Brighton & Hove City Council

Overview & Scrutiny Committee

Title:	**Health Overview & Scrutiny Committee**
Date:	**5 October 2016**
Time:	**4.00pm**
Venue	**Council Chamber, Hove Town Hall, Norton Road, Hove, BN3 4AH**
Members:	**Councillors:** Simson (Chair), Allen, Bennett, Cattell, Deane, Knight, Marsh, Peltzer Dunn, O'Quinn and Taylor **Co-opted Members:** Zak Capewell, Frances McCabe (Healthwatch), Caroline Ridley and Colin Vincent (OPC)
Contact:	**Giles Rossington** Senior Scrutiny Officer 01273 295514 giles.rossington@brighton-hove.gov.uk

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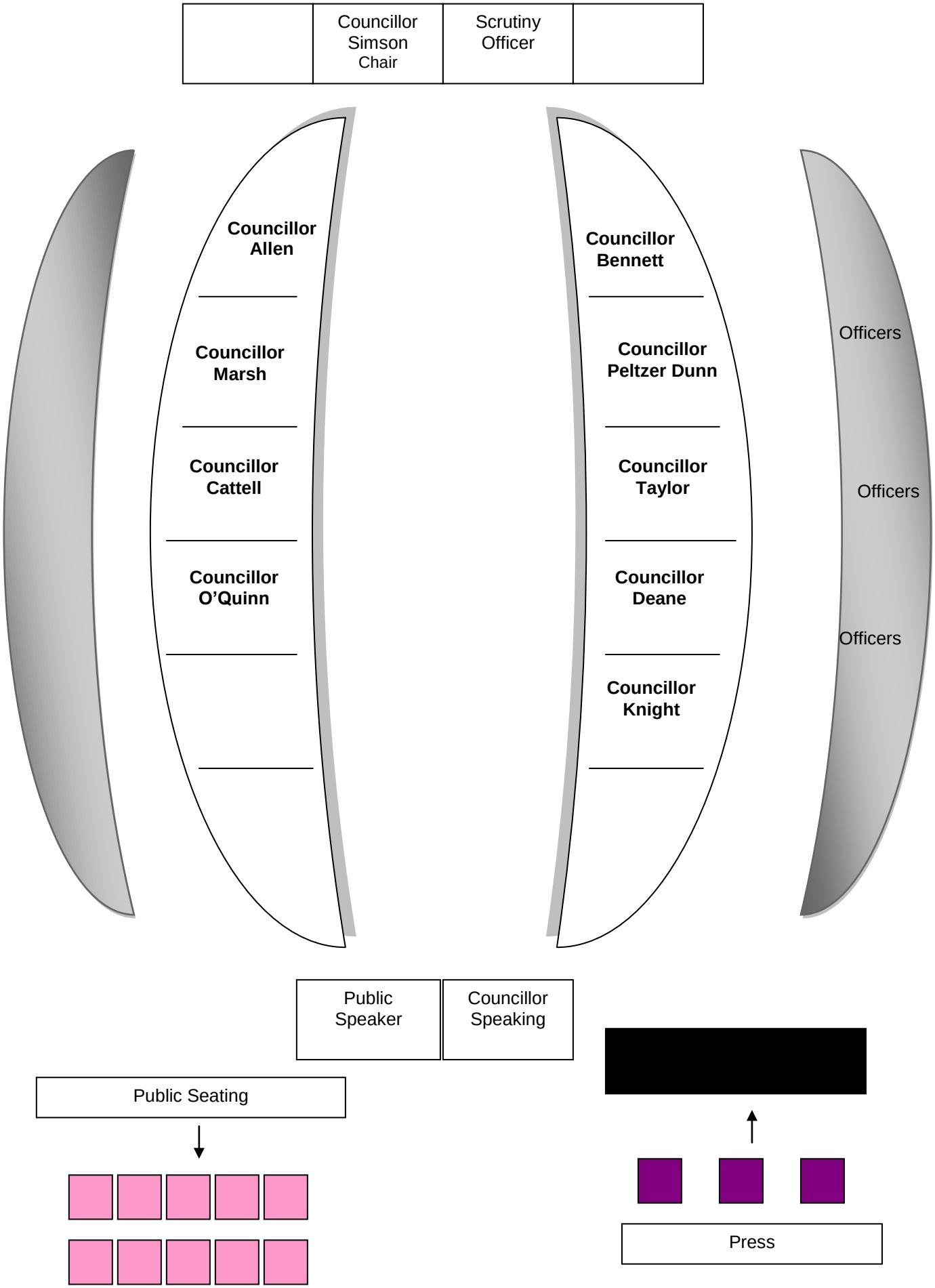
Democratic Services: Overview & Scrutiny Committee



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24 PUBLIC INVOLVEMENT

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

(a) **Petitions:** to receive any petitions presented by members of the public to the full council or at the meeting itself;
(b) **Written Questions:** to receive any questions submitted by the due date of 12 noon on the (insert date);
(c) **Deputations:** to receive any deputations submitted by the due date of 12 noon on the (insert date).

25 MEMBER INVOLVEMENT

To consider the following matters raised by councillors:

(a) **Petitions:** to receive any petitions submitted to the full Council or at the meeting itself;
(b) **Written Questions:** to consider any written questions;
(c) **Letters:** to consider any letters;
(d) **Notices of Motion:** to consider any Notices of Motion referred from Council or submitted directly to the Committee.

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Contact Officer: *Giles Rossington* *Tel: 01273 291038*
Ward Affected: *All Wards*

OVERVIEW & SCRUTINY COMMITTEE

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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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Date of Publication - Date Not Specified

HEALTH OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 26 Brighton & Hove City Council

Subject:		**Care Quality Commission (CQC) Inspection of Brighton & Sussex University Hospitals Trust (BSUH)**
Date of Meeting:		**05 October 2016**
Report of:		**Executive Lead for Strategy, Governance & Law**
Contact Officer:	**Name:**	**Giles Rossington** **Tel: 29-5514**
	Email:	**Giles.rossington@brighton-hove.gov.uk**
Ward(s) affected:		**All**

FOR GENERAL RELEASE

1. PURPOSE OF REPORT AND POLICY CONTEXT

1.1 The Care Quality Commission (CQC) is the statutory inspector of health and social care services. The CQC is responsible for a rolling programme of inspections of NHS providers.

