. BHCC Human Resources are involved in this work as is the Voluntary & Community sector.

13.7 Cllr McNair asked a question about whether the roles of community nurses might change. Lola Banjoko, Brighton & Hove CCG Managing Director, responded that this is being actively considered as part of the development of place-based planning, particularly in terms of providing wrap-around support for patients with complex needs (e.g. multiple Long Term Conditions). The system recognises that there are currently significant staffing challenges in community healthcare.

13.8 In response to a question from the Chair on financial pressures on Adult Social Care, Mr Persey told members that there is less money available in real terms than 10 years' ago, despite an increase in demand and in acuity of need. In recent months there has been increased funding via Government grants and a significant degree of additional support from the local NHS. This has enabled more funding to be passed on to care providers; and there has been really effective working between ASC and the NHS: for example, the joint procurement of care beds. This additional support and funding has been welcome, but short-term and short notice funding does not allow for the proper planning of services; what is required is a long-term ASC funding settlement.

13.9 In reply to a question from the Chair about capacity within the HASC Commissioning team, Mr Persey told the committee that HASC is working closely with BHCC Families, Children & Schools and with NHS commissioners to align commissioning activity. It is currently too early to say what if any additional capacity may be required in HASC commissioning.

13.10 In answer to a question from the Chair about co-production, Mr Persey told members that officers are seeking to identify best practice in current commissioning in order to embed this in the new strategy.

13.11 The Chair asked what care workforce problems are specific to Brighton & Hove, rather than just shared issues nationally. Mr Persey responded that Brighton & Hove has a large hospitality and retail sector which can attract care workers as pay and conditions in hospitality and retail may be better than in care. Also, the city care market is made up of a large number of small providers. This means that providers are not always able to provide the staff training that larger providers could, with the council having to offer additional support. In addition, organisational staff career pathways may be limited for small providers; the system needs to think about how to offer career progression in order to retain staff in the sector.

14 SUSSEX-WIDE WINTER PLAN 2021/22

14.1 This item was introduced by Rob Persey, BHCC Executive Director, Health & Social Care; Lola Banjoko, Managing Director, Brighton & Hove CCG; Dr Sarah Richards, CCG Medical Director; Becky Woodiwiss, Public Health Principal; and Ben Stevens, University Hospitals Sussex (UHS) Chief Operating Officer.

14.2 Lola Banjoko explained that winter planning is an annual process as there is a consistent surge in health and care demand in the winter months. The biggest risk this winter is likely to be capacity in the local care market, particularly in terms of the interrelations between the care market and hospital admission avoidance and timely discharge. There are also significant challenges across the health and care workforce, particularly as staff have been working ceaselessly on the pandemic and then on service recovery, so have had no opportunity to take a breath before the winter surge. The system has been working hard to provide enhanced nursing support to care homes; on public messaging (working closely with Healthwatch Brighton & Hove); and on enhanced primary care services, with a particular focus on identifying and supporting vulnerable people in the community.

14.3 Ben Stevens added that the main challenges for UHS are around workforce and demand. There is a particular focus on managing hospital bed capacity, especially in terms of the timely discharge of patients who are Medically Fit for Discharge. The Trust is trying to recruit more medical and clinical staff, but is also investing in community services such as admission avoidance. UHS is also working to enhance critical care capacity and general bed capacity, but workforce is a factor here.

14.4 Becky Woodiwiss told the committee that having an annual Cold Weather Plan (CWP) is a statutory requirement. Cold weather typically impacts on people with respiratory conditions, and particularly on those who struggle to afford to heat their homes. This impact can be felt even when the weather is not especially cold: e.g. where temperatures are below 8 degrees outdoors/18 degrees indoors. Really severe weather can create additional problems: e.g. snow and ice can impede people’s access to services. This year there will be additional risks and pressures from Covid and it is vital that as many people as possible get vaccines and booster jabs. The CWP is a relatively high-level plan, with detailed service plans sitting beneath it.

14.5 Cllr West asked a question about staff getting to work in harsh weather. Mr Stevens responded by noting that UHS, and other providers, have severe weather plans, which include the use of volunteer 4x4 drivers.

14.6 Cllr West asked whether there is capacity within severe weather plans to deal with prolonged extreme weather. Mr Persey replied that there is capacity for severe weather within the plans, but there will inevitably be challenges in a really harsh winter.

14.7 Cllr John asked whether both a system winter plan and a local CWP are really required. Ms Woodiwiss responded that the plans do have different focuses, with the CWP looking at broader determinants of health and the winter plan at services. However, both are national requirements, so the local system is obliged to plan in this way.

14.8 In response to a question from Cllr John about fuel poverty in the context of rising energy prices, Ms Woodiwiss told members that fuel poverty is challenging to measure, and that there is an unavoidable lag in data reporting. However, an Excess Death Working Group does meet regularly to evaluate the latest data, so the system is as up to date as it can be.

14.9 In answer to a question from Cllr John on support for homeless people, Dr Richards told the committee that locally homeless people have been classified as clinically extremely vulnerable and have been prioritised for vaccination and boosters. Services have worked closely with Arch Healthcare to provide outreach to homeless people and to other vulnerable communities.

14.10 Cllr Grimshaw noted that the funding for fuel poverty work seems limited, and that advice on managing heating costs may not be relevant to everyone at risk, particularly for people who have pre-pay meters. Ms Woodiwiss agreed that fuel poverty is a big worry this winter. The council is working closely with the Local Energy Advice Partnership to ensure that good advice is communicated as widely as possible.

14.11 Cllr Brennan noted that advice to keep warm (e.g. by leaving heating on overnight) was of limited use to people who simply can't afford to keep their heating on for long periods. Could the council look at other measures, such as loaning out small electric heaters? Cllr Brennan also noted that the Severe Weather Emergency Protocol (SWEP), designed to offer beds to rough sleepers in cold weather, will only accept people after a key worker assessment. However, some people feel unable to take part in assessments. What can be done for these people, and how many SWEP beds will be available this winter? Ms Woodiwiss agreed to provide a written response to these questions and also to pass on member comments about pre-pay meters and an electric heater scheme to the Excess Deaths Working Group.

14.12 Cllr McNair asked a question about the availability of face-to-face GP appointments. Dr Richards responded that GP services have been open throughout the pandemic and that GPs have been meeting patients face-to-face when clinically indicated. However, demand is very high, and GPs are also leading on the Covid vaccination programme. In addition, with rates of Covid remaining high, there is a clinical risk for patients in attending GP surgeries. For these reasons it is not possible to give a percentage target for face-to-face appointments.

14.13 RESOLVED – that the report be noted.

15 CANCER SERVICES (DIAGNOSIS AND TREATMENT)

15.1 This item was presented by Ben Stevens, University Hospitals Sussex (UHS) Chief Operating Officer; Lola Banjoko, Managing Director, Brighton & Hove CCG; Becky Woodiwiss, Public Health Principal, BHCC; and by Dr Sarah Richards, Brighton & Hove CCG Medical Director.

15.2 Mr Stevens told the committee that the pandemic has impacted cancer services, with a significant reduction of referrals as fewer people have been accessing healthcare. This is reflected in performance against the national cancer targets:

- 62 day referral to treatment target: the national target is for 85% of people to begin receiving treatment within 62 days of referral. UHS is currently performing at 65-75%. This is a national problem, and many systems are struggling with this target.

- 28 Day referral to diagnosis target: the national target is for 75% of people to begin diagnosis within 28 days of referral. UHS is currently meeting this target.

15.3 Services are planning to increase treatment and diagnostic capacity to meet these challenges. This includes the deployment of a new community diagnostics hub at the Amex in addition to diagnostic services at the Royal Sussex County Hospital. Services are also looking at re-designing treatment pathways: e.g. by enhanced use of virtual appointments and by using new diagnostic techniques. There is a major focus on NHS restoration & recovery around cancer, particularly targeting long waits.

15.4 Ms Woodiwiss told members that there are three main national cancer screening programmes:

- Breast screening – the national target is to screen 70% of those eligible. Current local performance is 66%.

- Cervical screening – the national target is 80%. Current local performance is 68%.

- Bowel screening – the national target is 60%. This is currently being met locally.

15.5 The pandemic has had a major impact on screening, but rates are beginning to pick up locally. Services strive to communicate about screening, working closely with Albion in the Community.

15.6 Lola Banjoko told members that services are very conscious of the importance of inequalities in screening rates, with some geographical communities and some groups of people having much lower rates of screening.

15.7 Dr Richards told the committee that there is an enhanced early diagnosis service now in primary care. Primary care is also starting to follow-up on patients who do not attend screening appointments. Brighton & Hove is also a pilot area for targeted health checks: e.g. offering x rays/CT scans for any smokers. Ms Banjoko added that there is additional annual funding from NHS England for enhanced cancer services.

15.8 Cllr Grimshaw noted that current difficulties in getting non-urgent GP appointments may discourage people from seeking advice on possible cancer symptoms. Ms Banjoko

acknowledged the problem, and that some communities are much more reluctant to come forward than others. Dr Richards agreed that current access to primary care is sub-optimal, particularly for the most deprived communities. There is investment in digital and in longer opening hours to improve access. However, GPs are exceptionally busy, and there is no easy fix to this.

15.9 Cllr Deane noted that historically breast screening rates were lowest in areas of the city with no easy access to the Preston Park screening centre. Ms Woodiwiss responded that access is a recognised problem. However, schemes such as travel vouchers have not proved successful. There is more to unpick here in terms of what the real access barriers are.

15.10 Cllr Brennan noted that the Princess Royal Hospital has arrangements in place that allow people to travel free on buses as long as they show proof of an appointment. Ms Banjoko responded that this such a scheme would be the responsibility of the council.

15.11 Cllr Brennan also noted that the diagnostics centre at the Amex is poorly signed from bus stops. Ms Banjoko agreed to feedback to the service on its signage.

15.12 The Chair noted that Brighton & Hove had poor performance against cancer screening and treatment targets long before the pandemic, and that this was an issue that the HOSC should maintain an overview of. Members agreed to receive an update report in 18 months' time.

15.13 RESOLVED – that the report be noted.

The meeting concluded at Time Not Specified

Signed Chair

Dated this day of

Brighton & Hove City Council

Health Overview & Scrutiny Committee

Agenda Item 22

Subject: **Care Quality Commission Inspection Report: University Hospitals Sussex Maternity and Surgery at the Royal Sussex County Hospital**

Date of meeting: **26 January 2022**

Report of: **Executive Lead, Strategy, Governance & Law**

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 on the recent Care Quality Commission (CQC) inspection of surgery and maternity services at the Royal Sussex County Hospital (RSCH), and on University Hospitals Sussex NHS Foundation Trust (UHS) actions in response to the CQC's findings.

2. Recommendations

2.1 That Committee notes the information included in this report.

3. Context and background information

3.1 The Care Quality Commission (CQC) is the statutory regulator of NHS services. Part of the CQC's role is to inspect NHS providers; this includes both a rolling programme of inspections and more targeted inspections of specific services in response to concerns raised.

3.2 The CQC rates services as either 'outstanding', 'good', 'requires improvement' or 'inadequate'. The CQC aggregates service ratings to give an overall rating for every provider.

3.3 University Hospitals Sussex NHS Foundation Trust (UHS) provides acute and specialist healthcare services across a number of sites in Sussex including general hospitals in Chichester, Worthing, Hayward's Heath, and Brighton.

3.4 In September and October 2021, the CQC conducted unannounced focused inspections of UHS maternity services at Chichester, Worthing, Hayward's

Heath, and the Royal Sussex County Hospital (RSCH) in Brighton. The CQC also inspected surgery services at the RSCH. The inspections were undertaken in response to concerns received about the safety and quality of the services. These included staff whistleblowing, patient complaints and information from other healthcare partners.

3.5 The CQC published its inspection report on December 10th 2021. Maternity services at St. Richards Hospital, Chichester, and at Worthing Hospital were rated as 'requires improvement' (previously rated 'outstanding'). Maternity services at Princess Royal Hospital, Hayward's Heath, were rated as 'requires improvement' (previously rated 'good'). Maternity and surgery services at RSCH were rated 'inadequate' (previously rated 'good').

3.6 The CQC notes that this is the first inspection of the Trust since the merger of WSHT and BSUH, highlighting some issues with integration across the new organisation.

3.7 The CQC report on RSCH is included as **Appendix 1** to this report. The CQC report contains more detailed findings with regard to RSCH surgery and maternity services.

3.8 UHS has already undertaken a number of actions in response to the CQC's findings. These include renewed efforts to recruit as well as:

- Reinforcement of infection prevention and control compliance, including weekly audits and a new escalation policy to manage theatre activity.
- The appointment of a Director of Midwifery.
- A clinically-led review and reduction in incident backlogs.
- Engagement and listening events held for staff in surgery and maternity to
- hear and understand concerns.
- Developing further workforce and wellbeing action plans.
- Greater visibility of senior leadership.
- Renewed focus on staff training.
- Review of and investment in the Trust's governance systems.

3.10 More information on UHS improvement plans is included as **Appendix 2** to this report.

3.11 There is no prescribed role for HOSCs in terms of responding to CQC inspections of local providers. However, HOSCs do typically seek to work with NHS Trusts with 'inadequate' ratings in order to seek assurances that robust improvement plans are implemented.

4. Analysis and consideration of alternative options

4.1 Not relevant to this report for information.

5. Community engagement and consultation

5.1 None undertaken.

6. Conclusion

6.1 Members are asked to note information about the recent CQC inspection of maternity and surgery services at RSCH and the Trust's improvement planning in response to the CQC's findings.

7. Financial implications

7.1 There are no financial implications for Brighton & Hove City Council to this report to note.

8. Legal implications

8.1 There are no legal implications to this report to note

Name of lawyer consulted: Elizabeth Culbert Date consulted 29/12/2021

9. Equalities implications

9.1 There are none to this report to note.

10. Sustainability implications

10.1 Not relevant for this report to note which focuses on the quality of current provision rather than plans to make changes to services.

11. **Other Implications** [delete any or all that are not applicable]

11.1 None for this report to note

Supporting Documentation

1. Appendices

1. CQC Inspection Report on RSCH maternity and surgery services (10 Dec 2021)
2. Additional information on improvement planning provided by UHS.

Care Quality Commission

University Hospitals Sussex NHS Foundation Trust

Royal Sussex County Hospital

Inspection report

Eastern Road
Brighton
BN2 5BE
Tel: 01273696955
www.bsuh.nhs.uk

Date of inspection visit: 28 September to 04 October 2021
Date of publication: 10/12/2021

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 inspection of maternity and surgery because we received information of concern about the safety and quality of the service.

Information of concern had been received from several sources about the maternity and surgery services across the hospital. This included staff whistleblowing, patient complaints and information from other regulatory bodies.

We asked the trust to send an anonymous staff survey to give all maternity and surgery staff to give them opportunity to share their experience of working at Royal Sussex County Hospital and to raise and share concerns in a safe and confidential way. The staff survey for was open to staff from 01 to the 15 September 2021. The anonymous results and staff comments have been used as evidence to support our report.

We inspected surgery and maternity and focussed on the safety and well led key questions as the information about the safety and quality we received related to these key questions.

We rated both maternity and surgery as inadequate in both key questions.

Our rating of services went down. We rated them as inadequate because:

The service did not have enough staff to care for patients and keep them safe.

Infection prevention and control standards and practices were not consistently applied across some areas.

Staff did not have training in key skills. Not all staff were up to date with emergency life support training.

The service did not manage safety incidents well and did not always learn lessons from them.

Leaders did not run services well or support staff to develop their skills.

Staff did not understand the service's vision and values or how to apply them in their work.

Staff did not feel respected, supported and valued. Staff were not always clear about their roles and accountabilities.

However:

Staff have a good understanding of their responsibilities for safeguarding vulnerable people and could demonstrate their knowledge and awareness in this area. However not all staff had up to date safeguarding training.

Medicines optimisation was managed safely.

Staff assessed risks to patients and acted on them

Our findings

Staff were focused on the needs of patients receiving care.

The service engaged well with service users and the community to plan and manage services.

Staff collected safety information.

University Hospitals Sussex NHS Foundation Trust was formerly called Western Sussex NHS foundation Hospital. It changed its name on 1 April 2021 when it acquired Brighton and Sussex NHS foundation Trust.

The trust has five hospitals – Worthing Hospital, St Richards Hospital, Royal Sussex County Hospital, Princess Royal Hospital and Southlands Hospital – which provide a full range of acute services.

When a trust acquires another trust in order to improve the quality and safety of care we do not aggregate ratings from the previously separate trust at trust level for up to two years. The ratings for the trust in this report are therefore based only on the ratings for Western Sussex NHS Foundation Trust.

Our normal practice following an acquisition would be to inspect all services run by the enlarged trust. However, given we were responding to concerns in the maternity and surgery core services we inspected only those services where we were aware of current risks. We did not rate the hospital overall. In our ratings tables we show all ratings for services run by the trust, including those from earlier inspections and from those hospitals we did not inspect this time.

How we carried out the inspection

During the inspection we spoke to 40 members of staff including maternity care assistants, administrators, nursery nurses, midwives, senior leaders, doctors and anaesthetists, health care assistants, medical students, doctors in training, nurses and allied health professionals. We attended four multidisciplinary meetings, reviewed 18 patients notes and ten prescription charts. We reviewed a variety of data and meeting minutes. Twenty staff have contacted the Care Quality Commission to share their views as they were not able to speak to us on the day of the inspection.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Surgery

Inadequate ⬤ ↓↓

We carried out this unannounced focused inspection of surgery because we received information of concern about the safety and quality of the service.

Information of concern had been received from several sources about the maternity and surgery services across the hospital. This included staff whistleblowing, patient complaints and information from other regulatory bodies.

We asked the trust to send an anonymous staff survey to give all surgery staff an opportunity to share their experience of working at Royal Sussex County Hospital and to raise and share concerns in a safe and confidential way. The staff survey for was open to staff from 01 to the 15 September 2021. The anonymous results and staff comments have been used as evidence to support our report.

We inspected surgery and focussed on the safety and well led key questions as the information about the safety and quality we received related to these key questions.

We rated surgery as inadequate in both key questions.

Our rating of services went down. We rated them as inadequate because:

The service did not have enough staff to care for patients and keep them safe.

Infection prevention and control standards and practices were not consistently applied across some areas.

Staff did not have training in key skills. Not all staff were up to date with emergency life support training.

The service did not manage safety incidents well and did not always learn lessons from them.

Leaders did not run services well or support staff to develop their skills.

Staff did not understand the service's vision and values or how to apply them in their work.

Staff did not feel respected, supported and valued. Staff were not always clear about their roles and accountabilities.

However:

Staff have a good understanding of their responsibilities for safeguarding vulnerable people and could demonstrate their knowledge and awareness in this area. However not all staff had up to date safeguarding training.

Medicines optimisation was managed safely.

Staff assessed risks to patients and acted on them

Staff were focused on the needs of patients receiving care.

The service engaged well with service users and the community to plan and manage services.

Surgery

Staff collected safety information.

Is the service safe?

Inadequate ⬤ ↓↓

Our rating of safe went down. We rated it as inadequate.

Mandatory training

The service provided mandatory training in key skills to all staff but did not provide protected time for them to complete it. Completion of mandatory training was below the trust target for all staff groups except for administration staff. Staff did not have up to date training in life support.