1.2 Brighton & Sussex University Hospitals Trust (BSUH) is an NHS trust providing general hospital services for the populations of Brighton & Hove and Mid Sussex, and more specialist services on a sub-regional and a regional basis. BSUH operates from two major sites: the Royal Sussex County Hospital (RSCH) in Brighton, and the Princess Royal Hospital (PRH) in Hayward's Heath.

1.3 The CQC conducted a full inspection of BSUH services in April 2016 and published its inspection reports in August 2016. The CQC's summary report is included as **Appendix 1** to this report. The full inspection reports are on the BSUH website: https://www.bsuh.nhs.uk/about-us/our-performance/our-cqc-ratings/

2. RECOMMENDATIONS:

2.1 That HOSC members note the general information on the CQC inspection process and specific information relating to the BSUH inspection included in this report and its appendix;

2.2 That HOSC members agree to appoint three members to an informal joint HOSC working group to monitor the implementation of quality improvement planning in response to the CQC's recommendations.

3. CONTEXT/ BACKGROUND INFORMATION

3.1 The CQC Inspection Process

3.1.1 The CQC undertakes a rolling programme of inspection of NHS provider trusts. Every NHS trust is inspected at least every three years, although

underperforming trusts may be inspected more frequently. When it inspects an NHS trust, the CQC examines key service-areas against five quality domains: ***caring***, ***well-led***, ***safe***, ***effective***, and ***responsive***. The CQC scores performance under each domain as either: ***outstanding***, ***good***, ***requires improvement*** or ***inadequate***. Where an organisation operates across more than one major site, each site is typically inspected and scored separately. The CQC also gives each trust an overall organisational score.

3.1.2 CQC inspection reports highlight areas where trusts either *must* make improvements (e.g. where there are clear legal breaches occurring) or *should* make improvements. Following an inspection every Trust is required to develop and publish a Quality Improvement Plan (QIP). NHS Improvement (NHSi), the NHS trust regulator, monitors the implementation of QIPs.

3.2 Special Measures

3.2.1 Should the CQC judge that a trust is inadequate across a significant number of domains, it may recommend to NHSi that the trust be placed in Special Measures. Trusts in Special Measures are able to access additional support for improvement.

3.3 BSUH

3.3.1 BSUH is a large NHS trust which provides acute (i.e. general hospital) services for the populations of Brighton & Hove and Mid Sussex. BSUH operates two major hospital sites: at the Royal Sussex County Hospital, Brighton (RSCH) and the Princess Royal Hospital, Hayward's Heath (PRH). BSUH also operates the Royal Alex Children's Hospital (RACH), the Sussex Eye Hospital, and the Queen Victoria Hospital, Lewes. Significant numbers of people from other areas also choose to use the RSCH and PRH as their local hospital (particularly people living on the western edge of East Sussex and the eastern edge of West Sussex).

3.3.2 BSUH increasingly also provides specialist hospital services for the whole of Sussex, and some very specialised services (e.g. trauma) on a regional footprint.

3.3.3 BSUH employs just over 7000 people and has an annual turnover of C £500M. Standard hospital services are commissioned for their populations by Clinical Commissioning Groups (CCGs), and specialised services are commissioned by NHS England (NHSE). BSUH receives significant funding from NHSE for its specialist provision; and from Brighton & Hove CCG, Horsham & Mid Sussex CCG, West Sussex Coastal CCG, and High Weald Lewes Havens CCG for general hospital care.

3.4 BSUH CQC Inspections

3.4.1 BSUH underwent a full CQC inspection in 2014, resulting in an overall score of ***Requires Improvement***. There was a follow-up inspection of emergency services in 2015 which resulted in a score of ***Inadequate***. There was a further full inspection of the Trust in April 2016, the results of which were published in August 2016. The Trust was rated as ***Inadequate*** and was subsequently placed in Special Measures by NHSi. The overall summary CQC report is included for

information in **Appendix 1** to this report. The full inspection reports are available on-line: https://www.bsuh.nhs.uk/about-us/our-performance/our-cqc-ratings/

3.4.2 BSUH has agreed a Quality Improvement Plan (QIP) with the CQC and with its commissioners. Once published, the QIP will be regularly updated, showing how the trust is progressing in implementing its quality improvement plans.

3.5 The Role of HOSCs in the CQC Inspection Process

3.5.1 HOSCs have a defined statutory role as stakeholders in CQC inspections of NHS trusts. The CQC contacts local HOSCs in advance of an inspection to ask them for comments and invites the relevant HOSCs to take part in the Quality Summit preceding the publication of an inspection report. However, there is no prescribed role for HOSCs following the publication of an inspection report: it is up to each committee how it scrutinises the implementation of CQC inspection report recommendations.

3.5.2 It is important to stress that it is not necessarily the HOSC's role here to itself suggest ways in which an NHS trust might improve its performance or to highlight the need for improvement. Whilst these might be appropriate actions in a different context, the fact of there being a CQC inspection report (and particularly a critical report) means that there is invariably a focus on a trust's shortcomings and a good deal of quality improvement work taking place. Neither is it necessarily the role of the HOSC to act as a conduit for public views on trust performance. Healthwatch is also a statutory stakeholder for CQC inspections, and it holds the brief for direct public engagement.

3.5.3 Rather, the obvious role for a HOSC is to seek assurance that the improvement planning in response to the CQC's inspection report recommendations is robust enough to lever significant improvement; and then to monitor implementation of the required changes. This is by no means a given, particularly in situations where there are longstanding quality problems that have resisted various attempts to resolve them. Should a HOSC not be assured that sufficient quality improvement measures are being taken, it could choose to escalate the issue to NHS commissioners and/or regulators.

3.5.4 Since BSUH provides services across Sussex, it is scrutinised by West and East Sussex HOSCs as well as by Brighton & Hove HOSC. Whilst each HOSC could choose to act separately, there are obvious advantages in coordinating scrutiny of this issue. These include reducing the burden of duplication on NHS colleagues and most effectively managing the administrative resources of each of the HOSCs.

3.5.5 Sussex HOSC Chairs have consequently suggested that an informal joint HOSC working group be established, consisting of three members from each of the HOSCs. The working group would be tasked with monitoring the implementation of BSUH's Quality Improvement Plan (QIP). The working group would have no delegated decision-making powers, acting wholly in an advisory capacity, and reporting back periodically to the HOSCs. Each individual HOSC would retain its statutory powers in relation to this issue, and any significant decisions (e.g. that a HOSC was satisfied with quality improvement measures and should cease

scrutinising them; or that it was dissatisfied and should seek to escalate its concerns) would be a matter for the determination of each HOSC individually.