The trust had nine mandatory training modules which included manual handling, health and safety and infection prevention and control. The trust target for completion of mandatory training was above 90%.

Data provided by the trust showed across the surgical wards; administration staff were 100% compliant, healthcare support staff were 77% compliant, nursing staff were 80% compliant and medical staff were 76% compliant. In the basic life support module healthcare support staff were 63% compliant, nursing staff were 66% compliant and medical staff were 43% compliant.

Data for staff working in neurosurgery theatres showed; administration staff were 63% compliant, healthcare support staff were 74% compliant, nursing and operating department practitioners' staff were 74% compliant and medical staff were 72% compliant. In the basic life support module healthcare staff were 33% compliant, nursing and operating department practitioners were 62% compliant and medical staff were 72% compliant.

Data for staff working in main theatres and recovery showed; administration staff were 81% compliant, healthcare support staff were 77% compliant, nursing and operating department practitioners were 80% compliant and medical staff were 79% compliant. In the basic life support module healthcare support staff were 47% compliant, nursing and operating department practitioners were 64% compliant and medical staff were 48% compliant.

Staff said they were not given protected time to complete mandatory training and when booked onto training this was often cancelled at the last minute as they needed to work clinically.

Not all staff felt that mandatory training was comprehensive and met the needs of patients and staff. Staff working in the recovery units did not complete additional mandatory training in caring for patients who would normally be cared for in a different area of the hospital. For example, patients from the emergency department or patients with critical care needs.

Managers monitored mandatory training and alerted staff when they needed to update their training. However, they did not ensure they were given the time to complete it. Practice educators told us that they had escalated the issue to managers but due to clinical pressures teaching time was not ring fenced. For example, theatre staff were unable to attend protected monthly teaching sessions, due to being short staffed and operating theatre list overruns.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had training on how to recognise and report abuse.

Not all staff received training specific for their role on how to recognise and report abuse. Training records showed nurses were compliant with the trust target of 90% for both adult and children safeguarding training, doctors were not compliant with the trust target with either modules.

However, staff showed a good understanding of the trust's safeguarding policy and gave examples of when they had reported a safeguarding concern and were positive about the support they had received from the trust's safeguarding team.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. The service used systems to identify and prevent surgical site infections. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. However, the equipment and the premises were visibly clean. Records showed that cleaning was undertaken in line with trust policies. However, infection prevention and control audits had not been undertaken in theatres to provide.

Staff cleaned equipment after patient contact but there was no evidence of what equipment had been cleaned. Only commodes had "I am clean stickers" showing the date that it was last cleaned.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). In theatres, some staff were not bare below the elbows and some staff were not wearing face masks correctly on ward areas. We observed some staff challenged colleagues who were non-compliant on this but not all.

Rooms had not been risk assessed for maximum occupancy to ensure social distancing was maintained.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. In theatres, storage was an issue and there were staff belongings such as bags and umbrellas within the operating theatre, this posed an infection risk as germs could be transferred to the theatre environment. Staff told us that storage of their belongings was an issue as their lockers were a distance away from the theatres in the staff changing rooms. Staff did not feel the changing rooms and lockers were secure.

Staff had easy access to PPE such as masks, face shields, gowns and gloves. There was also sufficient access to antibacterial hand gels, as well as handwashing and drying facilities.

One of the handwashing sinks in the anaesthetic room of theatre one was not compliant with national guidelines as it had an overflow and the tap was directly over the plug hole. There was another handwashing sink in the anaesthetic room which was complaint.

Surgery

Patients underwent infection screening (such as Covid-19 and MRSA) prior to admission. Patient records confirmed this was undertaken. Patients identified with an infection were isolated in side-rooms. Appropriate signage was used to protect staff and patients.

Staff worked effectively to prevent, identify and treat surgical site infections. We observed antibiotic cover was discussed and administered to a patient in theatre. Staff could seek advice and support from the trust-wide infection prevention and control team.

There were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment. Cleaning schedules were complete.

Cleanliness of the environment and equipment and hand hygiene compliance was monitored as part of routine monthly audits. These audits on wards showed good compliance. However, in theatres the audits had not been consistently undertaken and results were not acted upon. For example, hand hygiene audits had not been completed for four months out of the last six months and infection prevention weekly assurance audit results were below 96% for four of the last audits. The trust told us that if any audit findings were below 96% that remedial action and a re-audit was undertaken, but there was no evidence this had happened.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Not all staff were trained to use them. Staff managed clinical waste well.

The service did not have suitable facilities to meet the needs of patients' families. Some patients were kept in the recovery area for extended periods when a bed in the hospital, high dependency unit or intensive care unit was not available.

Theatres were meant to undertake monthly prothesis verification audits, to ensure the checking process was adhered to, this ensured the correct prothesis was implanted. This audit had been completed for four months out of the last six and the average compliance score was 75%. All audit results were below 95% which was meant to prompt action to be taken and a re-audit undertaken, but there was no evidence this had happened. This meant that the service could not be assured that the correct checks were being completed to ensure the correct prothesis was implanted into a patient. A prosthesis is a device designed to replace a missing part of the body or to make a part of the body work better.

Surgical count audits were meant to be undertaken in theatres to ensure every item was accounted for in an operation. However, these had not been completed for four months out of the last six months.

Resuscitation equipment was visible and accessible. Resuscitation trolleys were kept on all surgical wards and in theatres. Trolleys had tamper evident tags. The contents of the trolleys were checked in line with trust policy and records were complete. The only exception to this was on Gastro level 9 ward where one of the resuscitation trolleys had not been checked on 10 occasions in a four-week period. Staff told us that there was confusion over who had responsibility for checking the trolley, the other trolley on the ward had been checked daily consistently. We found emergency equipment was fit for use. After the inspection the trust provided CQC with assurance all equipment was now checked in line with trust policy.

Staff carried out daily safety checks of specialist equipment. Records confirmed anaesthetic equipment was available and fit for purpose and checked in line with professional guidance.

Equipment was serviced by the trust's maintenance team using a planned preventive maintenance schedule. All equipment had a sticker indicating when it last underwent an electrical safety test, so staff knew it was safe to use. However, the defibrillator on the resuscitation trolley on Gastro level 9 ward, the due date of the next test was March 2021. The trust provided additional assurance the defibrillator was checked and added to the routine maintenance schedule.

Due to the complexity of operations performed, highly specialised equipment was used. Theatre staff told us that due to being short staffed and experienced staff leaving there were not enough staff trained and competent to use the equipment. Staff gave us examples of near misses involving equipment. In addition, staff told us of an incident involving the incorrect use of a surgical instrument resulting in injury to the patient.

We reviewed the patient safety incident investigation report for an incident involving a piece of equipment called a dermatome which resulted in an injury to a patient. A dermatome is an air-powered surgical skin grafting instrument, with an adjustable depth gauge which takes skin grafts. The blade on the dermatome was assembled incorrectly which resulted in two full thickness grafts instead of partial thickness these then required treatment. The investigation did not find the reason why it was assembled incorrectly by staff. In response to the incident the service had developed a dermatome checklist, for staff to follow to ensure it was assembled correctly.

Storage areas and corridors in theatres were cluttered, and staff told us there was a shortage of storage space. Theatre doors with signs on stating do not block doors were blocked with theatre equipment. However, there was an effective system for safe storage of consumables and surgical implants.

There was no clear signage to indicate the maximum person occupancy of rooms to ensure compliance with social distancing rules within a healthcare facility.

Fire safety was not always managed safely. On 8A East ward we saw a fire extinguisher stored on the floor and fire doors that were to be kept locked were open and vice versa.

There were effective arrangements for the safe handling, storage and disposal of clinical waste, including sharps.

Data showed that between July 2021 and September 2021, 168 patients spent more than one hour in recovery awaiting a bed in the hospital. Patients were delayed in recovery ranging from 41 minutes to 41 hours. This meant patients did not have their privacy when they needed it, did not have free access to washing and toilet facilities, could not move freely around the recovery area and could not see their relatives whilst in this area.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, staff without the necessary skills, competence and training were caring for patients. Patients requiring surgery experienced delays and cancellations placing them at risk of deterioration.

Due to 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. This impacted on the department's ability to maintain flow and staff, without the required skills, knowledge and competence, cared for patients. In addition, staff also undertook aspects of care normally outside of their role, meaning they may not be familiar with risks assessments, policies and procedures. For example, theatre staff and anaesthetists cared for recovering patients in theatres as the recovery area was full.

Surgery

The Royal College of Anaesthetists: Guidelines for the Provision of Anaesthetic Services for Postoperative Care 2019 states: "When critically ill patients are held in the recovery area because of a lack of availability of appropriate facilities elsewhere, this should only occur if recovery staff are appropriately trained, and the recovery area is appropriately equipped to enable monitoring and treatment to the standard of a level 3 critical care unit". Not all staff were appropriately trained in line with these guidelines. However, the recovery area was appropriately equipped.

Staff working in the recovery area were highly trained in looking after patients recovering from an operation, however they were not trained to look after high dependency patients, ventilated patients and patients transferred from the emergency department to the recovery unit.

Data showed between July 2021 and September 2021 a total of 40 patients requiring high dependency care were cared for in recovery, of these 25 patients spent more than three hours in recovery. In the same time period 25 patients requiring intensive care were cared for in recovery, of these 20 spent more than three hours in recovery. In addition, in July and September four medical patients were cared for in recovery.

The trust told us that if a post-operative patient was too ill to return to a ward and there was no high dependency or intensive care bed then they remained in recovery as this was the safest place for them. When this occurred the intensive care unit nursing team and the anaesthetic consultants assisted with care. However, staff and the directorate leadership told us that this was not always possible, due to challenges in intensive care.

We reviewed an incident form completed in April 2021, in relation to patients requiring high dependency care, being cared for in recovery. On the day the recovery unit was full and included four patients who required high dependency care one of these patients deteriorated and required intensive care. Concerns within the incident related to not being able to keep up with all the care patients needed and although some support was provided by an advanced care practitioner and anaesthetist staff did not always feel supported. The incident was not investigated by managers until 12 October 2021 we were not assured that the actions recorded, or the time taken to investigate the incident reduced the risk of further similar incidents. The only recorded action was that staffing concerns were being managed through the directorate and divisional recruitment programme. The trust also provided a narrative for this incident and stated that the care and supervision of a significantly complex post-operative recovery period was appropriate.

Staff in theatres told us due to staff shortages they didn't always have the ability to respond to patients who required emergency lifesaving surgery. The trust told us that due to shortages of staff and over-running theatre lists there had been occasions where between 6pm-9pm there was a shortage of staff to manage emergencies which required immediate surgery.

Patients requiring emergency trauma surgery that experienced delays were at risk of further complications from their injury. On the day of our inspection 34 patients required emergency trauma surgery, who were either at home waiting or were an inpatient. There were 18 patients admitted to the hospital waiting for emergency surgery. The longest wait for surgery was 16 days and the patient's operation had been cancelled three times, other inpatients had waited between 15 days and one day. Of the patients waiting at home for surgery the longest a patient had waited was 20 days. Of all patients five had been cancelled five times, three patients had been cancelled three times and two had been cancelled twice.

Surgery

Patients requiring general emergency surgery experienced delays and were at risk of their condition getting worse. Between 31 August and 28 September 2021, 76 patients were booked to have emergency surgery of these 45% had their surgery postponed. The most common reason for postponement (64% of all) was more urgent case added. Of the 76 patients, two had been waiting seven days, two had waited six days, two had waited five days, four had waited four days, eleven had waited three days, 18 had waited two days and the remainder had waited one day.

Between January 2021 and June 2021 there were 49 high risk patients needing an emergency laparotomy (a type of open surgery of the abdomen to examine the abdominal organs).Of these 96% had consultant surgeon and consultant anaesthetist who delivered care, 100% of had a consultant surgeon operating, 96% of patients had consultant anaesthetist presence. This was in line with National Emergency Laparotomy Audit guidelines.

Between the 01 July and 01 October 2021, September, a total of 113 patients had their elective operations cancelled on the day, four patients had been cancelled twice and one patient had been cancelled four times. Of these, the most common reason (41%) for cancellation was no intensive care or high dependency bed.

Theatre staff told us they were often allocated as part of the staffing of a theatre whilst carrying an emergency bleep, therefore they were unable to respond to other clinical emergencies in the hospital.

Staff undertook the World Health Organisations (WHO) ‘5 steps to safer surgery’ checklist in theatres and undertook audits to measure compliance. We saw staff consistently undertaking all five steps of the checklist. However, observational WHO audits were meant to be completed every month but had not been completed for four months out of the last six months. This meant the service could not be assured that WHO processes were adhered to.

A manager told us that compliance was poor with the debrief step as staff had to return the WHO debrief document at the end of the day to be included in the audit. If staff did not return the form, then it was assumed it was not done.

Staff understood how to identify the signs of sepsis and the management of sepsis in line with national guidelines. Patient records showed they received appropriate care and treatment for sepsis.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Assessments such as for venous thromboembolism (VTE – blood clots), pressure ulcers, nutritional needs, risk of falls and infection control risks were consistently completed.

Safety huddles were undertaken in theatres and on the wards. Patient safety issues were discussed, and action taken to mitigate the risks. For example, communicating patients at risk of falls. A ‘wrap up’ ward round was undertaken at 4pm, to ensure any patients who may be deteriorating were identified.

Staff used the national early warning score systems (NEWS2) tool and regular monitoring based on patients’ individual needs to ensure any changes to their condition was promptly identified.

Shift changes and handovers included all necessary key information to keep patients safe. We observed a handover which was comprehensive and identified any risks and patients at risk of deterioration.

Nurse staffing

Surgery

The service 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. Managers regularly reviewed and tried to adjust staffing levels and skill mix however, it was not always possible to ensure that the number of staff and skill mix was safe. The service had high turnover and vacancy rates. Bank and agency staff had a full induction.

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.

Several staff members mentioned the department sometimes felt unsafe due to staffing numbers, skill mix and the acuity of patients. Staff had been going above and beyond to work in extremely challenging circumstances. Due to ongoing pressures and lack of clear leadership across the department, this had left many staff exhausted and several had left as a result.

Data showed within main theatres and recovery there was a vacancy of just over 20 whole time equivalent (WTE) staff. The highest vacancy was amongst qualified nurses/ nurse managers which was nearly 18 WTE staff. The overall vacancy rate was just over 13%, for qualified nurses/ nurse managers the vacancy rate was nearly 26%. The trust told us that as part of the international recruitment programme 15 WTE conditional offers had been made.

Data showed across the surgical wards there was a vacancy of nearly seven WTE staff. All but half a WTE were within qualified nurses.

Data showed the average vacancy rate amongst all staff groups in neurosurgery was 15%. The highest vacancy rate was 35% (10 WTE) amongst nursing staff in neurosurgery theatres.

Data showed the average staff turnover rate in the surgery division was 10%. The highest turnover rate was 22% amongst nursing staff in main theatres and the lowest was amongst administration staff (no turnover of staff). The average staff turnover rate in neurosurgery was 7%. The highest turnover rate was 12% amongst nursing staff in neurosurgery theatres and the lowest was amongst administration staff (no turnover of staff).

Recovery staff were caring for patients who required either high dependency or intensive care or had been transferred from the emergency department. Theatre staff were recovering patients in theatres, when recovery was full, they may not be familiar with recovery processes or policies.

The trust told us that every morning each operating theatre team conducted a safety huddle which involved all the theatre staff and was used to discuss: the trust's message of the week, the day's planned operating, resolve any problems/issues for example patient flow, resolve any staffing/skill mix issues and any safety issues. However, we saw on inspection that it was not always possible to resolve these issues and staff told us that they had raised patient safety concerns, and these had not been acted upon.

Managers in theatres and recovery could not always adjust staffing levels daily according to the needs of patients. Although daily staffing levels were calculated based on expected theatres lists; staff sickness, bed vacancies, emergency attendances and patients requiring intensive and high dependency care attendances, currently could not be met with the staff available.

The leadership team acknowledged significant challenges with staffing in theatres and this made it difficult to complete a rota which was balanced with staff who had the right skills and experience. The high vacancy rate also impacted for the flow of patients through theatres and recovery.

During August, September and up until the trust provide the data for October 2021, there were 56 incidents reported by staff regarding staff shortages in theatres and recovery.

Theatre staff told us that operating lists went ahead when staffing was below national guidelines, such as the Association of Perioperative Practice (AfPP) guidelines. Data provided to us by the trust showed that between April and September 2021 there were 406 theatre sessions that were undertaken with staffing below AfPP guidelines.

The directorate leadership team told us that a risk assessment was undertaken before allowing a theatre list to go ahead without staffing that was in line with national guidance. However, were not able to evidence that these risk assessments were undertaken and said it would be discussed at the World Health Organisation (WHO) five steps to safer surgery briefing, but audit data for WHO briefings showed low compliance, so this did not provide assurance that the risk assessments were completed

The directorate leadership team had reduced the theatre activity to try and ensure theatres were covered by a safe level of staff. However, the staffing was still insufficient to cover the planned theatres sessions safely. During the inspection an elective list was cancelled due to a lack of theatre staff, we saw that the chief of service made a clinical decision in consultation with their colleagues on which an operating list was cancelled.

Staff told us that a lack of staffing was particularly a problem during weekends and nights. Staff covering the evening shift for emergency operations were often used to take over from the day stay when elective procedures overran. This meant there was not adequate staffing to respond to patients requiring emergency surgery.

Staff told us that the leadership team had tried to mitigate the risk during nights by having staff on call from home, but staff felt this did not help and more staff on the shifts was needed. The trust told us that there was always either a qualified nurse of Operating Department Practitioner on call out of hours but there was not agreed response times from being called in and arriving in the department. Between April and September 2021 staff have been called in on 11 occasions. The trust told us that there was also a senior member of staff on call in the event of a major incident.

Staff working in the neurosurgery theatres told us that they often had to work a shift the following day when they had been resident on call and may have been working through the night. Data provided to us by the trust showed that between April 2021 and September 2021, 23 staff had worked a day shift after working in the night during whilst resident on call.

Data provided to us by the trust showed that between April 2021 and September 2021, 79% of planned day time emergency surgery operating lists were actually undertaken. In the same time period 96% of planned day time trauma operating lists were actually undertaken.

The directorate leadership team told us that a successful international recruitment programme meant that the staffing issues in theatres would be improved, this relied on there being enough suitable staff to provide training and a period of consolidation for the new staff.

Surgery

The trust told us that safety was assessed and monitored when carrying out changes to the service or the staff. For example, a recent local consultation processes, involved the temporary redeployment of the day surgery staff, Hurstwood Park Ward and Sussex Orthopaedic Treatment Centre staff to support other areas within the perioperative directorate as a result of the Covid-19 pandemic. This involved group and team discussions and 1:1 sessions with staff involved. This consultation process aligned with the Trust Policy Managing Organisational Change.

The trust recruited new staff from overseas. We expect this to have a positive impact on the service delivery in the coming months.

Medical staffing

The service did not always have 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.

Data showed there were no consultant surgeon or anaesthetist vacancies. There were just over 14 WTE surgical trainee doctor vacancies, this was a vacancy rate of 30.5%. The highest vacancy rate was 25% within Specialty Registrar doctors who had completed three or more years of their specialist training.