3.6 Partnership with Healthwatch

3.6.1 Brighton & Hove Healthwatch plans to undertake a series of activities in response to the CQC inspection report – for instance, Healthwatch has already begun investigating the kinds of problems local people are experiencing with booking and attending Outpatient appointments, a services area that was highlighted as problematic by the CQC. B&H Healthwatch has kindly agreed to update HOSC members regularly on these work-streams, and this information could also be shared with the informal working group should a group be established.

4. ANALYSIS & CONSIDERATION OF ANY ALTERNATIVE OPTIONS

4.1 The proposal above is for informal joint scrutiny of the BSUH CQC inspection report. Alternative approaches would be either (1) to conduct all scrutiny separately; or (2) to create a formal Joint HOSC (JHOSC).

4.2 Option (1) is possible, but it would potentially require NHS officers to provide essentially the same information to three separate HOSCs. This level of duplication cannot be easily justified. Option (2) is also possible, but it would require HOSCs to delegate their statutory scrutiny powers (in respect of this issue) to a joint body. Members involved in previous JHOSCs have been uneasy about such a transfer of responsibility. Historically, Sussex JHOSCs have also proved cumbersome and expensive to run.

5. COMMUNITY ENGAGEMENT & CONSULTATION

5.1 None directly for this report. Future scrutiny of this issue is very likely to seek to engage community opinions, most obviously via the local consumer champion, Healthwatch.

6. CONCLUSION

6.1 Members are asked to agree to the establishment of an informal joint Sussex HOSC working group as the most efficient way to monitor BSUH quality improvement.

7. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

7.1 None for the council. Any additional HOSC activity will be managed within existing budgets.

Legal Implications:

7.2 The proposals relate to establishing an informal advisory working group. The working group will not have decision making powers and any decisions required by HOSC will continue to be required to be made by HOSC. The Working Group will therefore need to report back to the BHCC HOSC in order for the BHCC HOSC to take informed decisions on actions it may wish to take/recommend.

Lawyer Consulted: Elizabeth Culbert *Date: 6th September 2016*

Equalities Implications:

7.3 None directly. Future scrutiny of this issue is likely to include assessing the impact of BSUH quality improvement plans on protected groups, and may also focus on specific problems identified by the CQC in terms of protected groups (e.g. BME workforce).

Sustainability Implications:

7.4 The establishment of an informal joint HOSC working group would avoid duplication of work across all three Sussex HOSCs and should lead to a reduced demand for travel to and from meetings etc.

Any Other Significant Implications:

7.5 None identified.

SUPPORTING DOCUMENTATION

Appendices:

1. CQC Summary Report on BSUH

Documents in Members' Rooms

None

Background Documents

None

Brighton and Sussex University Hospitals NHS Trust

Quality Report

Eastern Road
Brighton
BN2 5BE
Tel: 01273 696955
Website: www.bsuht.nhs.uk

Date of inspection visit: 5th-8th April 2016
Date of publication: 17/08/2016

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Inadequate
Are services at this trust safe?	Inadequate
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Requires improvement
Are services at this trust responsive?	Inadequate
Are services at this trust well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal Sussex County Hospital (RSCH) in Brighton forms part of Brighton and Sussex University Hospitals Trust. RSCH is a centre for emergency and tertiary care. The Brighton campus includes the Royal Alexandra Children's Hospital (The Alex) and the Sussex Eye Hospital.

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

The Trust has two sites, Royal Sussex County in Brighton and the Princess Royal Hospital in Haywards Heath, consisting of 1,165 Beds; 962 General and acute, 74 Maternity, and 43 Critical care. It employs 7,195.92 (WTE) Staff; 1,050.59 of these are Medical (WTE), 2,302.52 Nursing (WTE), 3,842.81 other.

It has revenue of £529,598km; with a full cost of £574,417k and a Surplus (deficit) of £44,819k

Between 2015-2016 the Trust had 118,233 inpatient admissions; 640,474 Outpatient attendances, and 156,414 A&E attendances.

This hospital was inspected due our concerns about the Trusts ability to provide safe, effective, responsive and well led care. We inspected this hospital on 4-8 April 2016 and returned for an announced inspection on 16 April 2016.

Our key findings were as follows:

Safe

- Incident reporting was understood by staff but there was a variation in the departments on completion rates and a lack of learning and analysis.
- The trust had reported seven never events (5 of which were at RSCH) between Jan' 15 to Jan' 16, all seven were attributed to surgery and four of which were related to wrong site surgery incidents.
- Not all areas of the hospital met cleaning standards and the fabric of the buildings in some areas was poor, and posed a risk to patients, particularly with regard to fire safety.
- We had particular concerns that the risk of fire was not being managed appropriately. We found that the Barry and Jubilee buildings were a particular fire safety risks as they were not constructed to modern safety standards and had been altered and redesigned many times during their long history. They were overpopulated, overcrowded and cluttered with narrow corridors and inaccessible fire exits. We found flammable oxygen cylinders were stored in the fire exit corridors. We found that fire doors with damaged intumescent strips which would not provide half an hour fire barrier in the event of horizontal evacuation.
- Patients in the cohort area of the emergency department were not assessed appropriately; there was a lack of clinical oversight of these patients and a lack of ownership by the Trust board to resolve the issues.
- There were no systems in place for the management of overcrowding in the 'cohort' area. Staff were not able to provide satisfactory details of "full capacity" protocols or triggers used to highlight demand exceeding resources to unacceptable levels of patients in the area.
- The recovery area at RSCH in the operating theatres was being used for emergency medical patients due to having to reduce the pressure on an overcrowded ED and to help meet the emergency departments targets such as 12 hour waits. Some patients were transferred from the HDU to allow admission to that area and some patients were remaining in recovery when there was no post-operative bed available. Some patients were kept in the recovery area for anything between four hours and up to three days
- Staffing levels across the hospital were on the whole not enough to provide safe care for example the mixed ICU and cardiac ICU frequently breached the minimum staff to patient ratios set by the Intensive Care Society and the Royal College of Nursing.
- In some areas the trust had systematically failed to respond to staff concerns about this and mitigating strategies had failed.