Health Education England, had ongoing concerns regarding the supervision, support and workload of junior doctors on the general surgery rotation and were closely monitoring the action plan developed by the trust in response to the concerns raised.

Junior doctors told us that their workloads in the daytime were not achievable and they often stayed after their shift had finished to complete tasks.

We reviewed the Guardian of Safe Working Hours Quarterly Report covering October 2020 to December 2020 for general surgery at this hospital. The report showed there were 38 exception reports; all cited late finishes as the reason for submission. The common theme was ward was busy with lots of high acuity patients. Trauma and orthopaedics had 13 exception reports five were due to missed educational opportunities, particularly missing scheduled theatre lists or trauma theatre lists because of being re-allocated to ward cover. The other eight reports related to busy ward workload and reduced staffing leading to late stays.

The service did not always have a good skill mix of medical staff on each shift. Senior support during nights and weekends were of particular concern especially if the senior staff were in theatres, this left junior doctors in charge of patients when they may not have the experience or competence to care for patients if they deteriorated. The trust had a number of plans to address these concerns and Health Education England was monitoring this closely.

Data provided by the trust showed that between 04 August 2021 and 12 October 2021 there were 13-night shifts that did not have a foundation (junior doctor) surgery doctor. Of these 10 were covered by locum doctors, three were covered by the more senior doctors in training that were on the night shift. This meant if the two more senior doctors were busy in theatres or responding to emergencies, there may not be adequate support for patients on the surgical wards.

The trust had introduced some additional roles to reduce the burden on general surgical junior doctors and to increase support and supervision. A prescribing pharmacist had been employed to assist with prescribing medicines and to offer support and guidance to junior doctors involving medicines. Additional locum middle grade doctors had been employed to provide support and supervision for junior doctors at night and at weekends. The locum middle grade doctors were due to commence employment in November 2021.

Surgery

To gain feedback from staff in a confidential way the CQC undertook an online staff survey. The online survey ran between 01 September and 15 September 2021. The survey received 63 responses from staff working in general surgery at the hospital and included 24 comments from staff. Some of these comments were from junior doctors and included “juniors are not valued”, “consultant politics passed on to juniors” and “bad leadership, bullying, undermining”.

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care. However, patient record audit findings showed mix compliance.

Patient notes were comprehensive. Staff recorded the necessary information. We reviewed eight patient records, and all had dates, times or notes about patients’ preferences or wishes. Staff could find the most up-to-date information about patients when they needed it.

Patient records were mainly paper based. Patient records were stored securely in locked trolleys. When patients transferred to a new team, there were no delays in staff accessing their records.

Patient records showed that nursing and clinical assessments were carried out before, during and after surgery and that these were documented correctly. Patient risk assessments were reviewed and updated on a regular basis in line with trust policy. Care plans were person-centred.

The service used a software system to collect data to measure compliance on a variety of different audits, including documentation. Between July and September 2021 documentation audits showed compliance between 97% (ophthalmology) and 74% (L9A ward). There were three different wards and departments when the audits were not completed.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, medicines were not always accessible for patients in recovery.

Recovery did not keep medicines that were needed to meet the needs of patients. Therefore, staff had to borrow them from wards. This may lead to a delay in patients receiving time essential and critical medicines. The service was working with the pharmacy team to improve the supply of medicines for patients who may have extended stays in the recovery area.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. We saw safety alerts were displayed throughout to inform staff of any medicine recalls.

Staff carried out daily checks on controlled drugs and medicine stocks to ensure that medicines were reconciled correctly. Controlled drugs stock levels were correct and the controlled drug registers were completed correctly.

The trust pharmacy department supplied medicines as stock to wards and departments. Medicines were stored securely and within their recommended temperature ranges.

Medicine administration records showed patients were given their medicines in a timely way, as prescribed, and records were fully completed including any allergies to medicines. However, medicine safety audits in theatres had only been completed for four months out of the last six and the average audit score was 75%. This meant that remedial action and a re-audit was meant to be undertaken and the service could not be assured that medicines were being handles safely in theatres.

Staff followed current national practice to check patients had the correct medicines. A pharmacist reviewed all medical prescriptions, including antibiotics to identify and minimise the incidence of prescribing errors.

Incidents

The service did not manage patient safety incidents well. Staff recognised and reported incidents and near misses. However, managers did not investigate incidents and therefore lessons learned were not shared with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

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. However, staff said they did not always get feedback on incidents and did not feel listened to when they raised concerns. Information about incidents was not shared with others to promote learning, including those that have potential for harm. Investigation reports we reviewed showed that patients were invited to contribute to the investigation, were supported and apologised to.

Managers did not review and investigate incidents in a timely manner. At the time of the inspection there were 128 incidents within the service that had not been reviewed and investigated by managers. Of these, the majority were reported in theatres (62%) and recovery (22%). Forty four percent of all incidents reported related to short staffing in theatres and recovery.

To gain feedback from staff in a confidential way the CQC undertook an online staff survey. The online survey ran between 01 September and 15 September 2021. The survey received 63 responses from staff working in general surgery at the hospital and included 24 comments from staff. Comments from staff reflected a poor incident reporting culture and lack of feedback on incidents reported. Comments from staff included; that if staff report an incident, managers did not discuss it with them but then they receive an email to say they have been offered support when they had not.

The same online survey asked staff to rate and give feedback regarding how incidents were managed within the organisation.

In response to the question: I hear about incidents that happen in my part of the organisation and the learning from them, 17% strongly agreed,33% agreed,21% neither agreed or disagreed,16% disagreed and 13% strongly disagreed.

In response to the question: My organisation encourages us to report errors, near misses or incidents, 43% strongly agreed, 32% agreed, 6% neither agreed or disagreed,10% disagreed and 9% strongly disagreed.

In response to the question: When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again, 24% strongly agreed,30% agreed,16% neither agreed or disagreed,14% disagreed and 16% strongly disagreed.

Surgery

The service had one never event in surgery at this hospital which happened in the Sussex Eye Hospital in April 2021.We were told that not all staff had undertaken training in how to investigate never events or incidents. However, the directorate risk and governance team were able to provide support and guidance.

We reviewed the patient safety incident investigation (PSII) report of the never event, which identified contributory factors. It could not be confirmed that staff had all received and read the most recently updated guidelines, and staff were unable to recall when they had last received training specifically on prosthesis verification. The investigation also revealed that staff working in the Sussex Eye Hospital were unable to attend quality and safety education sessions, not all staff were aware how to report an incident and did not follow national and trust guidelines. We were not assured that managers shared learning about never events with their staff and across the trust. The PSII report stated that action plans received oversight from the trust evidence of improvement panel and the trust patient safety group. However, it was not clear how learning from the never event would be shared with staff or how any changes of practice would be communicated to staff.

Staff mainly reported serious incidents clearly and in line with trust policy. The only exception of this was staff reporting the never event, they did not report it until five days after it occurred. The investigation found that staff were uncertain about whether the incident met the criteria for a never event and not all staff were comfortable with the incident reporting system.

The two investigation reports we reviewed did not assign individuals to actions or include time frames for when the actions should be completed, meaning actions may not be completed. Although the trust told us that action plans received oversight from the trust evidence of improvement panel and the trust patient safety group. It was not clear how actions were monitored at local level.

Staff did not always meet to discuss the feedback and look at improvements to patient care. Operational pressures and short staffing in theatres meant department meetings were not effective in supporting lessons learnt and improving patient care. However, surgical wards had daily safety huddles where incidents and learning were discussed. We saw an example which confirmed this occurred.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors. However, the service did not collect data on catheter acquired urinary tract infections.

Safety thermometer data was displayed on wards for staff and patients to see.

Between April and September 2021, there was 38 reported falls across wards and departments at the hospital. One fall resulted in moderate harm and occurred on Level 11 West (orthopaedics) in April, no other falls resulting in moderate harm have occurred since. The rolling average falls rate (per 1000 bed days) was 3.16 which was below the trust average of 3.60 falls per 100 bed days and the national average of 6.63.

In the same time frame, there was 55 acquired pressure damage and eight venous thromboembolisms recorded on the trust's incident reporting system.

In the same time frame, 55 reports of acquired pressure damage and eight venous thromboembolisms were recorded on the trust's incident reporting system.

Staff used the safety thermometer data to further improve services. For example, there was a focus on reducing patient falls.

Is the service well-led?

Inadequate ●↓↓

Our rating of well-led went down. We rated it as inadequate.

Leadership

Not all leaders had the skills and ability to run the service. They did not fully understand and manage the priorities and issues the service faced. However, this was improving. Staff did not feel all leaders were visible and approachable in the service for patients and staff. Staff did not feel supported to develop their skills and take on more senior roles.

The perioperative directorate is part of the surgical division. The perioperative directorate was led by chief of service, divisional director of operations and divisional nurse lead (current post holder was acting). This leadership style is referred to as a triumvirate. The triumvirate were responsible for perioperative care at; theatres level five and Sussex Eye hospital at the Royal Sussex County hospital site, Princess Royal hospital, Lewes Victoria hospital and the Sussex Orthopaedic Treatment Centre. The triumvirate were supported by a clinical director, a directorate manager and directorate lead nurse (current post holder was acting). In addition, there were 14 band sevens and two theatre managers. Neurosurgery theatres sat within the specialist division which had a similar leadership structure. The surgical wards and departments sat within the surgery division and abdominal surgery and medicine directorate, which had the same triumvirate leadership structure.

Members of the perioperative triumvirate had clear roles and responsibilities, but we were not assured they had a clear oversight or understanding of challenges that staff faced, performance, risk, governance and culture especially within theatres and recovery. However, following the listening event held with theatre and recovery the triumvirate acknowledged that decisive and urgent action was needed and had developed an action plan which was achievable, with some actions to reduce the burden on staff were made and implemented quickly. Other aspects such as changing culture and re-establishing governance process would take longer to change and embed which they acknowledged.

Each surgical speciality had a clinical director and a matron who was supported by the ward managers.

There was disparity between what the executive team and the triumvirate leadership team were doing to engage with staff and how that was perceived by staff working in theatres and recovery. Ward staff said they considered local leadership and management teams to be accessible, responsive and supportive, most staff said they rarely saw senior staff above matron level. Leaders did not manage the priorities in a way which reduced pressure and assisted staff treating patients within theatres and recovery.

Staff had mixed views regarding the visibility, how approachable trust leaders were, and the transparency of processes followed by leaders. Theatre and recovery staff told us that they had not ever seen a member of the executive team in the department.

Surgery

Staff had raised concerns regarding the precarious staffing situation in theatres, managers had not acted on these concerns and had not reviewed incidents relating to patient safety raised by staff. There was no tangible evidence that managers understood until recently the risks, culture, leadership and morale in theatres and recovery.

Staff did not feel supported to develop their skills and take on more senior roles. Theatre and recovery staff told us that due to staff shortages there was no dedicated time to undertake aspects of their role and for teaching and learning. Band six and seven staff in theatres and recovery did not have time to perform appraisals for junior staff or line management responsibilities.

Theatres and recovery had a historical issue of interim leaders which did not provide the stability and oversight required. Leaders in theatres were not supported to run the department, due to the staffing shortages they spent the majority of their time firefighting to keep the service running. Not all theatre and recovery staff felt that leaders had the skills and ability to run the service.

The perioperative leadership team, supported by human resources and the trust's Patient First Improvement System team, held a listening event with recovery and theatre staff in September 2021. The leadership team told us the meeting had given them a better understanding into the risks, challenges and concerns that staff had. As a result, they had developed an action plan to address the issues raised.

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

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action but were not able to achieve it due to staff shortages and lack of high dependency and intensive care capacity. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The vision and strategy for the surgical division, of which perioperative services form a significant part, is embedded in the trust's overall vision and strategy – Patient First. Patient First sets out the trust's overall vision and describes the trust's strategic framework across its strategic domains – patient, people, quality, sustainability, and systems and partnerships.

Staff told us they did not feel engaged with the Patient First Improvement System and felt there was a disconnect between local staff experience and the understanding of divisional leadership and above.

The trust's clinical strategy (Brighton and Sussex University Hospitals 2019 to 2024) set out the trust's overall approach. Within this, the key priorities and decisions for the surgical division, and more specifically for perioperative services. The clinical strategy highlighted the following priorities; development of capability for a surgical robot, centralising theatre management and improvements in efficiency, modernisation of preoperative services and the development of a urology investigation unit at Princess Royal Hospital.

In May 2020, the trust board approved a new clinical strategy framework for the merged organisation. The development and delivery of the new clinical strategy was overseen by the trust's quality committee. Within this, perioperative services were seen as critical to delivering the trust's overall clinical strategy. Alongside all other services within the trust, perioperative services will be developing its own 'Mission Statement' which will capture the key strategic issues and risks facing the service and set out the priorities for the next three years.

Culture

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 they needed. The service was not able to demonstrate that it promoted equality and diversity in daily work and provided opportunities for career development. Staff did not feel the service had an open culture where patients, their families and staff could raise concerns without fear.

Low morale and perceived bullying and harassment was reported from some groups in theatres and recovery including at managerial level. Staff did not always recognise the leadership team as dealing with their concerns around these matters. There were some staff who did not feel able to express their concerns or speak up for fear of reprisal.

There was a mixed perspective from staff regarding feeling respected, supported and valued, including the actions taken as a result of raising concerns.

After listening to staff about their experiences working in main theatres and recovery, we had concerns about the culture amongst colleagues. We were given an examples of inappropriate behaviour between colleagues which indicated a toxic culture.

In the same CQC survey mentioned previously in the report. Of all the 24 comments received, there was only one positive comment about the service. Comments from staff on culture included: “A very hostile department to work in”, “problems are resolved in a disciplinary manner rather than an opportunity for change” and “improvement, bullying complaints are dismissed, juniors are not valued” and “a toxic culture of intimidation and bullying has been created”. Of the 24 comments 10 mentioned a poor reporting culture, failure of leaders to follow up on concerns raised or bullying and harassment.

Theatre and recovery staff felt the executive team did not understand the pressures they experienced in the department. We found evidence of strained relationships between theatre and recovery staff and local leaders.

Whilst the trust undertook a variety of events and initiatives to support the well-being of staff, theatre staff and recovery staff were not able to access these. The triumvirate leadership team recognised that they needed to find alternative ways of supporting this staff group’s welfare.

Patients having to wait longer for emergency operations, cancelling patients and staff shortages had a negative effect on staff morale. Staff in theatres and recovery told us that staff morale had never been as low.

The trust had a part time Freedom to Speak Up Guardian, there were no Freedom to Speak Up champions. Staff told us they didn’t know who the Freedom to Speak Up Guardian was or how to contact them, as there was no information available. We did not see any information informing staff of who the Freedom to Speak Up Guardian was or how to contact them.

The hospital had a Workforce Race Equality Standard action plan which was developed in 2018 and was due to cover the time period between 2018 until 2021. The plan had 12 actions, of these six had been completed, the rest had not been updated to indicate if they had been completed or were still in progress.

The trust’s Workforce Race Equality Standard 2021 data suggested that white candidates were more likely than black minority and ethnic candidates to be appointed from shortlisting. The data also suggests that black minority and ethnic staff members were less likely than white staff to enter into a formal disciplinary process. Compared to the previous year, trust staff saw an increase (and white staff a slight decrease) in stating they have experienced discrimination from their manager/team leader or other colleagues.

The trust assured CQC it was addressing the culture concerns raised during the inspection.

Governance

Local, triumvirate and trust wide governance was not clear. Not all staff were clear about their roles and accountabilities. Due to staffing issues within recovery and theatres staff were undertaking additional roles.

Each surgical speciality undertook monthly mortality and morbidity meetings. We reviewed a selection of the presentations and meeting minutes from these which showed good attendance and any actions to take forward. All had any learning identified and actions had a person assigned to them. This was in line with the Royal College of Surgeons guidelines.

We reviewed three theatre and recovery audit meeting minutes, these did not follow a set agenda, include risks, learning from incidents and didn’t always record who attended the session. This did not provide assurance that these meetings were effective and kept staff informed.

The trust told us that monthly quality and safety meetings for the surgery division were undertaken whereby representatives from all specialities and areas within division would meet. We requested minutes for these meetings from the trust, but we were provided with different meeting minutes. We also requested governance meeting minutes, but these were not provided.

The trust told us that the issues we found in recovery and theatres were discussed at monthly quality and safety meetings, but we were unable to confirm this. Therefore, we were not assured the local departmental risks and concerns were effectively escalated up to and including board level.

The trust was preparing to launch a new governance strategy in the months after the inspection.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify effective actions to reduce their impact. They had no plans to cope with unexpected events. Staff reported a lack of oversight and collaborative working from trust wide leadership.

The system to manage, identify, document and understand risk did not capture clinical and patient risks.

We reviewed the risk register which included eight risks across surgery, five risks had the same risk score which was the highest and all related to equipment. The delays in patients leaving recovery leading to poor patient experience was also on the risk register but with a lower risk rating.

The description of the risk included; inappropriately skilled staff dangerous staffing ratios for critical care patients and reduction in productivity through theatres, leading to delays and cancellations of patients' surgery. This risk had been

reviewed twice, in April 2021 and on the 30 September 2021 (two days after our inspection) The most recent update stated the use of recovery continues to be monitored and reported upon, however no overall improvement. The control measures in place were not effective in reducing the risk and this was recorded on the risk register. The leadership team told us that there was an arrangement for support to be provided by anaesthetists and staff from the intensive care unit, however, this was not included as a control measure. Control measures and risks had staff assigned to them.

The risk register included comments that risks were discussed at quality and safety meetings, however we were unable to confirm this as the meeting minutes were not provided to us, meaning we had limited assurance that the risks we identified were known by the division leaders and the executive team.

Leaders did not always identify and escalate relevant risks and issues. The short staffing in theatres was not on the risk register at the time of our inspection. A manager told us that they had recently added it, although they had not received training in the process for adding risks to the register. Since our inspection the risk of delayed emergency and cancelled elective surgery due to staffing had been approved and added to the risk register. The adequacy of control measures were recorded as inadequate on the risk register.

We found some local risks were not recognised outside of the department. For example, poor infection prevention and control practices in theatres had not been identified and action taken.

Staff told us they felt pressured into caring for patients in recovery who had higher dependency care needs. Staff felt this would heighten patient safety risks and promote unsafe practice.

The trust told us that the recovery area was an escalation area within the hospital as this was a safer place for patients requiring a higher level of care. However, staff were not aware that this was an escalation area. We requested a copy of the hospital escalation policy however, an escalation policy for junior doctors was supplied. The trust later provided a copy of the full capacity protocol however, this did not mention theatres or recovery and was focussed on the emergency departments.

After the inspection, the trust told us to support the pressures on recovery one of the key actions in the theatre improvement plan was to construct and agree a robust standard operating procedure for the use of recovery and escalation about concerns with patients remaining in recovery. This was to provide the team with a clear process for escalation of concerns, and a policy which provided support when there were intensive care patients or ward patients remaining in recovery post-operation that were unable to be moved in a timely fashion. The timeline for completion was 15 November and involved agreement across the organisation, including theatres, intensive care, and the site management team who were all engaged in the process.

The trust said all the recovery team had either completed recovery competencies or were in the process of completing them. Not all staff had undertaken critical care courses, and they did not all have relevant intensive care experience. Trust data showed 25% of recovery staff had undertaken the relevant care of the critically ill training. Staffing allocations were reviewed as part of normal daily processes to try and ensure the skill mix was balanced and appropriate on each shift. Daytime shifts had a co-ordinator who supported junior staff in training. Recovery staff told us that they felt unsupported and at times had to prioritise the sickest patients, which meant they may not identify a patient who was at risk of deterioration.

The trust said to support the staffing shortages theatre sessions had been reduced by seven theatre sessions per week to free up skilled staff for redeployment and support. Staff did not think this was sufficient to be able to meet the needs of patients and be able to provide an emergency and trauma service. Elective lists were routinely cancelled and patients requiring emergency or trauma surgery experienced delays.

The trust told us that the anaesthetic rota had been amended to ensure more doctors were on call each day to offer additional support to the intensive care unit and recovery if needed. Recovery staff told us that if they required support from the intensive care unit on a particular aspect of a patient's care then intensive care nurses would support them, but they would not routinely be present in recovery providing support as they were also challenged staffing wise.

The trust told us that surgical cases were prioritised on the basis of the nationally recognised 'P' rating system and all emergency cases rated more highly on this system than elective cases. The current situation was more difficult than at the height of the Covid-19 surge and had resulted in the postponement of elective cancer cases recently because of intensive care bed availability and theatre staff shortages.

Consultants had raised concerns regarding the ability to be able to treat patients requiring emergency surgery and felt they were not listened to or their concerns were not taken seriously.

Staff did not contribute to decision-making to help avoid financial pressures compromising the quality of care. Theatre and recovery staff felt there was no collaborative working to optimise flow, which would lead to major, improvements in patient and service user experience and outcomes.

The service regularly reviewed the Covid-19 recovery dashboard at divisional safety and quality committees. Progress against a variety of metrics were reviewed monthly which included; cancer referrals, day surgery cases performed, elective cases performed and new referrals against the service's recovery plan.

Theatres and recovery were not able to demonstrate how it was performing in key audits as the majority had not been undertaken in the last six months, audits that had been completed showed a requirement for remedial action and re audit but this had not been undertaken.

Information Management

The service collected data and but did not always analyse and act on 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 hospital used a cloud based real time inspection and reporting tool for healthcare quality inspections. This eliminated administration by capturing inspection results directly onto mobile electronic devices which provided automated reporting.

It was launched in October 2020 and initially focussed on five inspections undertaken across all wards and departments on a five-weekly rotation. It included inspections on documentation, medicine safety, patient experience, staff and environment. In Spring 2021, two further inspections were added which were weekly infection prevention and control

assurance (weekly) and hand hygiene (monthly). In addition, at the same time theatres also added some inspections and audits to provide assurance on a number of specific theatre standards. These included; perioperative care metrics (monthly), prosthesis verification (monthly), count policy (monthly) and World Health Organisation 5 steps to safer surgery observation (monthly).

Between April 2021 and September 2021 main theatre and recovery had an overall compliance rate of 62% in terms of undertaking the audits as per agreed schedule of submission.

Engagement

Leaders and staff engaged with patients to plan and manage services. Public engagement was hospital wide, rather than locally facilitated. Staff did not feel included or engaged with decisions made by senior leadership.

Staff used a closed social media platform to share information and make requests such as shift swaps.

Not all staff received good support and regular communication from their line managers. Department and team meetings had been impacted by the pandemic and operational pressures particularly in theatres and recovery. Ward staff told us there was good support and regular communication with line managers.

The trust engaged with staff through newsletters and staff briefings from the trust's executive team. Other general information and correspondence was displayed on notice boards.

As part of the pandemic responses to the first and second wave Covid-19 surges, all internal business meetings were stood down. This included staff meeting in theatres and recovery and therefore opportunities for managers to engage with staff and to fully understand their concerns may have been missed.

The perioperative leadership team spoke clearly about compassion for the wellbeing of staff and the need to be inclusive, empathic and compassionate. The wellbeing of staff in theatres and recovery was a focus in the action plan to address concerns raised by theatre and recovery staff.

The senior leadership team had developed an action plan to address concerns raised by recovery and theatre staff following a recent listening event. The action plan focussed on workforce, wellbeing, values, behaviours, safety, skill mix, theatre utilisation and flow. There were 28 actions and 20 of these had been completed or started, each action had a person responsible for the action and time frames for completion. The actions reflected many areas that we found that needed improvement, which provided some assurance that our concerns had started to be addressed.

The trust undertook stakeholder engagement with service users to gain their feedback on what was important to service users.

The trust used a variety of approaches which included surveys, interviews and focus groups to help understand what was most important to patients.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services however, due to operational pressures this had not been a priority within the service. Previously the service had a number of staff trained in quality improvement methods and the skills to use them however, many had left the service.

Surgery

The Patient First Improvement System had been implemented across the trust. Patient First is a continuous process of improvement within existing processes and pathways that leads to measurable improvements for patients and staff. The focus of the system is on empowering front-line staff to make improvements themselves. Staff were given training in the tools to work out where opportunities for improvement are in their daily work and to develop the skills to make sustainable change happen.

Staff in theatres and recovery told us that they were disengaged from the Patient First Improvement System as many of those trained in using the system had left. The leadership team told us that they wanted to reinstate the Patient First Improvement System and use it as a method to drive change and tackle many of the concerns and challenges within the service.

In September 2021, the Patient First Improvement System team worked with a consultant anaesthetist and lecturer to develop training and coaching for junior doctors to help them to work on their own quality improvement projects. A further session will take place in November with an estimated 35 doctors planning to attend.

Areas for improvement

Action the trust MUST take to improve:

The trust must operate effective governance systems to ensure compliance with all relevant sections as set out in Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 17(1)

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

The trust must ensure it improves its management of risk and issues and ensure they can plan effectively to tackle patient safety issues. Regulation 17(1)

The trust must ensure leaders at all levels are supported and leadership improves at all levels across the hospital. Regulation 18 (2)

The trust must improve staffing levels to maintain safe staffing levels. Regulation 18 (1)

The trust must improve the culture and ensure all staff are actively encouraged to raise concerns and in particular clinicians are engaged and encouraged to collaborate in improving the quality of care. Regulation 12 (1) (2i)

The trust must ensure regular checks on lifesaving equipment are undertaken. Regulation 12 (2) (b, e)

The trust must ensure all staff follow the trust's infection control policy and national guidelines in relation to infection prevention and control. Regulation 12 (2)(h)

The trust must ensure that all incidents investigations are completed in a timely way to allow opportunity for action on learning to be shared and action taken swiftly. Regulation 17 (2) (b)

The trust must ensure that managers have the required skills, knowledge experience to lead the service. Regulation 18 (b)

Surgery

SHOULDS

The trust should ensure that:

The trust should consider restarting regular formal staff meetings to improve staff engagement.

Surgery core service

Action the service MUST take to improve:

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 have the qualifications, competence, skills and experience to keep patients safe. Regulation 12 (2)(c)

The service must ensure all staff follow the trust's infection control policy. Regulation 12 (2)(h)

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

The service must ensure that all incidents investigations are completed in a timely way to allow opportunity for action on learning to be shared and action taken swiftly. Regulation 17 (2) (b) (e)

The service must ensure all risks are escalated as appropriate and documented on the relevant risk register. Regulation 17 (2)(b)

The service must ensure it takes staff's concerns seriously and takes demonstrable action to address their concerns. Regulation 17 (2)(b)

The service must undertake scheduled audits and take action to address poor performance in order to monitor the safety and quality of the service. Regulation 17 (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 nurse staffing levels meets the needs of patients and national guidelines. Regulation 18 (1)

The service must not care for patients with high dependency needs in recovery without an appropriate standard operating procedure and risk assessments. Regulation 17(2)(b)

The service must ensure that all rooms display the maximum safe occupancy. Regulation 12 (2)(h)

Surgery

The service must ensure their governance processes link with all staff to provide a safe service. Regulation 17

The service must ensure patients experiencing prolonged periods of time in recover have their privacy and dignity maintained. Regulation 17(2) (a)

Action the service SHOULD take to improve:

Surgery core service

The service should ensure action is taken regarding identified themes to resolve concerns. Regulation 17 (2)(e)

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

The service should continue to complete and review the action plan developed for theatres and recovery.

The service should consider the views of staff with regards to culture and take appropriate action.

The service should consider how it improves the storage space and facilities within main theatres.

The service should consider how it improves communication and decision making between the senior executive team and clinical leaders within the surgery division.

The service should consider reviewing the strategy and vision of the service to ensure it still fits the service needs.

The service should consider how to ringfence time for teaching and training for theatre and recovery staff.

The service should consider how to recommence theatre and recovery unit meetings and ensure these follow a set format, include who has attended and discuss key issues.

Maternity

Inadequate ⬤ ↓↓

We carried out this unannounced focused safety inspection of maternity services, provided by the University Hospitals Sussex NHS Trust (UHS), because we received information of concern about the safety and quality of the service.

Information of concern had been received from several sources about the maternity services across the trust. This included staff whistleblowing, patient complaints and information from other regulatory bodies.

University Hospitals Sussex NHS trust provide maternity services at the Princess Royal Hospital, Royal Sussex County Hospital, St Richards Hospital and Worthing Hospital. This report focuses on our findings at the Royal Sussex County Hospital.

We also asked the trust to send an anonymous staff survey to give all maternity staff the opportunity to share their experience of working at UHS and raise and share concerns in a safe and confidential manner. The survey was open to staff between 1 September and 15 September and at the Royal Sussex County Hospital there were 80 responses. The anonymous results related to the Royal Sussex County Hospital have been used as evidence to support our report.

This inspection has not changed the ratings of the location overall. However, our rating of maternity services went down. Overall, we rated safe and well-led as 'inadequate' we did not have enough evidence to re-rate the effective domain.

Our rating of this location went down. We rated it as requires improvement because:

The service did not have enough staff to care for women and keep them safe. Staff did have training in key skills. The service did not always control infection risk well. Staff did not always keep good care records. The service did not manage safety incidents well and did not always learn lessons from them. Staff did not use nationally recognised tools to triage women for treatment.

Leaders did not run services well or support staff to develop their skills. Staff did not understand the service's vision and values or how to apply them in their work. Staff did not feel respected, supported and valued. Staff were not always clear about their roles and accountabilities. Staff collected safety information, but this was not always accurate.

However:

Staff understood how to protect women from abuse.

They managed medicines well.

Staff assessed risks to women and acted on them

They were focused on the needs of women receiving care.

The service engaged well with women and the community to plan and manage services.

Maternity

Is the service safe?

Inadequate ⬤ ↓↓

Our rating of safe went down. We rated it as inadequate.

Mandatory training

The service provided mandatory training in key skills to all staff but did not ensure everyone completed it.

Staff did not always receive or keep up to date with their mandatory training. Some 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 nursing and midwifery was 81.27% and for medical staff it was 70.28%. This was worse than the trust target of 90%.

The mandatory training provided was comprehensive and met the needs of women and staff. The mandatory training met the standards required to meet Health and Patient Safety standards for clinical and non-clinical staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us they would receive an email to notify them when they needed to attend mandatory training.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff did not all have training on how to recognise and report abuse however they knew how to apply it.

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

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. During the inspection we observed staff discussing safeguarding risks and clearly identifying adults and children who may be at risk of harm. During handover the staff noted a patient's family members had been verbally aggressive to staff and ensured they had time alone with the patient to explore the situation in more detail.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. During the inspection we reviewed the Safeguarding Children and Child Protection – Maternity Protocol. This document was seven months overdue for review and referred to out of date intercollegiate guidance. However, staff of all grades could describe how to make a safeguarding referral and who to inform. The department had two safeguarding midwives who visited the clinical area daily during the week to support staff.

Maternity

Staff followed the baby abduction policy but had not undertaken recent baby abduction drills. The trust had a baby abduction policy which was seven months overdue for review. During the 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%.

Cleanliness, infection control and hygiene

The service generally controlled infection risk well. Staff did not always use infection control measures to protect women, themselves and others from infection. They did not always keep equipment and the premises visibly clean.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). Although the majority of staff were bare below the elbows, we observed some staff wearing long sleeved cardigans over their uniforms. We observed most staff washed or decontaminated their hands before giving care. All clinical areas had supplies of PPE including gloves, aprons and antibacterial hand gel.

Staff did not always clean equipment after patient contact or label equipment to show when it was last cleaned. We observed staff using equipment after patient contact and not cleaning it afterwards. For example, when taking patients observations with a blood pressure monitor and thermometer. There was no labelling of equipment to show when it was last cleaned. We observed a trolley in the nursery nurses' room on the post-natal ward was dusty.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. During the inspection we observed domestic staff regularly cleaning the floors and the clinical areas. Staff cleaned bed areas after the patient was discharged to make the area clean for the next patient.

The service generally performed well for cleanliness. In the last Patient-Led Assessments of the Care Environment (PLACE) 2019 – England the Royal Sussex County Hospital scored 98.55% for cleanliness of the environment. This assessment has not been repeated since 2019 due to the Covid pandemic.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We reviewed records for three months before the inspection and found them to be fully completed.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use the equipment. Staff managed clinical waste well.

Staff did not always carry out daily safety checks of specialist equipment. In all clinical area's records showed that specialist equipment was not checked on a daily basis. Every month for the previous three months records showed checks had not been completed on two to seven days over the month. On the post-natal ward, the inspection team found a paediatric defibrillation pad that had expired a year before the inspection on the resuscitation trolley. This meant staff could not be assured the checks completed were identifying expired pieces of equipment. The midwife in charge of the ward was informed at the time and removed the item immediately.

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

Women could reach call bells, but staff did not always respond quickly when called. We observed call bells ringing for more than ten minutes before a staff member was available to answer the call bell. Women often came to the ward office to get the attention of staff if they needed assistance. Nursery nurses told us they would answer bells even when it was not part of their role and become caught up trying to find a midwife for the women. This was time consuming and taking them away from their role.

The design of the environment in most clinical areas followed national guidance. Mothers and babies were kept secure on the maternity unit. There was secure access to the central delivery suite, ante-natal and post-natal wards. Maternity unit staff could access the unit with a swipe card, and patients and visitors were required to ring a buzzer and advise who they were visiting to be granted access. We observed staff preventing people from 'tailgating' onto the unit.

Staff told us the second maternity theatre could only be accessed via a lift that had a history of breaking down. This lift was not for public use and was generally used to remove clinical waste from the ward areas. The lift required a key to access it. The staff planned their workday to avoid using the second theatre as they considered the delay in accessing the theatre a risk in an emergency situation. Records showed this risk was recorded on the maternity risk register.

Staff on the labour ward were concerned that the emergency bell could not be heard from the office. We were given an example of when a midwife had pulled the emergency buzzer and no doctor had attended as they could not hear the emergency buzzer in the office.

The rooms on the labour ward were small and if specialist equipment was needed during the labour the furnishings in the room needed to be rearranged to accommodate the equipment.

The service had suitable facilities to meet the needs of women's families. The birth partners of women were supported to attend the birth and provide support. The clinical areas currently had limited visiting due to the pandemic restrictions.

There was a bereavement area called The Willow Suite. It was situated away from the labour ward and had a delivery room, bedroom area and facilities to make tea and coffee. It was a very relaxed and homely area. This area had been developed with support from the Stillbirth and Neonatal Charity (SANDS).

Staff generally disposed of clinical waste safely. We reviewed sharps bins in all clinical areas and found one that had not been assembled correctly as the labelling on the outside had not been completed. Clinical waste was separated and placed in the correct bins. Waste was stored in locked bins while waiting to be removed from the hospital site.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each woman or take action to remove or minimise risks. Staff did not always identify and quickly acted upon women at risk of deterioration.

Staff did not use a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. 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. The Royal Society of Obstetricians and Gynaecology guidelines recommend that an initial standardised assessment of each woman which identifies her presenting condition, key clinical symptoms and physiological indicators should be undertaken on admission.

Maternity

Staff told us women in the maternity assessment unit were reviewed by a midwife within one hour of arrival but waited up to six hours to be reviewed by a doctor. The National Institute for Health and Care Excellence guidelines for safe midwifery staffing (2015) defined a delay of 30 minutes or more between presentation and triage as a 'red flag event'. This long wait for clinical assessment was a significant risk for women attending the department.

Staff completed risk assessments for each woman on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff told us they used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for each woman. We reviewed five MEOWS charts during the inspection and found them to be correctly completed and concerns had been escalated to senior staff.

Staff knew about and dealt with any specific risk issues. Each woman had a patient care record which contained a variety of risk assessments. We reviewed ten sets of patient care records and found all risk assessments to be completed fully.

Staff shared key information to keep women safe when handing over their care to others. The patient care record was on a secure electronic patient record system which was used by all staff involved in the pregnant woman's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

Shift changes and handovers included all necessary key information to keep women and babies safe. During the inspection we attended a number of staff handovers in the clinical area and found all the key information needed to keep women and babies safe was shared. Staff told us that although they planned safety huddles during the shift to update the team with any changes this had not been happening due to lack of time. Staff told us that they used to have two safety huddles a shift to ensure all staff were up to date with key information but due to staff shortages a safety huddle occurred once a week if staffing allowed. Each member of staff had an up to date handover sheet with key information about the patients. The handover shared information using a format which described the situation, background, assessment, recommendation (SBAR) for each patient.

Staffing

The service did not 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 not have enough midwifery staff to keep women and babies safe. All staff we spoke to before, during and after the inspection told us that low numbers of staff made them feel unsafe. Staff were allocated to areas they were unfamiliar with at short notice to cover gaps in the rota. For example, a midwife told us they had been sent to work on the labour ward when they were employed to work on the antenatal ward. They felt out of their depth on the labour ward but felt obliged to work there due to low numbers of staff.

All staff we spoke to put low staffing numbers as their biggest concern. Comments we recorded from staff included "staff are exhausted and on their knees", "I feel it is only a matter of time before something bad happens", "Staff are reduced to tears every day because it is so short staffed", "I have a constant sense of dread that something awful will happen", "I cannot even relax on my day off worrying if I might have made a mistake", and "I am looking for another job I just do not want to work here anymore".

Staff told us that low numbers of trained staff delayed women being discharged home. In particular new mothers were waiting up to six hours to have a midwife assessment before being discharged. Staff of all grades told us in was unusual to get a break while on duty and often went home feeling dehydrated and exhausted.

All staff told us that they were unable to provide the standard of care they wanted to. For example, the midwives told us they had too many women to care for at one time in the antenatal, postal natal and triage area they were frightened of missing a deteriorating woman or baby.

Midwives were often doing baby transitional care, normally completed by nursery nurses, as well as looking after the women who had recently given birth. This was because there were not enough nursery nurses on duty.

A home birthing service was available to patients who were assessed as suitable. There was a home birth midwife on duty who worked as a supernumerary member of staff. The safety of providing the home birthing service was assessed by the labour ward coordinator at the change of each shift. It would be suspended if there were not enough midwives to ensure the service could be provided safely.

The labour ward coordinator should work as a supernumerary member of staff to lead the shift, coordinate the care and provide senior clinical support to the midwives caring for women in labour. Staff told us this rarely happened due to the shortage of midwives. This meant the coordinator had their own patient to care for as well as being responsible for the rest of the labour ward.