Summary of findings

- Medicines management in the hospital was generally good, with the exception of Critical Care and out patients, significantly below the standard expected.
- We mostly saw that records were well managed and kept appropriately, However in OPD we observed records lying in unlocked areas that the public could access.
- The trust had a safeguarding vulnerable adults and children policy, and guidelines were readily available to staff on the intranet and staff were able to access this quickly. However, safeguarding training for all staff groups was lower than the Trusts target.
- Staff compliance in mandatory training, statutory training and appraisals fell below the trust target of 95% for statutory training and 100% for mandatory training, for both nurses and doctors across every department in the hospital.
- The trust had a Duty of Candour (DOC) policy, DOC template letters and patient information leaflets regarding DOC, and we saw evidence of these. The trust kept appropriate records of incidents that had triggered a DOC response, which included a DOC compliance monitoring database and we saw evidence of these. Most staff we spoke with understood their responsibilities around DOC.

Effective

- Staff generally followed established patient pathways and national guidance for care and treatment. Although we saw some examples of where patient pathway delivery could be improved.
- National clinical audits were completed. Mortality and morbidity trends were monitored monthly through SHIMI (Summary Hospital-level Mortality Indicator) scores. Reviews of mortality and morbidity took place at local, speciality and directorate level although a consistent framework of these meetings across all specialities was not in place. The trust's ratio for HSMR was better than the national average of 80%.
- Staff knew how to access and used trust protocols and guidance on pain management, which was in line with national guidelines.
- Patient's nutritional needs were generally met although patients in the cohort area at RSCH, ED at PRH and recovery RSCH did not always have easy access to food and water. In critical care there was no dedicated dietician.
- Appraisal arrangements were in place, but compliance was low across the hospital. Trust wide 68% of staff had received an annual appraisal against the trust target of 75%. Accountability for these lapses was unclear.
- Some services were not yet offering a full seven-day service. For example in medical care constraints with capacity and staffing had yet to be addressed. Consultants and support services such as therapies operated an on-call system over the weekend and out of hours. This limited the responsiveness and effectiveness of the service the hospital was able to offer.
- There were innovative and pioneering approaches to care with evidence-based techniques and technologies used to support the delivery of high quality care and improve patient outcomes in children and young peoples services

Caring

- Staff were caring and compassionate to patients' needs, and patients and relatives told us they received a good care and they felt well looked after by staff.
- Children and young people at the end of their lives received care from staff who consistently went out of their way to ensure that both patients and families were emotionally supported and their needs met.
- Privacy, dignity and confidentiality was compromised in a number of areas at RSCH, particularly in the cohort area, out patients department and on the medical wards in the Barry building.
- The percentage who would recommend the trust (Family and Friends Test) was lower than the England average for the whole time period until the most recent data for Dec '15, where is it currently above the England average.

Summary of findings

- Patients reported they were involved in decisions about their treatment and care. This was reflected in the care records we reviewed.
- We saw no comfort rounds taking place whilst we were in the ED department. This meant patients who were waiting to be treated may not have been offered a drink or had their pressure areas checked.

Responsive

- The admitted referral to treatment time (RTT) was consistently below the national standard of 90% for most specialties. The trust had failed to meet cancer waiting and treatment times.
- The length of stay for non-elective surgery was worse than the national average for trauma and orthopaedics, colo-rectal surgery and urology
- The percentage of patients whose operations were cancelled and not treated within 28 days was consistently higher than the England average.
- According to data provided by the trust, between January 2015 and December 2015 3,926 people waited between 4 to 12 hours (and 71 people over 12 hours) from the time of "decision to admit" to hospital admission. Since the inspection an additional 12 patients have been reported as waiting over 12 hours.
- Interpreters were available for those patients whose first language was not English. This was arranged either face to face or through a telephone interpreter. Staff told us that under no circumstances would a family member be able to act as an in interpreter where a clinical decision needed to be made or consent needed to be given.
- We saw examples of wards including the dementia care ward that operated the butterfly scheme. The butterfly scheme is a UK wide hospital scheme for people who live with dementia. We also saw that they had a dignity champion. This is someone who works to put dignity and respect at the heart of care services.

Well Led

- Staff in general reported a culture of bullying and harassment and a lack of equal opportunity. Staff survey results for the last two years supported this. Staff from BME and protected characteristics groups reported that bullying, harassment and discrimination was rife in the organisation with inequality of opportunity. Data from the workforce race equality standard supported this. Staff reported that inconsistent application of human resource policies and advice contributed to inequality and division within the workforce and led to a lack of performance and behaviour management within the organisation. These cultural issues had been longstanding within the trust without effective board action.
- There was a clear disconnect between the Trust board and staff working in clinical areas, with very little insight by the board into the key safety and risk issues of the trust, and little appetite to resolve them.
- The trust had a complex vision and strategy which staff did not feel engaged with. There was a lack of cohesive strategy for the services either within their separate directorates or within the trust as a whole. Whilst there were governance systems in place they were complex and operating in silos. There was little cross directorate working, few standard practices and ineffective leadership in bringing the many directorates together.
- The culture at RSCH was one where poor performance in some areas was tolerated and 50% of staff said in the staff survey they had not reported the last time they were bullied or harassed.
- There was a problem with stability of leadership within the trust. There were several long term vacancies of key staff. During the inspection we noted a number of senior management staff had taken leave for the period of the inspection.
- BME staff felt there was a culture of fear and of doing the wrong thing. They told us this was divisive and did not lead to a healthy work place where everyone was treated equally.
- Ward mangers and senior staff reported that they received little support from the trust's HR department in managing difficult consultants or with staff disciplinary and capability issues. They told us that HR advised staff to put in a grievance as a first step in resolving any issue. However the Trust

workforce evidence that HR Department supported 36 disciplinary matters and 16 dismissals and that the grievance rate had reduced significantly during 2015/16.

- The relocation of neurosurgery intensive care from Hurstwood Park to Brighton in June 2015 had been managed without appropriate planning and risk assessment and also lacked evidence of robust staff consultation. This had led to a culture in which nurses did not feel valued and there was significant and sustained evidence of non-functioning governance frameworks.
- The executive team failed on multiple occasions to provide resources or support to clinical staff in critical care to improve safety and working conditions and there was no acknowledgement from this team that they understood the problems staff identified.