Managers calculated and reviewed the number and grade of staff needed for each shift in accordance with national guidance. However, when we reviewed the staffing rotas we saw there were gaps in the planned number of midwives, nursery nurses and maternity healthcare assistants in the majority of shifts. Staffing on the labour ward the night before the inspection should have been 13 members of staff but they only had nine until 2 am and then reduced even further to seven staff for the rest of the shift. This staffing level was not unusual.

The ward manager could adjust staffing levels daily according to the needs of women. Managers moved staff according to the number of women in clinical areas however staff told us this was at short notice and they were often expected to work in areas that were unfamiliar to them.

The service had high vacancy rates, turnover rates, sickness rates and high use of bank nurses. Twelve midwives had left the service in the six months prior to the inspection. Staff told us sickness rates were increasing as staff became more stressed. The head of midwifery told us exit interviews were conducted by the line manager and was unable to provide any themes or trends from recent exit interviews. Records showed there was a 51% vacancy rate for Band 5 midwives. The inspection team also noted the trust had over the establishment of band 6 and band 7 midwives but this had no impact on the staffing levels because of the high number of vacancy levels in the band 5 group.

Managers made sure all bank staff had a full induction and understood the service. Bank staff were usually sourced from the normal workforce and were familiar with the service. Managers had not given permission to source staff from agencies.

The trust recruited new staff from overseas. We expect this to have a positive impact on the service in the coming months.

Records

Staff kept detailed records of women’s care and treatment. Records were not always clear, up to date, stored securely or easily available to all staff providing care.

Women's notes were comprehensive, but all staff could not access them easily. 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.

We reviewed ten electronic patient records during the inspection and found all the electronic patient records to be fully completed. Staff told us there were areas in the hospital with poor access to wireless internet and women’s records could not be accessed in these areas. This meant staff could not always access patient records easily.

We reviewed five paper notes and found them to be hard to follow as they were not always fully completed. In two sets of notes we found documents belonging to other patients on the ward. We informed the staff, and this was corrected on the day of inspection.

When women transferred to a new team, there were no delays in staff accessing their records. Both the community and hospital team caring for the women had access to the electronic patient record which contained the most recent information about the women’s care.

Records were not stored securely. 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.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The women had paper prescription charts for medicines that needed to be administered during their admission. We reviewed 10 prescription charts and found them to be correctly completed.

Staff reviewed women's medicines regularly and provided specific advice to patients and carers about their medicines. A pharmacist visited the ward daily and reviewed the medicines prescribed to each woman. Evidence of these checks was visible in the prescription charts we checked on the day of inspection.

Staff generally stored and managed medicines and prescribing documents in line with the provider’s policy. The clinical rooms where the medicines were stored on the antenatal, post-natal ward and labour ward was locked and could only be accessed using a swipe card issued to authorised staff. Controlled drugs were stored in a lockable cupboard attached to the wall. Records showed controlled drug stocks were checked daily except on one occasion on 25 August 2021. Records showed that controlled drugs had been received from pharmacy and stored in the controlled drug cupboard without a witness signing to confirm they had been received.

The refrigerator that stored medicines was checked daily to ensure the temperature was within the correct levels. Records showed that these checks were missed on eight occasions in August and September 2021. On the day of the inspection the fridge contained influenza vaccines that had expired in July 2021. We notified the midwife in charge and they were removed.

Staff followed current national practice to check women had the correct medicines. We observed staff following current national practice when administering medicines.

Incidents

The service did not manage safety incidents well. Staff recognised but did not have time to report incidents and near misses. Managers did not always 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. All staff we spoke to were clear on what incidents were reportable and how to use the electronic reporting system. We reviewed ten incidents reported in the three months before inspection and found them to be reported correctly.

Incidents were reviewed at a monthly incident review meeting. Once the incident had been reviewed the outcome was shared with the staff member who reported the incident but not with the wider team.

Staff did not raise concerns or report incidents and near misses in line with trust policy. 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.

The service had no never events on any wards. In the 12 months before the inspection the service had not reported a never event.

Managers did not share learning with their staff about never events that happened elsewhere. 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'. This was a paper bulletin with a safety message and was displayed in the office. 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.

Staff reported serious incidents clearly and in line with trust policy. If a serious incident had occurred during the shift staff would remain on after the shift to report the incident in their own time.

Staff did not all understand the duty of candour. Although each clinical area had leaflets on display explaining duty of candour not all staff we spoke to could tell us what it was. Duty of candour is a legal obligation to be open and transparent with patients when something had gone wrong.

Staff did not receive feedback from investigation of incidents, both internal and external to the service. Staff told us they only received feedback on incidents they had reported and were unaware of any wider learning either internal or external to the service.

Staff did not meet to discuss the feedback and look at improvements to patient care. Staff were aware of a system called 'message of the week'. This was a paper bulletin with a safety message and was displayed in the office. However, staff told us they were too busy to read this message and non could recall a recent safety message that had been shared.

Managers investigated incidents thoroughly. Women and their families were involved in these investigations. We reviewed three serious incident investigations and found they involved women and their families. All three had evidence of duty of candour and draft reports being shared with the families for comment.

Managers debriefed and supported staff after any serious incident. We reviewed three serious incident investigations and found they contained a list of staff who would be offered debriefing and support following the serious incident.

Safety Data

The service used monitoring results to improve safety. Staff collected safety information but did not shared it with staff, women and visitors.

Safety data was not displayed on wards for staff and patients to see. Although safety data was monitored it was not displayed for staff and patients to see. Records showed the maternity dashboard reviewed data for the organisation, activity, workforce and clinical indicators. Clinical indicators that were outliers were denoted in red. Improvement or decline in performance could be tracked over time.

Is the service effective?

Inspected but not rated

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

The service participated in relevant national clinical audits. Records showed the service participated in relevant national audits which included recent recommended audits by the maternity Ockenden Report.

Outcomes for women were positive, consistent and met expectations, such as national standards. We reviewed the Regional External Panel Review Assurance and Action Plan for maternity which showed assurance that they were not an outlier for the number of neonatal deaths and 3rd and 4th degree tears.

Managers and staff used the results to improve women's outcomes. We reviewed the Regional External Panel Review Assurance and Action Plan for maternity which showed clear actions to improve women’s outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers shared and made sure staff understood information from the audits. Records showed that audit results were discussed in monthly audit meetings. These meetings were minuted and the minutes distributed to staff electronically.

Competent staff

The service did not make sure staff were competent for their roles. Managers did appraise staff’s work performance and hold supervision meetings with them to provide support and development.

Staff were not experienced, qualified or have the right skills and knowledge to meet the needs of women. 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 that the training target of 90%.

Managers did not always give all new staff a full induction tailored to their role before they started work. 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.

Managers supported staff to develop through regular, constructive clinical supervision of their work. A team of twelve Professional Midwives Advocates (PMA) were shared between the Royal Sussex County Hospital and Princess Royal Hospital and provided restorative clinical supervision for midwives. Staff told us they received a tremendous amount of support from the PMA team. Staff told us they were concerned that two PMAs had left and had not been replaced.

The clinical educators supported the learning and development needs of staff. Staff told us the clinical skills facilitators were very supportive and worked clinically alongside the midwives to maintain their clinical skills.

Managers did not ensure staff attended team meetings or had access to full notes when they could not attend. When staff meetings took place, minutes were recorded and shared with staff who could not attend due to staffing shortages

Staff did not have the opportunity to discuss training needs with their line manager and were not supported to develop their skills and knowledge. Staff told us there were few opportunities to complete additional training.

Multidisciplinary Working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The inspection team observed four multidisciplinary meetings during the inspection. Three meetings were end of shift handover meetings and one was a ward round. They were attended by midwives, midwifery care assistants, nursery nurses and doctors.

Staff described good working relationships with all members of the clinical team including midwives, nursery nurses, midwifery care assistants, obstetricians and anaesthetists. During the inspection we observed positive and supportive interactions within the multidisciplinary team.

Obstetricians were on the hospital site until 8.30 pm every day. After that time there was an on-call rota and clinical advice could be sought over the telephone or the obstetrician would come to the hospital in person.

Is the service well-led?

Inadequate ● ↓↓

Maternity

Our rating of well-led went down. We rated it as inadequate.

Leadership

Leaders did not have the necessary experience or capacity to lead effectively and abilities to run the service. They did not manage the priorities and issues the service faced. They were not visible or approachable enough in the service for women, and staff. They did not support staff to develop their skills and take on more senior roles.

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.

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.

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.

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.

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.

The trust had twelve Patient Advocate Midwives who covered the east side of the trust. Their role was to supervise and support midwives. They continued to deliver this role to the midwives even though they felt unsupported by the senior leaders.

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

Vision and Strategy

Staff were not aware if the service had a vision for what it wanted to achieve and a strategy to turn it into action.

The trust had a vision and strategy that was displayed on the trust's website. Their mission was 'excellent care every time'. They describe all their efforts to do this put the interests of their patients first and foremost, and are underpinned by their values:

Compassion, Communication, Teamwork, Respect, Professionalism, Inclusion. The trust state "These values were selected by our staff, patients and public when we were talking about the merger and the sort of organisation we want University Hospitals Sussex to be. They combine the values of both Western Sussex Hospitals and Brighton & Sussex University Hospitals and added an important new focus on inclusion."

Staff were not able to describe the vision and strategy. Their main concern was supporting their colleagues and ensuring the women and babies in their care were safe. They felt disconnected from the trust vision or strategy for the future.

Culture

Staff did not feel respected, supported and valued by leaders. The staff were focused on the needs of patients receiving care.

All staff we met during our 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.

The Care Quality Commission surveyed maternity staff between 1 September and 15 September 2021, to explore how staff felt about the culture of their department. Combining the survey responses and staff feedback during and after the inspection told us staff felt disrespected, unsupported and undervalued by the leadership team. Quotes from the survey included “There is inadequate leadership, staffing, and an inability to address a culture which is failing families” and “Staff morale is exceptionally low at the moment”.

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.

Governance

Leaders did not operate an effective governance process, throughout the service and with partner organisations. Some staff were not clear about their roles and accountabilities and did not have regular opportunities to meet, discuss and learn from the performance of the service.

Senior leaders described the ward to board communication as good. The triumvirate leadership team consisted of the chief of service, obstetric lead and head of midwifery and reported to the chief nurse for the trust as the post of director of midwifery was vacant at the time of inspection.

The triumvirate leadership team used the governance structure to inform the maternity board about the current risks within the service. The governance structure included the patient safety group, patient experience group and finance group. These groups met monthly and discussed issues using a standard agenda template. The governance team membership included the education team, fetal wellbeing midwife, audit midwife, practice education midwife, risk midwife, bereavement team and complaints manager.

The governance processes in place did not alert the senior leaders to the concerns of the workforce in the clinical areas. Staff told us they had given up reporting staffing issues as nothing was changing.

Clinical areas had posters with the monthly dates for audit meetings, governance meetings and mortality and morbidity reviews. Most staff told us they did not have time to attend meetings or discuss and learn from the performance of the service. An out of date audit strategy document covering 2017 to 2020 was on display for information.

The trust was preparing to launch a new governance strategy in the months after the inspection.

Management of risk, issues and performance

Leaders and teams did not always use systems accurately to manage performance effectively. They did not identify or escalate 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.

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. However, staff told us not all risks were recorded as were often repeated or ongoing without resolution.

The triumvirate leaders told us the top three risks for the service was staffing, only having one maternity theatre and the temperature on the wards. The risk register showed the top three recorded risks for the service were unsafe staffing levels, community temporary premises and delays in care due to antenatal capacity. Staff were not given the time to be able to undertake required training or practice for emergency situations impacting on effective performance.

The themes from serious incidents and lessons learned included managing induction of birth, ruptured membranes and escalation of concerns. These cases were reviewed by the Healthcare Safety Investigation Branch. The maternity service had referred 19 cases to the Healthcare Safety Investigation Branch since 2018.

Maternity performance was discussed at the trust board meetings. The last public board meeting occurred on the 5 August 2021. Minutes from the meeting showed the board the data in relation to serious Incidents, maternity dashboards and Ockenden recommendations was very reassuring. However, the information used in reporting, performance management and delivering quality care was not always accurate, valid, reliable, timely or relevant.

Information Management

The service did not always collect reliable data for analysis. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The information used in reporting, performance management and delivering quality care was not always accurate, valid, reliable, timely or relevant. Leaders and staff do not always receive information to enable them to challenge and improve performance. Information was used mainly for assurance and rarely for improvement.

The service had electronic systems for collecting and analysing data. Electronic service user record systems in Maternity did not always support staff to maintain contemporaneous care records because of connectivity or system glitches. For example, the poor internet connection on level 5 in the Royal Sussex County Hospital meant staff could not access the electronic service user record. All areas had password protected computer terminals for staff to access information. All computer terminals were password protected when not in use.

Data was not used to assess and improve performance. Staff told us they were not reporting all reportable incidents as they did not have time. The used their judgement to decide what incidents were worth reporting. This resulted in incomplete data and it was not possible to assess and improve performance. In addition, staff did not complete required incident reports where it was considered to be repeat information such as for staffing levels therefore reducing the reliability of the information for analysis.

Information was not always managed well enough for reliable analysis, for example the maternity triage service was not using a standardised system for data recording to reduce the risk of unnecessary harm and was a subjective risk assessment.

The parameters had been set in agreement with local and national thresholds, which allowed the service to benchmark themselves against other NHS acute trusts. The service submitted data to external bodies as required, such as the National Neonatal Audit Programme and MBRRACE-UK.

Engagement

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

The service had developed the post of a communications midwife during the pandemic. The remit of this role was to use innovative ways to communicate with women and their families about the maternity service. They used a variety of social media platforms such as Facebook, Instagram, WhatsApp, and email to keep women updated.

The bereavement leads had established working links with the local Stillbirth and Neonatal Charity group and had developed a bereavement suite.

The maternity matters website signposted women to local groups such as National Childbirth Trust and support groups for vulnerable women. The service collaborated with partner organisations to help improve services for women. The service took account of the views of women through the Maternity Voices Partnership.

Learning, continuous improvement and innovation

Staff were not always able to commit to continually learning and improving services. They did have a good understanding of quality improvement methods and the skills to use them but not the time to focus on quality improvement.

The trust relied on the Patient First programme as a service improvement tool. However, staff told us that service improvement and engagement with the Patient First programme was difficult due to the current pressures.

Maternity

Although staff were committed to and going above and beyond to deliver a high standard of care, and were passionate about innovation and improvement, they felt they had no capacity to do anything other than clinical care due to the low staffing levels.

Areas for improvement

MUSTS

Royal Sussex County Hospital Maternity

Action the trust MUST take to comply with its legal obligations

The trust must ensure staff complete mandatory, safeguarding and any additional role specific training in line with the trust target. (Regulation 18 (2) (a)).

The trust must ensure leaders a. receive such appropriate support, training, professional development, supervision, and appraisal as is necessary to enable them to carry out the duties they are employed to perform. (Regulation 18 (2)).

The trust must ensure safe staffing levels at all times. (Regulation 18 (1))

The trust must ensure the maternity triage services are delivered in line with national guidance. (Regulation 12 (1) (2) (a, b))

The trust must improve the culture and ensure all staff are actively encouraged to raise concerns and in particular clinicians collaborate in improving the quality of care. (Regulation 12 (1) (2i)).

The trust must ensure regular checks on lifesaving equipment are undertaken. (Regulation 12: (2) (b, e)).

SHOULDS

Royal Sussex County Hospital Maternity

The trust should ensure that

The trust should ensure all clean equipment is labelled in line with trust policy.

The trust should ensure that cleaning records are kept up to date in all areas.

The trust should ensure that all incident investigation reports record the learning outcomes or whether feedback had been given to the reporter.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a second inspector and one specialist advisor. The inspection team was overseen by Amanda Williams Head of Hospital Inspection.

University Hospitals Sussex
NHS Foundation Trust

UHSussex
Response to Warning Notice
Maternity & Surgery

18th January 2022

UHSussex response to the CQC Warning Notice

NHS
University Hospitals Sussex
NHS Foundation Trust

- The CQC made an unannounced focussed inspection of Maternity Service and Surgery in the Royal Sussex County Hospital on 28th September 2021

- The CQC issued a Warning Notice which identified four areas that the Trust was required to make significant improvements in by 3rd December 2021:

  - Safe storage and administration of medicines in maternity
  - Safe, secure and contemporaneous medical records in maternity across the trust
  - Infection prevention and control in surgery at RSCH
  - Assessing and responding to risk

- The Trust provided a comprehensive response to these concerns on 6th April (response attached)

- It also identified a further two areas that required significant improvement by 29th April 2022:

  - Lack of sufficient numbers of suitably qualified staff to deliver safe services
  - Good governance

- The Trust is addressing these concerns and will achieve the improvement required across all areas no later than 31st March 2022

- An ICS led System Oversight Meeting, includes all key stakeholders and meets monthly to track and assure delivery of UHSussex Improvement Plans

CQC Feedback to Trust's response to the Warning Notice

The Trust has received feedback from the CQC on our response to the Warning Notice submitted 3rd December 2021

The CQC has:

- Confirmed that the action plan clearly addresses the breaches in regulation and all other areas of concern identified during our inspection

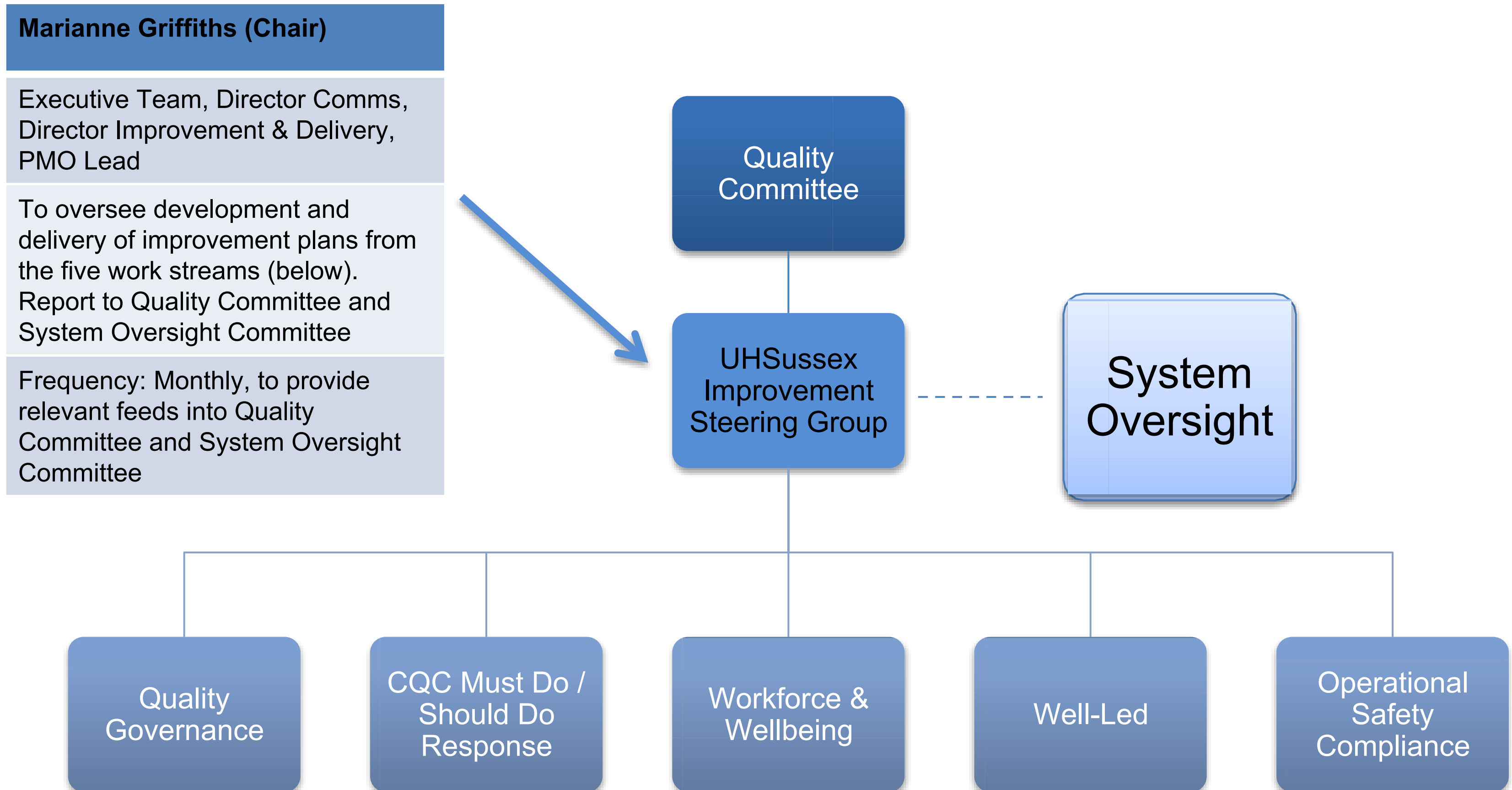
- Recognises the steps the Trust is taking to ensure improvement actions are embedded within the timeframes set out in the Warning Notice

- Requested three amendments to the action plan:
    - A specific time frame allocated for each action
    - A visible review date recorded
    - A responsible/named individual recorded against the actions

The Trust has made these amendments which are reflected in the following slides

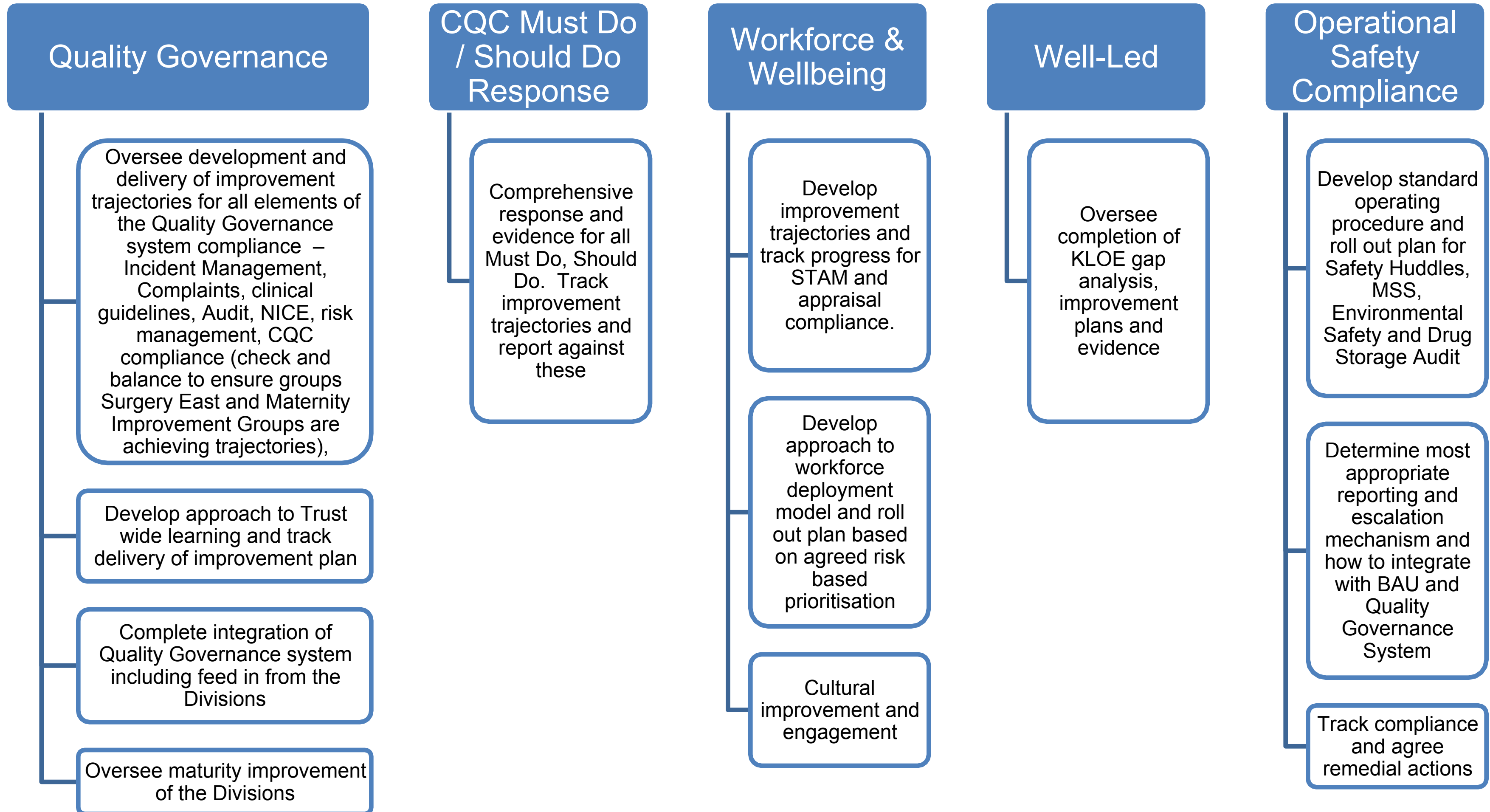
The Trust has also undertaken other improvements, which includes introduction of a new Executive role (agreed by Board 6th January 2022) to provide strengthened governance in the Trust, as well as immediate actions undertaken around a specific HR issue following original CQC visit.

UHSussex Improvement Governance



Workstream Structure and Scope

NHS
University Hospitals Sussex
NHS Foundation Trust

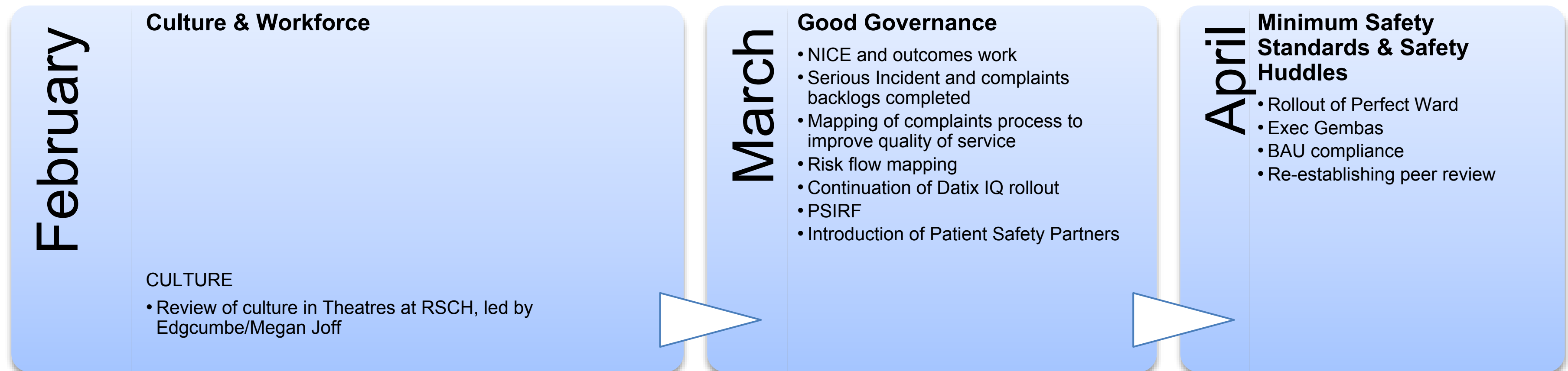


Next Steps

University Hospitals Sussex NHS Foundation Trust

Work will continue to monitor and deliver improvements in Maternity and Surgery East identified areas, according to Warning Notice requirements as well as items contained in the Final CQC Reports.

Whilst addressing specific items that were raised in the Warning Notice, the Trust is also ensuring that it takes each learning and ensures compliance across the whole Trust. Recognising that January 2022 will be primarily managing Covid surge, a series of deep dives have been scheduled for February – April on the following topics:-



These will enable the Trust to ensure that compliance actions are clearly in place, supported and working well, and embedded into business as usual activities. Where there remain any areas requiring additional support, resources will be identified to ensure support is maintained until embedding.

Other key actions in January/February include

- A refreshed focus on IT infrastructure, to ensure items such as bandwidth capacity and capability are being effectively managed and rolled out as required across UHSussex, in line with investment plans
- Detailed planning to allow the Trust to ensure all relevant local clinical guidelines are updated with electronic management solutions identified

Brighton & Hove City Council

Health Overview & Scrutiny Committee

Agenda Item 23

Subject: **Young People's Mental Health Services**

Date of meeting: **26 January 2022**

Report of: **Executive Lead, Strategy, Governance & Law**

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 The commissioners and providers of mental health services for young people have been asked to present an update at the 26 January 2022 HOSC meeting. This is within the context of addition pressures caused or exacerbated by the Covid pandemic. The update also addresses specific concerns about Child & Adolescent Mental Health Services (CAMHS) for young people with autism.

2. Recommendations

2.1 That Committee notes the information contained in this report.

3. Context and background information

3.1 The mental health and emotional wellbeing of children and young people is an important service area and one of both national and local concern. In October 2020, the HOSC received a presentation on Foundations for Our Future: the Sussex-wide Review of Young People's Emotional Health & Wellbeing Services. Steve Appleton, the independent Chair of the review, told the HOSC that, when the Review's findings were implemented, he hoped to see:

- A reduction in waiting times for young people services
- A wider range of support services being commissioned
- More outcomes-focused commissioning
- A broader focus on services to support young people's mental health (rather than a narrow focus on mental health).

3.1.2 At the time of the HOSC item, a programme to implement the review findings was still being developed.

3.2 In February 2021, the HOSC received a joint presentation from Sussex Partnership NHS Foundation Trust (SPFT) and from CCG Mental Health commissioners on how services were coping in the Covid pandemic. Issues relating to young people identified in this presentation included:

- A surge in demand for services from children and young people
- A particular increase in young people presenting with eating disorders or with ADHD/autism
- Additional funding for services for neuro-diverse young people
- Concerns about the long-term impact of the pandemic on the mental health of young people.

3.3 In November 2021, the HOSC received a Member Question from Cllr Grimshaw regarding a formal complaint about CAMHS provision for young people with autism that had been made by mASCot, a parent-led group, supporting young people with autism. The HOSC Chair asked SPFT and commissioners to include information about their response to this complaint in their presentation to the January 2022 HOSC.

4. Analysis and consideration of alternative options

4.1 Not relevant for this report to note.

5. Community engagement and consultation

5.1 None undertaken with regard to this report.

6. Conclusion

6.1 Members are asked to note the contents of this report and to reflect on how the issues and priorities identified in the report could inform the development of a HOSC work programme.

7. Financial implications

7.1 None for this report to note

8. Legal implications

8.1 There are no legal implications for this report to note

Name of lawyer consulted: Elizabeth Culbert Date consulted 29/12/21

9. Equalities implications

9.1 None directly for this report to note.

10. Sustainability implications

10.1 None directly for this report to note

Supporting Documentation

1. Appendices

None

Sussex
Health and Care Partnership

Children and Young Peoples Emotional Wellbeing and Mental Health

Briefing for Brighton and Hove Health Overview and Scrutiny Committee – 26 January 2022

Alison Wallis, Clinical Director, Children and Young Peoples Services, Sussex Partnership NHS Trust

Rachel Walker Operational Director - CAMHS, Specialist, Learning Disability/Neurodevelopmental Services, Sussex Partnership NHS Foundation Trust

Paula Gorvett, Director of Mental Health Commissioning, Sussex Clinical Commissioning Groups

Overview of presentation:

1) **System wide strategic framework for provision and improvement of emotional health and well being in Brighton and Hove**
    - Local Transformation Plan and Foundations for our Future
    - Thrive Framework
    - Outcomes Framework
    - Addressing Health Inequalities
    - 2021/22 transformation and investment plans

2) **Overview of core commissioned services**
    - Early Intervention Support
    - Specialist CAMHS services

3) **The Impact of COVID – on our children and young people and on service delivery**

4) **Challenges and our response**

5) **Performance summary**

6) **Next Steps**
    - Delivery of Transformation Plan
    - Summary

Sussex
Health and Care Partnership

System wide strategic framework for provision and improvement of emotional health and well being in Brighton and Hove

Our Ambition

As a system, we are committed to providing a strong start in life for our children and young people. Our strategy is one for our whole population which should support the journey from birth to old age. This includes key objectives across prevention, integration and supporting transition:

- **Prevention**: Supporting a good start in life, including delivering a whole systems approach to healthy weight, and promoting emotional wellbeing and good physical mental health in children and families.
- **Integrated care**: enabling primary, community and acute services: Our vision is to provide more responsive support for children and young people when they experience poor mental health or are in crisis so that they can access services when, where and how they choose, embracing digital and social media.
- **Supporting transition to adult services:** A more joined-up multidisciplinary approach as our children and young people transition to adult services is essential for increasing independence.

Our **ambition** is that by 2025, all people with mental health problems in Sussex will have access to high quality, evidenced-based care and treatment delivered by integrated statutory, local authority and third sector services that are accessible and well connected with the wider community, intervene as early as possible in someone's life journey to prevent mental ill health.

Our **mission** is that we will work together as an Integrated Care System, bringing together patient, statutory, third sector and local authority expertise, to design, develop, commission and oversee high quality, innovative and integrated care and treatment pathways for people with mental health problems.

The Foundations for our Future Programme and key transformation work programmes described in the Local Transformation Plan will support us to meet this ambition and deliver the requirements of the NHS Long Term Plan.

Foundations for our Future

Commissioned collectively by Sussex NHS leaders and Local Authorities, the Sussex wide review of children and young people's emotional health and wellbeing services was a response to the belief that experiences of those accessing emotional health and wellbeing services were not adequate. A year long independent review (2020) working with statutory bodies, community and voluntary sector, parents, carers and young people, resulted in an ambitious set of recommendations to improve the service experience across the whole system.

Foundations for our Future recommendations include improving access, Single Point of Access and Advice, THRIVE, Mental Health Support Teams, digital, improved engagement and communications and workforce developments. They are all strategic priorities in the Local Transformation Plan.

A **Sussex-wide Strategy for Children and Young People's Emotional Wellbeing and Mental Health** is now in development. The strategy will build on and incorporate the Foundations for our Future priorities and priority work streams included in the Local Transformation Plan.

Local Transformation Plan for emotional wellbeing and mental health support for children and young people – Annual Refresh 21/22

The **Local Transformation Plan (LTP)** brings together our collective strategic approach and plans across our three places Brighton and Hove, East Sussex and West Sussex (alongside our local authorities and other partners) and refreshes our previous Local Transformation Plans that were published annually in each of the three places (Brighton and Hove, East Sussex and West Sussex).

Our plan is published on the CCG website - Local Transformation Plan (LTP) - NHS Brighton and Hove CCG

The plan includes:

- Our **strategic direction** and approach
- The **needs** of our children and young people (including the impact of Covid-19)
- How we are achieving against our existing plans
- The **future plans** we have in place - this includes delivering the NHS Long Term Plan deliverables
- How we are addressing **health inequalities**
- How we can assess the impact of our plans - **measures for success**

LTP has been the backbone of strategic planning for 5 years and needs to be seen in the context Foundations for our Future. The strategic priorities provide the road map for transformational development of children and young peoples emotional wellbeing and mental health support in Brighton and Hove.

Local Transformation Plan 11 Strategic Priorities

1. Implement the **THRIVE** framework across Sussex – Overarching Framework
2. Further develop the **Single Points of Access**
3. Improve **access** to emotional wellbeing and mental health services
4. Further develop and expand **Mental Health Support Teams (MHST)** in schools
5. Continue to develop **Early Intervention in Psychosis provision**
6. Develop a system-wide integrated and expanded **Eating Disorder pathway**
7. Improve **urgent and emergency support**
8. Strengthening system-wide approach **to suicide prevention and reduction in self-harm**
9. Supporting children and young people with **Complex Needs**
10. Improve support for Young People (16-25) – Supporting **transition to adulthood**
11. Enabling priorities (**workforce, digital and engagement**)

▼ More detail can be found in the Local Transformation Plan - Local Transformation Plan (LTP) - NHS Brighton and Hove CCG

The THRIVE Framework

- A key part of our approach to Children and Young People's Mental Health and Emotional Wellbeing is the introduction of the THRIVE framework; which represents a shift away from the traditional tiered structure of services, instead focusing on the needs of children, young people and their families.
- It aims to talk about mental health and mental health support in a common language that everyone understands.
- The Framework is needs led; meaning that children, young people and families alongside professionals, through shared decision making, define their mental health needs.
- THRIVE places an emphasis on prevention and early intervention. Services offer swift and flexible support with professionals thinking holistically about the needs of the child or young person rather than focusing on a diagnosis.
- This framework will support the transformation emotional wellbeing and mental health support for children and young people in Brighton and Hove.

Developing our agreed outcomes for children and young people and measuring our success

Our Children and Young People's Mental Health and Emotional Wellbeing Strategy will be supported by an overarching outcomes framework which is being developed with children and young people and wider stakeholders. This will help determine what services should be planned and delivered in Brighton and Hove and what services benefit from our Sussex wide approach. Our Foundations for our Future Programme is leading this work, coordinated by a recently appointed Sussex-wide lead focusing on outcomes for our young people together with our Public Health colleagues.

Initial discussion and engagement has highlighted the outcomes below:

- More children and young people have good mental health
- Children and young people are protected from significant harm
- More children and young people recover, meet their potential and achieve their aspirations
- Integrated, aligned and co-ordinated service delivery is in place
- Children and young people, their parents and carers are instrumental in deciding which services they will use, where and when
- Funds are invested to achieve better outcomes
- Early intervention is in place to support children and young people at the point of need
- Time taken to receive a diagnosis and treatment is reduced
- Children and young people experience a seamless transition to adult services or other support services
- More children and young people have positive experiences of care and support
- Children and young people will develop their resilience capability and know how to put this into practice

Addressing Health Inequalities

Reducing health inequalities is at the core of our system. We recognise how, within mental health and children and young people's services, health inequalities have been persistent over many years and in some cases widening. We are continuing to strengthen our approach, within the context of our draft strategic framework to address health inequalities that is structured around six focus areas including early years, children and young people and mental health and learning disabilities.