We saw several areas of outstanding practice including:

- The play centre in The Alex children's hospital had an under the sea themed room with treasure chests full of toys and a bubble tank. There was also an interactive floor where fish swam around your feet and changed direction according to your footsteps.
- The children's ED was innovative and well led, ensuring that children were seen promptly and given effective care. Careful attention had been paid to the needs of children attending with significant efforts taken to reassure them and provide the best possible age appropriate care.
- The virtual fracture clinic had won an NHS award for innovation. It enabled patients with straightforward breaks in their bones to receive advice from a specialist physiotherapist by telephone.It reduced the number of hospital attendances and patients could start their treatment at home.
- We found that an outstanding service was being delivered by dedicated staff on the Stroke Unit (Donald Hall and Solomon wards). The service was being delivered in a very challenging ward environment in the Barry building. Staff spoke with passion and enthusiasm about the service they delivered and were focused on improving the care for stroke patients. The results of audits confirmed that stroke care at the hospital had improved over the past year.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly the trust must:

- Ensure that there are sufficient numbers of staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of patients using the service at all times.
- Ensure that all staff have attended mandatory training and that all staff have an annual appraisal.
- Ensure that newly appointed overseas staff have the support and training to ensure their basic competencies before they care for and treat patients.
- Undertake an urgent review of staff skill mix in the mixed/neuro ICU unit and this must include an analysis of competencies against patient acuity.
- Establish clear working guidelines and protocols, fully risk assessed, that identify why it is appropriate and safe for general ICU nurses to care for neurosurgery ICU patients. This should include input from neurosurgery specialists.
- Take steps to ensure the 18 week Referral to Treatment Time is addressed so patients are treated in a timely manner and their outcomes are improved. The trust must also monitor the turnaround time for biopsies for suspected cancer of all tumour sites.
- Ensure that medicines are always supplied, stored and disposed of securely and appropriately. This includes ensuring that medicine cabinets and trollies are kept locked and only used for the purpose of storing medicines and intravenous fluids. Additionally the trust must ensure patient group directives are reviewed regularly and up to date.
- Implement urgent plans to stop patients, other than by exception being cared for in the cohort area in ED.
- Adhere to the 4 hour standard for decision to admit patients from ED, i.e. patients should not wait longer than 4 hours for a bed.

Summary of findings

- Ensure that there are clear procedures, followed in practice, monitored and reviewed to ensure that all areas where patients receive care and treatment are safe, well-maintained and suitable for the activity being carried out. In particular the risks of caring for patients in the Barry and Jubilee buildings should be closely monitored to ensure patient, staff and visitor safety.
- Ensure that patient's dignity, respect and confidentiality are maintained at all times in all areas and wards.
- Stop the transfer of patients into the recovery area from ED /HDU to ensure patients are managed in a safe and effective manner and ensure senior leaders take the responsibility for supporting junior staff in making decisions about admissions, and address the bullying tactics of some senior staff.
- Review the results of the most recent infection control audit undertaken in outpatients and produce action plans to monitor the improvements required.
- Ensure its governance systems are embedded in practice to provide a robust and systematic approach to improving the quality of services across all directorates.
- Urgently facilitate and establish a line of communication between the clinical leadership team and the trust executive board.
- Undertake a review of the HR functions in the organisations, including but not exclusively recruitment processes and grievance management.
- Develop and implement a people strategy that leads to cultural change. This must address the current persistence of bullying and harassment, inequality of opportunity afforded all staff, but notably those who have protected characteristics, and the acceptance of poor behaviour whilst also providing the board clear oversight of delivery.
- Review fire plans and risk assessments ensuring that patients, staff and visitors to the hospital can be evacuated safely in the event of a fire. This plan should include the robust management of safety equipment and access such as fire doors, patient evacuation equipment and provide clear escape routes for people with limited mobility.

In addition the trust should:

- Review the consent policy and process to ensure confirmation of consent is sought and clearly documented.
- Review the provision of the pain service in order to provide a seven day service including the provision of the management of chronic pain services.
- Consider improving the environment for children in the Outpatients department as it is not consistently child-friendly.
- Ensure security of hospital prescription forms is in line with NHS Protect guidance.
- Ensure that there are systems in place to ensure learning from incidents, safeguarding and complaints across the directorates.
- Ensure all staff are included in communications relating to the outcomes of incident investigations.
- Implement a sepsis audit programme.
- Provide mandatory training for portering staff for the transfer of the deceased to the mortuary as per national guidelines.
- Ensure there is a robust cleaning schedule and procedure with regular audits for the mortuary as per national specifications for cleanliness and environmental standards.
- Review aspects of end of life care including, having a non-executive director for the service, a defined regular audit programme, providing a seven day service from the palliative care team as per national guidelines and recording evidence of discussion of patient's spiritual needs.
- The trust should ensure all DNACPR, ceilings of care and Mental Capacity assessments are completed and documented appropriately as per guidelines.
- The trust should implement a formal feedback process to capture bereaved relatives views of delivery of care.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Brighton and Sussex University Hospitals NHS Trust

Brighton and Sussex University Hospitals (BSUH) is an acute teaching hospital with two sites the Royal Sussex County Hospital in Brighton (centre for emergency and tertiary care) and the Princess Royal Hospital in Haywards Heath (centre for elective surgery). The Brighton campus includes the Royal Alexandra Children's Hospital and the Sussex Eye Hospital.

Providing services to the local populations in and around the City of Brighton and Hove, Mid Sussex and the western part of East Sussex and more specialised and tertiary services for patients across Sussex and the south east of England.

Out of 326 authorities, Brighton & Hove is ranked 102nd most deprived authority in England in 2015. This means they are among the third (31%) most deprived authorities in England

The health of people in Brighton and Hove is varied compared with the England average. Deprivation is higher than average and about 17.7% (7,700) children live in poverty. 13.3% (294) of children are classified as obese, better than the average for England. The rate of alcohol specific hospital stays among those under 18 was 63.1%, worse than the average for England. The rate of smoking related deaths in adults was worse than the average for England.

The health of people in Mid Sussex is generally better than the England average. Deprivation is lower than average, however about 7.7% (2,000) children live in poverty. Life expectancy for both men and women is higher than the England average. 11.6% (147) of children are classified as obese, better than the average for England.

The Trust has 1,165 Beds; 962 General and acute, 74 Maternity, and 43 Critical care. It employs 7,195.92 (WTE) Staff; 1,050.59 of these are Medical(WTE), 2,302.52 Nursing (WTE), 3,842.81 Other.

It has revenue of £529,598km; with a full cost of £574,417kand a Surplus (deficit) of £44,819k

Between 2015-2016 the Trust had 118,233 inpatient admissions; 640,474 Outpatient attendances, and 156,414 A&E attendances.

Our inspection team

Our inspection team was led by:

Chair: Martin Cooper Consultant

Head of Hospital Inspections: Alan Thorne, Care Quality Commission

The team included CQC inspectors and a variety of specialists: including consultants in Surgery, Medicine, Paediatrics, end of life care, senior nurses, a non-executive director, a director of nursing, allied health professionals and experts in facilities management, governance, pharmacy, and equality and diversity.

How we carried out this inspection

To understand patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following seven core services at the Princess Royal Hospital:

- Accident and emergency
- Medical care (including older people's care)

Summary of findings

• Surgery• Critical care

• Maternity and gynaecology

• End of life care

• Outpatients and diagnostic imaging

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included clinical commissioning groups (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch team.

We spoke with staff, patients and carers via email or telephone, who wished to share their experiences with us. We carried out the announced inspection visit on 4-8 April 2016 and returned for an announced inspection on 13 April. We held focus groups and drop-in sessions with a range of staff in the hospital including; nurses, junior doctors, consultants, midwives, student nurses, staff side representatives, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested. We talked with patients and staff from the majority of ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

Facts and data about this trust

Trust wide Safe:

- The trust have reported seven never events between Jan' 15 to Jan' 16, all seven were attributed to surgery and four of which were related to wrong site surgery incidents. All never events took place between June to December 2015. All reported within Surgery. Wrong site surgery accounts for the majority (4).
- 98% of NRLS incidents were rated as low or no harm.
- The trust reports lower incident numbers compared to the national average.
- There have been 54 serious incidents reported between Jan' 15 and Jan' 16.
- Safety thermometer Public Health observatory data for Dec' 14 to Dec' 15 reports low numbers of MRSA (2) compared to MSSA (21) and C.Diff (58).
- Between December 2014 to December 2015 there have been two MRSA cases.
- C. diff cases have peaked above the England average 7 out of 12 months.
- Safety thermometer data for Jan' 15 to Jan' 16 shows a decline in the number of Pressure ulcers and Falls and consistent C.UTIs reported across the time period. From Apr' 14 to Jul' 15 ambulance median time to initial assessment was significantly higher than the England average however fell to below the England average from Aug' 15 to Oct' 15
- Medical skill mix is similar to the England average for all staffing groups.

Trust wide Effective:

- Unplanned re-attendances to A&E within seven days percentages were consistently higher than the England average throughout the period Sep' 13 to Oct' 15
- Unplanned re-attendances to A&E within seven days percentages were consistently higher than the England average throughout the period Sep' 13 to Oct' 15
- Trust scores in the CQC A&E survey 2014 were rated as "about the same as other trusts" for questions relating to the effective domain.
- Trust scores were within the upper England quartile for three of the measures in the 2013 RCEM Consultant Sign-off Audit
- Scores for Royal Sussex County Hospital (RSCH) in the severe sepsis and septic shock 2013/14 audit

were within the upper England quartile for two, in the lower quartile for four and between the upper and lower quartile for the remainder of the 12 measures audited

- RSCH scores in the assessing for Cognitive impairment in older people audit 2014/15 were within the upper and between the upper and lower England quartile for the five measures audited.
- Asthma in children's audit 2013/14 placed the Royal Alexandra Children's hospital in the upper England quartile for five, and in the lower quartile for two of the seven measures.
- Mental health in the ED 14/15 audit for RSCH scores were in the lower England quartile forfour of the eight measures and between the upper and lower quartile for the remainder.
- No mortality indicators highlighted as a risk for this trust.
- There are no mortality outliers for this trust.
- Cancer patient experience survey, has eight measures in the bottom 20% comparable to other trusts, four measures were within the top 20% and the remaining were in the middle 60% comparable to other trusts.
- Paracetamol overdose audit 2013/14 scores at Royal Sussex County Hospital were in the upper England quartile for three of the four measures audited and between upper and lower quartile for the remaining one measure.

Trust wide Caring:

- The percentage who would recommend the trust (FFT) is lower than the England average for the whole time period until the most recent data for Dec '15, where is it currently above the England average.
- CQC inpatient survey 2014, the trust scored about the same compared to other trusts for all measures.
- Patient-led assessments of the Care Environment (PLACE) were found to be better in each audit from 2013 to 2015, however Privacy, dignity and wellbeing and Facilities have declined over the time period from previous scores.

Trust wide Responsive:

- The standardised relative risk of re-admission for elective procedures at Princess Royal Hospital for elective procedures were 33% higher than the England average noticeably for General Medicine (across all sites) and Clinical Haematology.
- Scores in the National Diabetes Inpatient Audit 2013 (NaDIA) at Royal Sussex County Hospital were worse than the England average for 17 of the 20 measures audited but better for the remaining three measures.
- MINAP 2013/14 scores at Royal Sussex County and at Princess Royal Hospitals were lower for two of the three measures compared to 2012/13 scores and lower than the England average for two of the three measures.
- The standardised relative risk of re-admission at Royal Sussex County Hospital for both elective and non-elective procedures were mostly the same as the England average.
- Trust scores in the Sentinel Stroke National Audit programme(SSNAP) for combined total key indicators (patient centred and team centred) at Princess Royal Hospital declined from C to D in the Jul' to Sep' 15 quarterly audit. Whereas the combined total key indicators improved from D to C at the Royal Sussex County Hospital in the same period.
- In the 2012/13 Heart failure audit Royal Sussex County Hospitals scored below the England average for in hospital care measures and mostly the same for discharge care measures whereas Princess Royal Hospital score below for in hospital measures and better than the England average for two of the seven discharge care measures.
- NaDIA 2013 scores for Princess Royal Hospital were better than the England average for seven of the 19 measures but worse for the remaining 12 measures.
- The percentage of patients seen within four hours were consistently lower than the England average and lower than the 95% target throughout the period Sep' 13 to Dec' 15.
- The total time spend in A&E was consistently longer than the England average throughout the period Sep' 13 to Oct' 15.