Work has concluded to finalise the Equality Health Impact Assessments across all programmes of work to ensure that our investments are targeted to achieve greatest impact. In addition to specific actions identified in the Equality Health Impact Assessments the following actions have taken place:

- ✓ Worked with Young Healthwatch and Healthwatch Brighton and Hove to explore their experiences and identify their preferences leading to 'Our Ready, Set Connect' which is a youth led solution based project.
- ✓ Engaged young people from Black, Asian and Ethnic Minority backgrounds across the city to better understand their experiences of mental health services
- ✓ Ensured access to interpreting and translation services to support good access for all local people.
- ✓ SPFT have recruited a transgender, LGBTQ and inclusion training lead, and team equity champions
- ✓ Improving capture and flow of data to help identify and overcome inequalities in access
- ✓ Established Mental Health Support Teams in schools in the areas of highest need (East Brighton)
- ✓ Inequalities Participation Lead appointed to work across the ICS mental health programmes.
- ✓ Introduced a blended approach of virtual and face to face appointments – improving both digital access whilst maintaining direct contact to maximise support to those who don't have access to technology

Year 1 delivery: 2021/22 Mental Health Transformation Plans and additional investment

The operational delivery of our plans for children and young people are being delivered as part of our ICS Mental Health Collaborative, system wide, transformation programme. To underpin this, we plan to spend a total of £8.156m in Brighton and Hove in 2021/22 on children and young peoples emotional wellbeing and mental health services.

The table below summarises our **additional investment** for this year (2021/22) aligned to our strategic priorities outlined in slide 8, to improve access to services (early intervention and specialist) and outcomes and experience for our children and young people in Brighton and Hove.

Priority Area	Investment
Expanding capacity and access, including improving access to CAHMS, Children with Complex Needs, Neurodevelopmental services, and Early Help services	£826,000
Mental Health Support Teams in Schools	£368,000
Eating Disorder Services	£86,000
Urgent and Emergency Support	£142,000
Total	£1,423,000

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Health and Care Partnership

Overview of core commissioned services

Introduction to Core Commissioned Services

The following slides will provide an overview of the core commissioned service offers in Brighton and Hove. *Please note that are a range of other support offers for children, young people and families that are not commissioned by the CCG but form part of the emotional wellbeing support offer.*

The core services are:

Early intervention – getting advice and getting help

- School Wellbeing Service and MHST
- Children and Young Peoples Wellbeing Service

Specialist Mental Health Support – getting risk support

- Specialist CAMHS

Schools Wellbeing Service

The Schools Wellbeing Service (SWS)

- The SWS is part of the Brighton and Hove Inclusion Support Service (BHISS) providing emotional and mental health support for mild to moderate need, including clinical interventions, whole school support strategies and training to parents and staff. A specialist team comprises of mental health clinicians work with schools (embedded in secondary schools and linked to primary clusters) across Brighton and Hove. B&H CCG contributes to the funding of this service.

The Mental Health in Schools team (MHST)

- The MHST is part of the national NHS programme and is co-located with SWS. Brighton MHST is based in East Brighton focused on the areas of greatest deprivation and need. The staffing structure is designed to provide a team, covering a wide range of skills and experience, which enables a whole school approach to supporting wellbeing and mental health.

'Our aim is to enhance emotional and mental well-being for all, to enable each child, family and professional to be the best they can be."

Children and Young Peoples Wellbeing Service

The CYP Wellbeing Service is the hub for **all mental health referrals** for young people in Brighton & Hove, including CAMHS. (This is different from our Single Point of Access that we are further developing)

The service is delivered by YMCA Downslink Group and offers a range of short-term support options for children and young people aged 4-25 with **mild to moderate mental health needs** who do not require specialist CAMHS services. Support options provided by the service include:

- Counselling,
- Low intensity psychological interventions (LIPI)
- Cognitive Behavioural Therapy (CBT)
- Family Therapy
- Age-specific interventions by presenting problem such as play therapy
- Social prescribing

Specialist CAMHS (Getting more help/ getting risk support)

Specialist CAMHS services in Brighton and Hove and across Sussex are provided by **Sussex Partnership NHS Foundation Trust.** Specialist CAMHS provides a range of mental health direct interventions with psychiatry and medication where required as well as an urgent response where there is a mental health crisis services which include:

- Community targeted services for diagnosable mental heath issues such as low mood, anxiety, depression, relationship with food, self harming behaviour, PTSD etc.
- Specialist services for vulnerable groups such as children in care, children with learning disabilities.
- Contribute to the diagnosis of neurodiverse conditions such as ADHD, ASC
- Urgent help Service for those in crisis, at risk of admission or stepping down from admission
- Intensive home treatment services
- Early Intervention psychosis (age 14 plus)
- Family eating disorder services
- Day services for those stepping down from inpatient admission
- Child forensic and adolescent mental health services (FCAMHS)
- Specialist inpatient services at Chalkhill

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Health and Care Partnership

Impact of COVID on children and young people and the services they access

Impact of COVID on Children and Young People – National Picture

The NHS Confederation Mental Health Network - Reaching the Tipping Point (August 2021)

- The report into children and young people's mental health outlines the significant increases in need for mental health support for children and young people across all services – from primary care to NHS specialist mental health services, voluntary sector, independent sector, and digital providers including also pressures on acute trusts and local authorities.
- In particular, the report emphasises:
  - The need for support for eating disorders
  - The need for continued transformation of services (especially support in schools and educational settings)
  - A greater focus on early intervention and addressing the social determinants of mental health
  - The need to respond to workforce challenges and bringing services together across the whole system.

Nationally, the evidence shows that whilst initial stages of Covid-19 pandemic led to a general trend in decreased use of children and young people's mental health services, the number increased with the second wave.

The longevity and frequency of lock-down led to children and young people spending extended times at home with limited access to play or socialisation and face-to-face education; both key and important to childhood development. Children and young people with pre-existing mental health challenges or disabilities, those from low-income families or with experience of trauma and domestic abuse also became at greater risk of developing mental health and emotional issues. These, coupled in some cases, with a delay in seeking support has led to an increased need for services.

Impact of COVID on Children and Young People – Local position

In 2020, we worked with Young Healthwatch and Healthwatch Brighton and Hove to explore young people's experiences of Sussex health and social care services during the Covid-19 pandemic. We have also asked young people: about their preferences towards the future of health and social care services, what have been the biggest challenges faced during the pandemic and how these have affected their lives. Key impacts were:

- Effects of social isolation, difficulties accessing mental health support for pre-existing conditions during, and maintaining a routine while schools, colleges, and universities are closed.
- Loneliness, acute and increased anxiety levels, insomnia and difficulties with relationships.
- Anxiety about digital and phone consultations and concerns about expressing themselves in phone or digital consultations. While the majority were happy to receive online support, 26% did not want to engage with remote support.
- Children and young people found it difficult to have privacy at home which was a challenge for video consultations.

Young people's preferences towards the future of health and social care services in Sussex - Youth Survey 2020

Impact of COVID on Children and Young People – local services

- The impact on the mental health and well-being of young people has been felt across the system, in schools, social care, 3rd sector, primary care as well as the acute sector

- Schools are reporting an increase in the number of children exhibiting mental health issues in the classroom has risen from 1:10 to 1:6. However, interventions reduced during periods of school closures

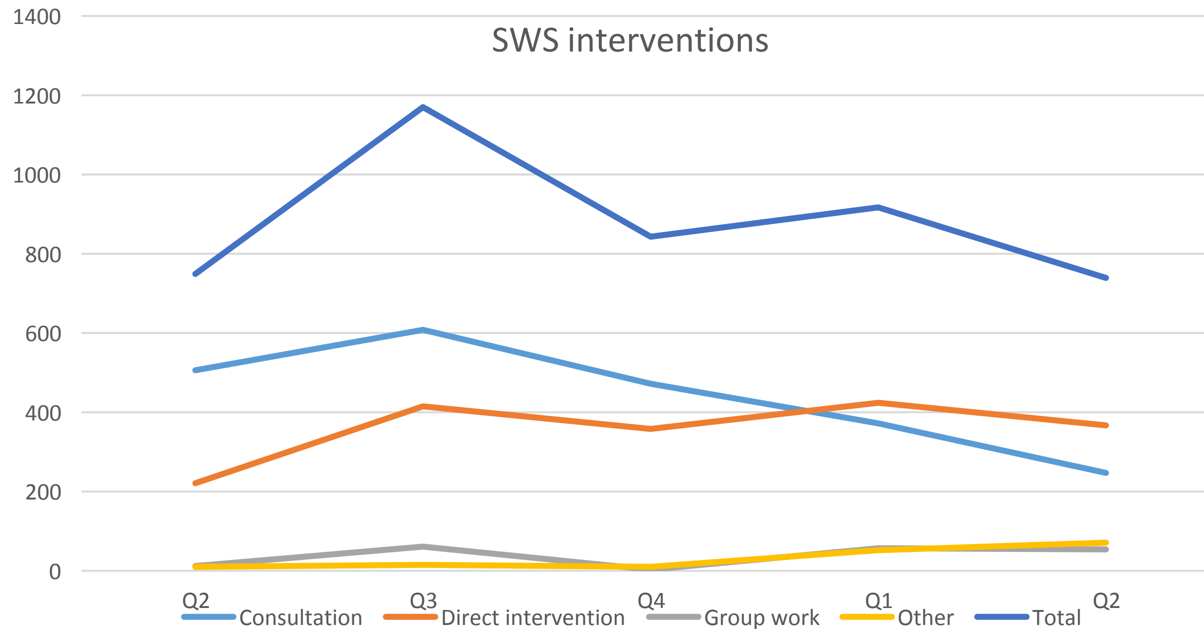
- There has been an increase in the number of number of young people referred into specialist CAMHS services, including the Sussex wide eating disorder service, since the second way of the pandemic. This has had an adverse impact on access to services and led to increases in waiting times and waiting list sizes together with an increase in service caseloads.

- There has also been an increase in the acuity and complexity of presentations as evident by the increase in CYP presenting in A&E, the increase in admissions to paediatric wards and the number of patients waiting a Tier 4 specialist CAMHS bed in Sussex.

➢ System partners working together to identify and manage clinical risk

Schools Wellbeing Service – activity levels

Number of Schools Wellbeing Service Interventions - July (Q2) 20/21 -September (Q2) 21/22



The data reflects the focus of the service changing to supporting young people directly with fewer consultations as a result of Covid school closures. Ability to work in groups was also significantly impacted due to Covid restriction. To note - Q2 contacts are generally lower as a result of summer holidays.

Children and Young Peoples Wellbeing Service – waiting times

The service, which is for young people with mild to moderate health needs, has seen an increase in the number of referrals for support. Activity levels have exceeded the indicative plan since March 2021, whilst referrals during the last quarter (October 2021 – December 2021) were on average17% above the planned target.

There are currently 413 young people waiting for interventions across the 20 different treatment pathways which are currently offered by the service. The wellbeing services which have seen the greatest increase in referrals, adversely impacting on the waiting times are:

- Autism Spectrum Condition (ASC) See and Treat
- Cognitive Behavioral Therapy (CBT)
- Wellbeing Assessment Age 4-12
- Counselling Age 4-12
- Counselling Age 13-24
- Play Therapy See and Treat

All referrals are subject to clinical triage through the well-being hub to ensure appropriate prioritisation.

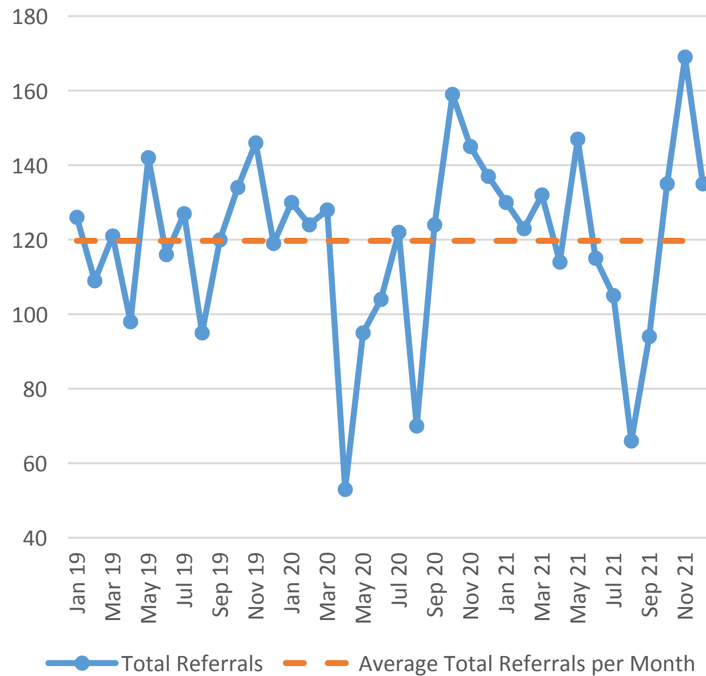
In response, additional resources were provided to enable increased 1:1 support for children to be provided. In tandem, YMCA services have reviewed the totality of children and young people on their waiting list to identify if alternative support measures would be appropriate. They also provide young people waiting with regular telephone contact and parent groups have been established for families waiting. E-wellbeing support directing young people and families to information and advice is also provided.

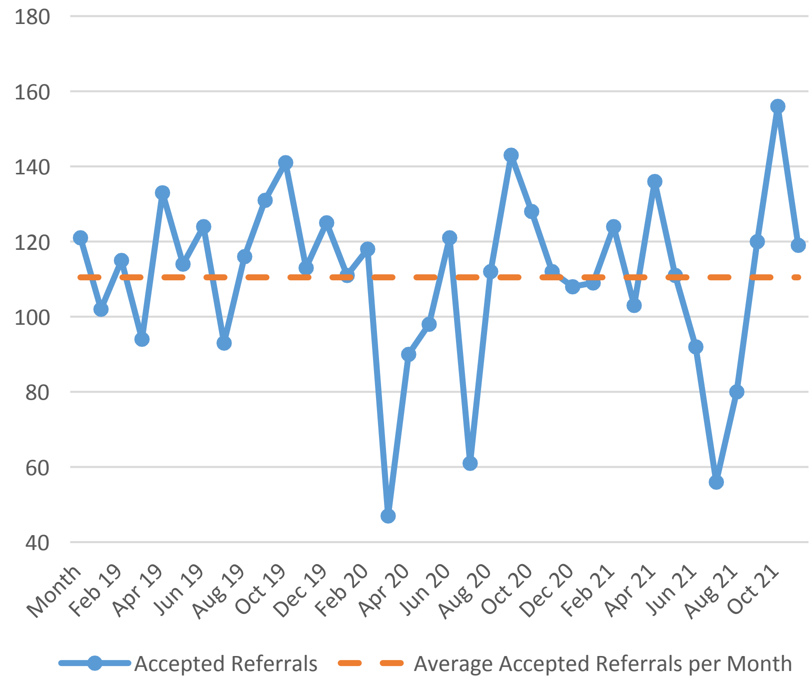
Proposals to expand services further and respond to the increase in referrals have been put forward as part of the 2022/23 planning process.

Specialist CAMHS - total and accepted referrals

Month	Total Referrals	Change	Accepted Referrals	Change
Nov-19	146	-	141	-
Nov-21	169	16%	156	11%

Referral rates have had a sustained increase since the second half of 2020 with 11 out of the last 16 months seeing higher than average numbers between September 2020 – December 2021 which has impacted on the number of young people waiting for assessment and treatment



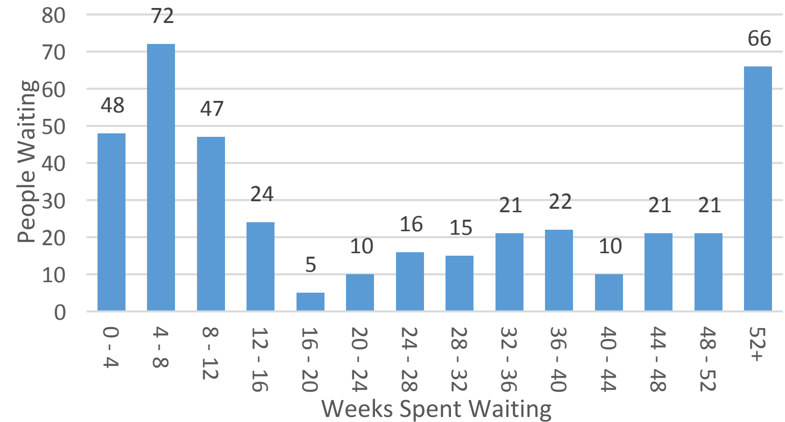


Specialist CAMHS - number of young people waiting for an assessment

These tables detail the total number of young people waiting for assessment for a specialist CAMHS service in Brighton and Hove by weeks waiting.

The table below demonstrates that the number waiting has increased significantly since the autumn 2020 which corresponds with the increases in referral experienced and the need to support the increase in number of young people receiving interventions from within the service.

These waiting the longest are predominantly young people waiting for an autism spectrum condition or attention deficit hyperactivity disorder assessment where we have some of our greater capacity gaps



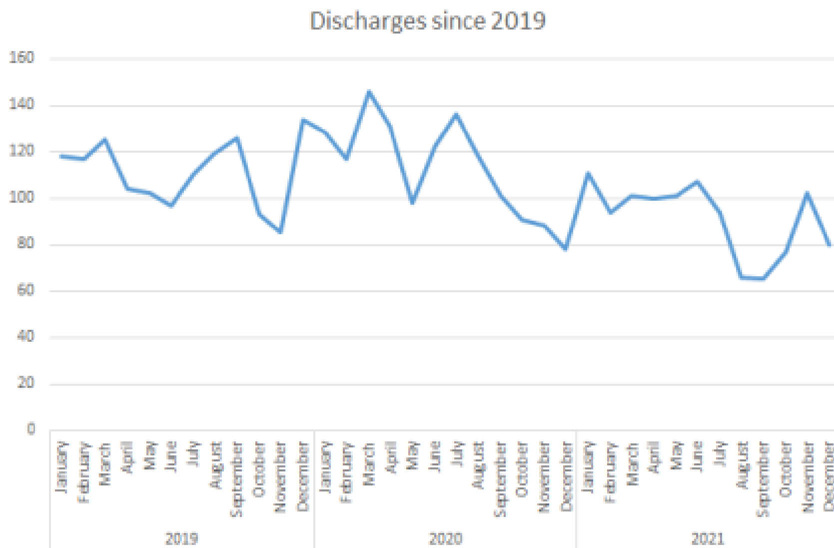
There is a significant programme of work with associated investment to expand the capacity of these services and enhance the current neurodiverse pathways. For children and young people waiting, the Trust has put in place good clinical and quality oversight and measures to support children and young people waiting for care. This includes an online drop-in group for all families who are awaiting an ASC or ADHD assessment.

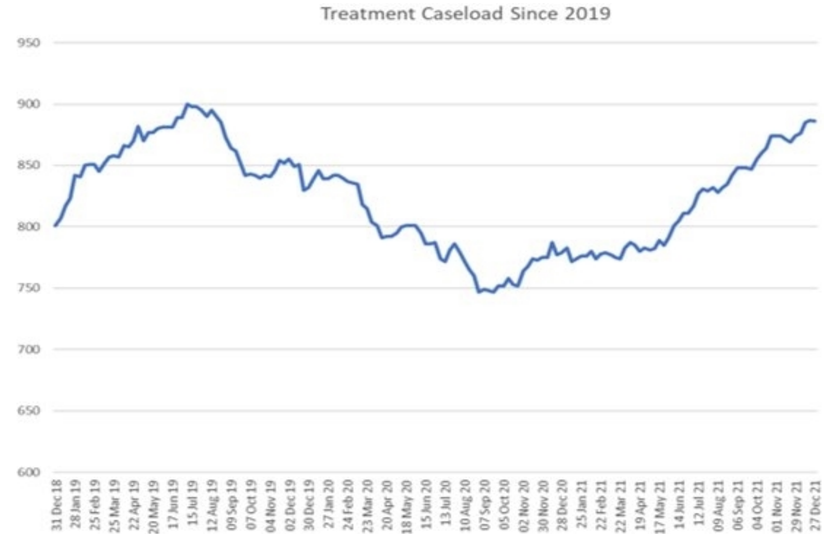
Proposals to further expand the service capacity have also been included in the 2022/23 planning process.