Summary of findings

- The percentage of patients waiting four to twelve hours from decision to admit to being admitted through the A&E were consistently worse than the England average for the period Jan' 15 to Dec' 15.
- The percentage of patients leaving before being seen were worse than the England average for the majority of monthsbetween Sept' 13 – Nov' 15
- The trust were rated as "about the same as other trusts" for all the questions in the A&E survey 2014 pertaining to the responsive domain.
- Delayed transfer of carebetween Apr' 13 and Aug' 15 has the top three reasons as waiting for further non acute NHS care (46.6%) patient or family choice (20.7%) and awaiting care package in own home (12.3%).
- Bed occupancy is below the national average between Q1 14/15 to Q1 15/16 the most recent data up to Q3 15/16 has it above the England average.
- The number of complaints have varied between 1,338 to 1,126 over the five year financial period.
- Since 2012/13 there has been a slight decline in the number of complaints with the lowest number reported in 2013/14 (1,126).

Trust wide Well-Led:

- General Medical Council 2015 national training survey highlights the trust score about the same as other trusts for all but two measures where it scored worse for Induction and Feedback.
- In the NHS Staff survey 2015 the trust has improved it score across most measures, it scored better than other trusts in 16 measures compared to the 2014 survey, where the trust scored worse than other trusts for 20 measures and was found to be similar to other trusts for all others questions.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? We rated the trust as inadequate for safety. This was because:- • Urgent and emergency services at both RSCH and PRH plus medical care, critical care and outpatients at RSCH were all rated as inadequate for safety. • Staffing levels and skill mix in emergency departments, medical wards, critical care and midwifery were significantly below standards. • The estate was poorly managed leading to utilisation without due consideration for dignity and safety. • Processes for learning and feedback from incidents were largely ineffective and not recognised by staff. • Infection control and other mandatory staff training levels were low. **Incidents** • The trust operated an electronic reporting system that was consistent across both sites. Staff reported that they found the system accessible and that they had been trained. • The incident reporting system was supported by policies and processes that most staff recognised and were consistently applied across the trust. • The trust had 7 never events and 54 serious incidents during the period January 2015 to January 2016. All seven never events were attributed to surgery of which four were wrong site surgery. As part of our inspection we reviewed the root cause analysis related to the never events and considered the responses to be satisfactory. • Across the trust we largely found staff responsive to reporting incidents and there was a good supportive culture for the reporting of incidents. However, in a number of areas of the trust, the staff had ceased to report staffing level related incidents due to the belief that such reports initiated neither feedback or action form senior staff. This was of particular concern on medical wards. In addition some services reported that incidents may not be reported due to excessive working pressures and staffing shortages. • In most areas we saw appropriate incident investigation processes. However, in both critical care and outpatients environments we found poor quality investigations, insufficient analysis and lack of feedback.	**Inadequate** 

Summary of findings

- Many staff reported that there was a lack of feedback to them subsequent to reporting of incidents. However, many areas had initiated programmes to support learning from incidents, such as bulletins, and included an innovative approach in emergency care of the creation of a podcast for staff. The incident action reviews in children and young peoples services were an excellent addition to the process of incident management. The surgery service had also initiated human factors training to support staff. However, despite such initiatives, when interviewing staff, evidence of learning from incidents across the trust was very inconsistent.
- Across the trust there was an awareness amongst staff of their responsibilities under the duty of candour regulation. Reviewing complaint and incident responses we were able to evidence that the trust largely discharged its duty under this regulation. However our report has noted that in a significant number of cases patients were waiting in excess of 60 days to be notified.

Cleanliness and infection control, equipment and environment

- It should be noted that the environment and building stock on the Royal Sussex County Hospital site presents a major challenge to staff in the maintenance of standards of cleanliness and care. However during our inspection we identified numerous areas in which environmental standards were below that expected.
- The emergency departments continued use of the cohort (corridor) area for care, the medical wards situated in the Barry building and the use of 'balcony' areas to create additional bed areas, bed spaces and ambient temperature in critical care and poor maintenance and condition in outpatients were all examples were design and condition impeded the provision of safe and dignified care.
- Of particular concern was the management of fire safety across the trust. In a number of areas, but notably the medicine wards in the Barry Building, we identified a lack of fire safety risk assessment, equipment and evacuation plans. As a result we ordered the trust to take immediate action to address the concerns.
- During our inspection it was apparent that areas of the trust had been decorated immediately prior to our arrival. Whilst the trust needs to maintain its decorating process following the

inspection to maintain credibility with staff, of more concern was the apparent lack of contractor control being provided in those areas where decoration continued during the inspection. This was seen to compromise both patient dignity and safety.

- The trust estate did include significant areas of more modern estate that did not face the challenges of the older buildings. Across the trust clinical environments were largely visibly clean. However, during inspection we identified a lack of cleaning schedules and curtain replacement programmes. A number of areas also exhibited poor protocols for the cleaning and labelling of commodes.
- The trust had an up to date infection control policy and there was a trust wide infection control team. Staff and visitors had appropriate access to hand hygiene sanitizers. However, we observed during the inspection an inconsistent approach to hand hygiene practice with some areas not observing hand cleansing or bare below the elbows practice. Where hand hygiene audits had identified issues we found no evidence of remedial action plans. Similar to our general findings with respect to mandatory training, we found that staff attendance for infection control training was significantly below the trust target in many areas.
- Staff reported that they largely had access to equipment that was required to provide care. Resuscitation equipment was available where required, although in some cases we identified that daily checks were not being consistently completed.
- Hospital operating theatre capacity was largely as required however access to emergency theatre facilities for obstetric emergencies at RSCH was highlighted in our report.

Safeguarding

- The chief nurse was the designated executive lead for safeguarding. The trust employed a team of nurses to support adult safeguarding. A comprehensive policy was in place. The trust has a dedicated safeguarding midwife and this area has a strong assessment framework.
- Safeguarding training compliance across the trust, as per infection control and mandatory training, was significantly below trust and expected targets.
- Our inspection identified that staff across the trust had a good awareness of safeguarding issues, processes of escalation and how to access safeguarding leads. In the maternity and gynaecology this included risks associated with domestic violence and genital mutilation.