Specialist CAMHS – current treatment caseload & number of discharges

This table shows the number of young people discharged from the service by month since January 2019. As evident from the graph, discharge activity has been trending down slightly, since August 2020.

One reason relates to young people requiring treatment interventions for longer periods of time, reducing the discharge rate.





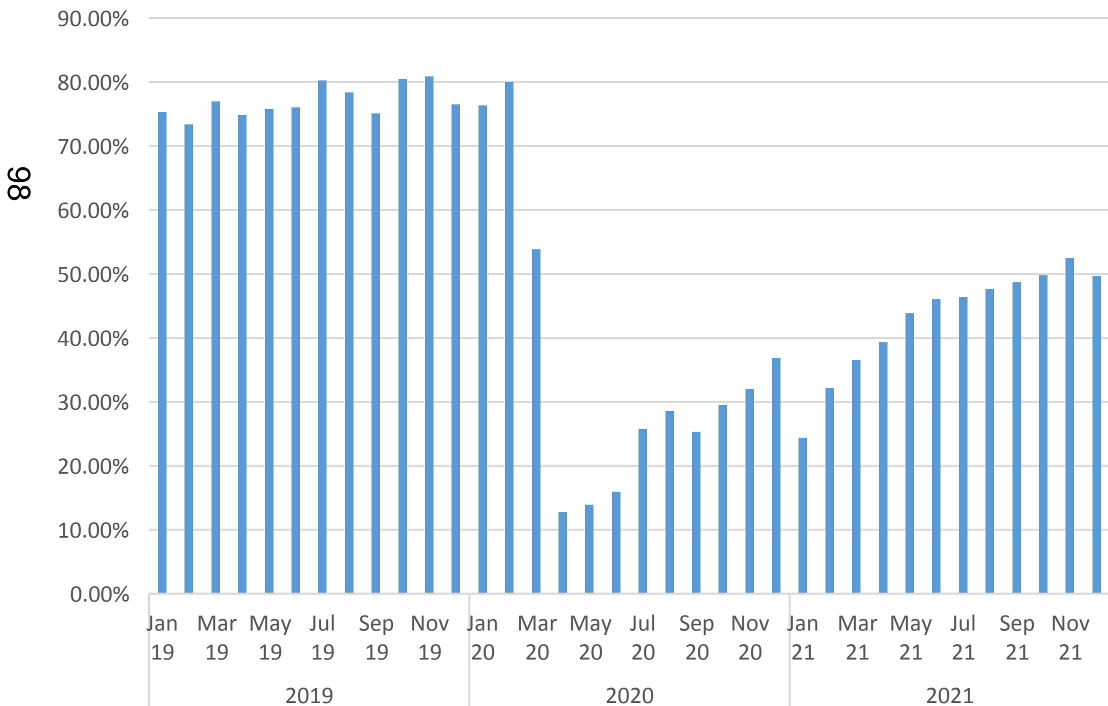
This tables demonstrates that, in line with national trends, referrals for services reduced during the first wave of the pandemic but has seen a significant increase since September 2020. This is due to both the increase in referrals and the slight reduction in discharges from the service since the autumn last year which has had a corresponding impact on the total treatment caseload.

A series of measures have been put in place to respond to this as summarized in slides 30 – 33.

Specialist CAMHS - percentage of contacts which are face-to-face

As evident from below, the Trust responded very promptly to Covid to provide virtual contacts to ensure continued service delivery

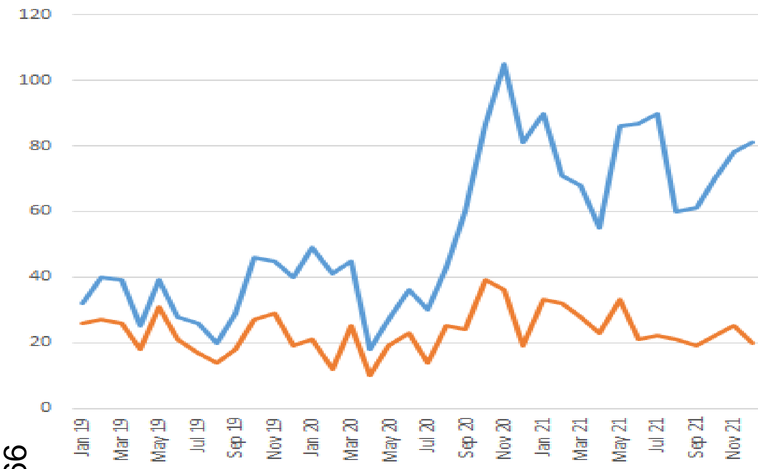
Month	%F2F	Change
Nov-19	81%	
Nov-21	52%	-28%

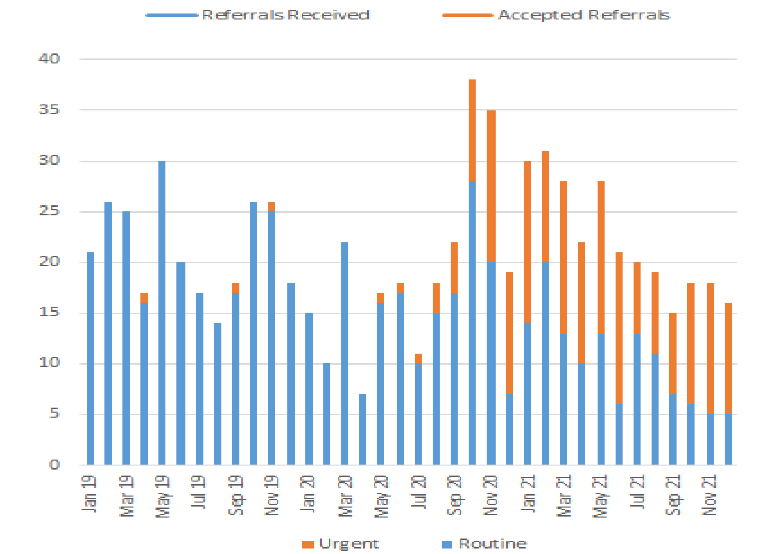


Face to Face activity then increased as lockdown measures were eased.

However, engagement with young people has identified a preference that access to virtual appointments should continue to provide choice and a blended approach and be integrated into the new normal, meaning we will likely never be running at 75%+ Face-to-Face again

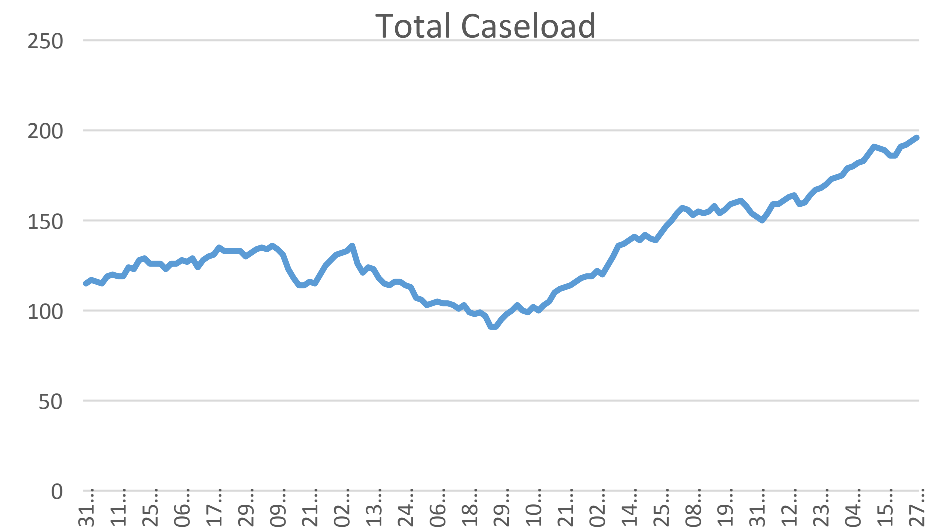
Specialist CAMHS - Sussex Family Eating Disorder Service – Referrals & Caseload





In line with national trends, the service has seen a significant increase in both urgent and routine referrals since late summer which has resulted in a corresponding increasing caseload.

A significant programme of work, and associated investment, has been put in place to both increase the available capacity and enhance and improve the current pathway and service offer.

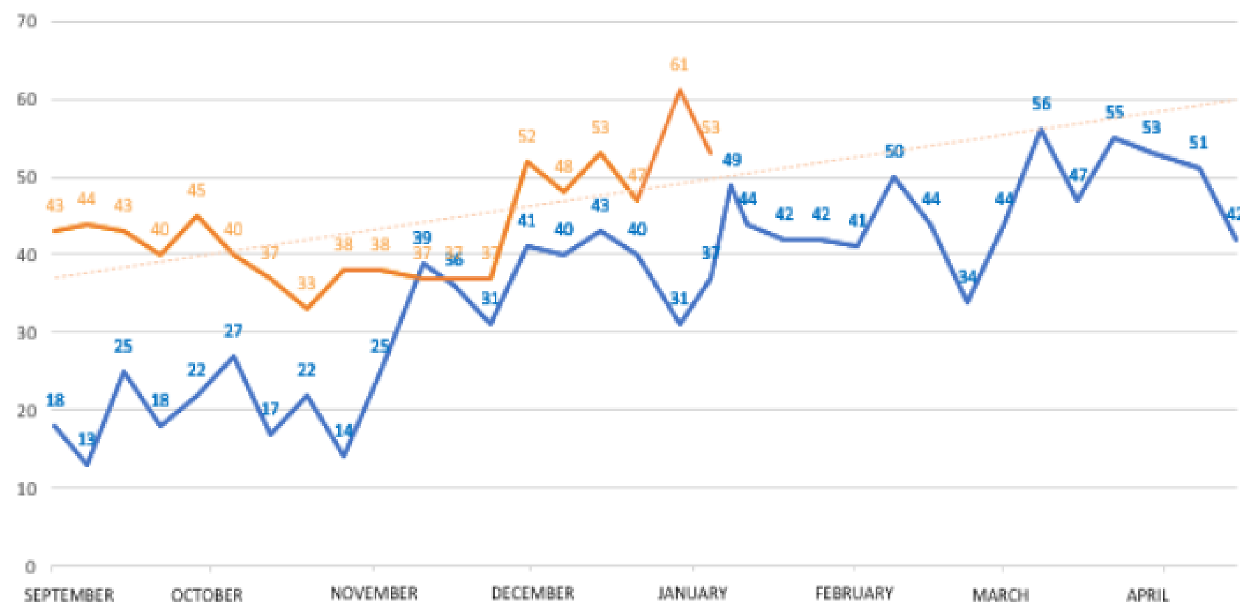


Working together across Sussex

NHSE South East Region – CAMHS Tier 4 inpatient services

The graph shows the increase in referrals for children and young people to access CAMHS Tier 4 services in the South East from September 2021 in comparison to the same period last year, indicating the increasing complexity of children and young people accessing services. It includes young people waiting at home as well as those in an acute hospital bed or already in a CAMHS inpatient setting but waiting for a more appropriate placement. This does not include the no of young people admitted to our acute paediatric hospitals who do not require very specialist T4 inpatient services.

As evident from the graph, this increase in is predicted to continue



Key:
- 2020/21
- 2021/22

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Challenges and Our Response

Challenges

Although plans are in place to develop and increase children and young peoples emotional wellbeing and mental health support there are a number of challenges in delivering the plans:

- Workforce expansion and development – we require a skilled workforce to deliver our plans and we have been unable to recruit to key clinical roles. This issue is recognised nationally and we are working to address the workforce gap.

- Covid-19 has not only had a significant impact on the emotional wellbeing and mental health of children and young people it has also had an impact on service delivery. Both in the way services are delivered (face to face or virtually) and the ability to deliver services when the workforce is reduced due to staff absence.

Services are also dealing with:

- Increased levels and complexity of need – a combination of Covid-19 suppressed and generated activity. This adds pressure to already stretched services and because of the level of need young people are often remaining in the service longer leading to increased case loads. This has led to increased waiting times in particular for Cognitive Behavioural Therapy (CBT) and ASCC and ADHD assessment.

- Increased Acute and Crisis Presentations

Summary of our response (1 of 3)

Our 2021/22 transformation and additional in-year investment plans of £1.23m have been targeted to:

- Deliver the NHS Long Term Plan and local priorities
- Address underlying capacity gaps and increase access to services
- Respond to the challenges associated with the adverse impact of Covid-19 on our children and young people and service, in particular
    - Longest waiting lists and length of wait
    - Access to eating disorder services
    - Better supporting young people in crisis

This work has focused on:

- Workforce expansion and development
- Pathway improvements to increase capacity and begin to address the long waits
- Development of new ways of working
- Improved access to information and guidance

Summary of our response (2 of 3)

Examples include:

Workforce Expansion and Development

- Successfully recruited to a number of roles and posts event in August 2021 to increase our local capacity to deliver services
- Established a SPFT Talent Acquisition Manager to provide expert help around advertising, campaigns etc.
- Increased use of social media e.g. Facebook
- Invested in the development of professional leadership, including improving links with local universities
- Introduced new initiatives e.g. Recruit To Train and approved/responsible clinician pilot

Pathway development:

- Streamlined the clinical model for neurodevelopmental pathway in advance of moving towards a new best practice target operating model
- Developed a new stepped care model will include CBT groups as first line of intervention
- Agreed plans to enhance home treatment offer and establish a specialist day service for young people with an eating disorder
- Implemented a new clinical model for children and young people in crisis

Summary of our response (3 of 3)

New ways of working:

- Introduced a blended offer of digital and face to face contacts to ensure continued access to services
- Introduced group sessions to support increases in capacity
- Early Intervention in Psychosis service has adopted the CARMEN project pilot, a finger-prick blood test option for testing for cardio-metabolic side effects of anti-psychotic medication, in order to reduce barriers to physical health assessment for service users, and deliver in-house.
- Introduced physical health clinics and group sessions for young people with eating disorders and their families or carers

Communication:

- Launched the Sussex Mental Healthline, a Freephone 24/7 triage service for young people
- Set up a digital wellbeing service to support young people being able to access the right support and information around their emotional health and wellbeing Home - e-wellbeing
- Published a clear online guide on how to get help from Sussex mental health and emotional wellbeing services in each local authority area, for children and young people with mild to moderate and severe problems.
- Improved information access via our website https://sussexcamhs.nhs.uk/ which details referral criteria as well as information and advice about help and support for children, young people, families and professionals.

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Performance

National access standards for children and young people

There has been an increase in the ambition of a number of national access standards in 2021/22 and new standards have been introduced.

These are summarised in table below. However, national reporting of the new urgent care and 18-25 measures have not yet commenced.

Status	Service Area	21/22 Standard
Existing	Children and young people eating disorders	95% target of people seen within 1 week of urgent referral 95% target of people seen within 4 weeks of routine referral
Existing	Access to CAMHS	35% of YP having 2 contacts within the last 12 months
New	Children and young people under 18	Increase access of under 18s by 292 to 10,085
New	Young people between 18-25	285 CYP accessing 18-25 youth appropriate services
New	Urgent Care	Increase coverage of 24/7 crisis provision from 37% to 57%

Latest validated performance against national access standards for children and young people

This tables provides the most up to date validated / reported data against the national standards for children and young peoples services.

This demonstrates that performance is compliant for access to CAMHS services, but is worsening for referrals into the Sussex Family Eating Disorder service as at quarter 2, 2021/22.
A range of mitigating actions have been put in place which, together with some successful recruitment have meant that the in-month performance improved to 66.7% for urgent referrals seen within 1 week in November 2021 with a further improvement in December 2021.

Measure Name		Sussex					Brighton & Hove	Date
		Current Period	Previous Period	Local Plan	National Plan	Trend	Current Period	
CYP with eating disorders (ED) (routine)		40.9%	59.5%	47.5%	95.0%	↓	60.0%	Q2 21/22
CYP with eating disorders (ED) (urgent)		34.3%	43.0%	65.1%	95.0%	↓	33.3%	Q2 21/22
Access to CAMHS	2 Contact Rate	38.7%	38.1%	37.6%	35.0%	↑	44.8%	Sep-21
	1 Contact	15,010	14,540	12,509		↑	2,535	Sep-21

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Next Steps

Priorities and Investment Planning for 22/23

Planning for 2022/23 and 2023/24 is currently in progress and being led through the strategic approach of our Foundations for our Future Programme. This is a multi-agency process, informed by local stakeholder including children and young people and their families and carers. Plans have been developed and a prioritisation is underway to ensure the investment plans best address need, are within our resource allocation, and continue to work towards our collective ambitions. The plans include:

- **Single Point of Access (SPOA)**
- **Early Help as part of THRIVE framework -** work is now focusing on the provision of emotional wellbeing services that will ensure that children and young people will have full access to earlier help and emotional wellbeing support.
- **Eating Disorders** – further expansion of the eating disorders service to increase treatment provision
- **Specialist CAMHS** – further expansion with a focus on increasing capacity within the neuro-developmental pathway and increasing the provision of cognitive-behavioural therapy (CBT) to continue to reduce waiting times.
- **Urgent and Emergency Support** – following scoping work in 2021/22, develop alternative crisis provisions for children and young people that aim to provide early support to children and young people in self-defined crisis that will complement existing crisis services.
- **Transition (16-25 year olds)** – a focus on care leavers and students as specific programme priorities but with an intention to ensure that all transformation work streams account for improving transition in their development. This will include the piloting of ARRS roles specifically for the 16-25 age range.
- **Suicide prevention and reducing self-harm** – as part of planning for 2022/23 - 2023/24, ensure developments to support suicide prevention and self-harm reduction are incorporated in line with our Sussex wide strategic approach.

So in summary…..

- Our **ambition** is that by 2025, all people with mental health problems in Sussex will have access to high quality, evidenced-based care and treatment delivered by integrated statutory, local authority and third sector services that are accessible and well connected with the wider community, intervene as early as possible in someone's life journey to prevent mental ill health.
- Local Transformation Plans integrated with the ambitions of the Long Term Plan will improve access to and quality of service provision along a pathway of need.
- There is a commitment to working with families to ensure the best outcomes for our families. Learning from families and best evidenced based care will ensure quality future proofed services are developed and sustained.
- The workforce will be skilled and valued supporting recruitment and retention.
- Data sources will be integrated into service development decision making to best utilise resources and understand levels of need.
- Challenges and opportunities will be understood in a context of changing environments and technologies and be inclusive of the needs all service users.
- There is optimism to deliver high quality services with a well trained healthy workforce.

B&H HOSC Work Plan 2022-23
13 April 2022
• Queen Victoria Hospital East Grinstead Specialist services (burns) • Winter 21/22 – update on how health and care services coped with winter pressures
13 July 2022
• Healthwatch Brighton & Hove Annual Report – for information
19 October 2022
• Winter planning 22/23 – Sussex-wide and local winter plans for information
25 January 2023
12 April 2023