- In children's services there was a named doctor and named nurse for safeguarding. Again staff were found to be very aware of safeguarding issues. Training in this area was compliant and was supported by information via a safeguarding newsletter. The information for staff on the intranet was of a high standard.
- As part of our inspection we requested the most recent board reports relating to safeguarding. We received the annual children's safeguarding board report dated December 2015 and it was comprehensive in coverage. However, there was an eighteen month gap between the board receiving an adult safeguarding report in September 2014 and March 2016.

Staffing

- The trust monitored safe staffing levels, sickness and vacancy rates and the use of bank and agency staff. This data was available for all core services.
- Nurse staffing on medical wards was of significant concern on both trust sites. Staff interviewed during our inspection indicated an overwhelming feeling of being short staffed. The trust did not utilise a patient acuity tool to determine appropriate staffing levels.
- Following the transfer of neurosurgery to the RSCH site, the staffing of critical units at RSCH had been problematic. As a consequence we found that the skill mix on the critical care unit managing these patients was not sufficient to provide the specialised care patients required. In addition the staffing levels were frequently below national guidance.
- Nurse staffing levels in the emergency department at RSCH fell below safe levels on more than 60% of shifts reviewed. In addition, at PRH we identified staffing levels supporting the resuscitation area were below expected 1:1 ratios. Staffing within this department had not been recently reviewed despite the impact of IT implementation and the department also had very high agency usage.
- Midwifery staffing allowed a birth to staff ratio of 1:30 and there was appropriate provision of supervision, however this ratio did not provide for 100% 1:1 care for mothers and midwives who were also used to support obstetricians in theatre, against current guidance.
- During our inspection we identified few issues relating to levels of medical staffing. We saw evidence that daily ward rounds were being completed and that on critical care these occurred every 12 hours. Consultant cover to labour ward was 24 hours and the emergency department at RSCH met national

guidelines. However, consultant cover in the emergency department at PRH was only 9-5 Monday to Friday. Support was provided by a trust grade doctor and consultant support by telephone, but not presence, was available from RSCH.

Assessment of patient risk

- Across the trust we saw risk assessment tools including early warning scores, nutrition, falls and VTE. The documentation of these assessments in patient notes was largely comprehensive and acted upon. A critical care outreach team in hours, and the clinical site management team out of hours, supported the care of deteriorating patients.
- However, in the cohort (corridor) area of the emergency department at RSCH we saw irregular assessment of patients, many of which were vulnerable.
- The utilisation of the cohort (corridor) area failed to take account of the risks afforded to patients from cross infection and other patients. Differentiation of responsibility for care between the trust and the ambulance service at times of congestion was denoted by the attachment of a clinical glove to the patients trolley. Processes for escalation at times of congestion lacked clarity and purpose.
- Handover of patients between shifts and teams was largely well organised and communicated. However, in the emergency department at PRUH we saw the inappropriate handover of an ambulance patient to a health care assistant. In the same department initial triage was occurred at reception without protocol and there was a lack of awareness of the full capacity escalation protocol.
- In operating theatres the trust had implemented the WHO Five steps to safer surgery. The trust regularly audited compliance with the use of brief and debrief requiring improvement.
- In outpatients appropriate signage to protect staff and patients to inadvertent exposure to laser equipment was not in place. In addition, despite extended waiting times for initial outpatients appointments (some waiting in excess of 52 weeks) there appeared to be no clinical oversight of the issue.

Medicines

- Policies procedures and guidelines are in place across the trust but they are not always followed. Notable was the lack of protocol control and labelling issues identified in critical care RSCH and the stock rotation in critical care at PRH. However, we found that medication incidents were reported appropriately and that all investigations have pharmacy input.

Summary of findings

- The trust had processes in place to manage patient group directives (PGD), however they had not proved effective in maintaining timely review and many were out of date.
- Medicines optimisation was prominent within the trust clinical governance structure, however the pharmacy service lacked a detailed annual plan.
- Medicines and controlled drug security and monitoring was variable across the trust. This was of particular concern in the emergency department at PRH where we also identified issues relating to unaccounted for controlled drugs. In addition, prescription pads were not held in a secure manner within outpatients services.
- For patients on end of life care pathways we saw suitable provision and guidance for the use of anticipatory medicines.

Records and information technology

- Our inspection indicated that record keeping across the trust was largely comprehensive. For patients on end of life pathways this included holistic assessment. During the inspection we saw evidence of medical records audit across the trust, however in some cases this was not supported by remedial action plans.
- In some areas medical records were not maintained securely, notably both emergency departments, medical wards and outpatients.
- The trust IT system across the two sites did not have comprehensive connectivity and functionality. The IT system in the emergency department at PRUH was seen to be giving serious cause for concern to staff using it, indicating the high risk of duplicate entries for care and medicines management. The staff did not believe that the trust was taking such concerns seriously.
- In the children's and young peoples service we saw innovative use of mobile technology to support clinical decision making and also the use of telemedicine in stroke services.
- There was limited availability of electronic prescribing functionality across the trust.

Are services at this trust effective?

Requires improvement

We rated this trust as requires improvement for effective care. This was because:-

- All services at RSCH were rated as requiring improvement for effective care with the exception of services for children and young people which was rated as outstanding.

Summary of findings

- All services at PRH were rated as requiring improvement with the exception of surgery which was rated as good.
- Staff appraisal rates were poor across the trust.
- Maintaining competency and updates was challenging due to staffing pressures and reflected in attendance at training.

However,

- Outcomes from national audits were largely good and the trust was not an outlier for any composite indicators of mortality.
- Multi-disciplinary team working was good although impeded by key staff shortages.

Evidence based care and treatment

- Staff had access to guidelines, policies and protocols. These policies were readily accessible via the trust information technology system and staff demonstrated awareness of guidelines.
- Guidelines, policies and protocols were largely up to date, however Maternity services had allowed a build up of out of date policies, which although subject to an action plan, had still not been fully resolved at the time of inspection.
- There was evidence in most core services of involvement in local and national audit programmes. During our inspection we saw that action plans had been developed subsequent to audit and that this had led in some cases to service change.
- The trust had implemented a number of care pathways including sepsis, deteriorating patients and ventilated patients. Of particular note was the innovative oesophageal atresia pathway in services for children and young people.
- The trust was only compliant with 2 of 16 national quality standards for end of life care. The trust had a draft action plan in place dated March 2016 that sought to address areas of non compliance and also included benchmark information.

Pain relief

- There was a trust wide pain team that supported clinical services Monday to Friday. During our inspection we saw evidence of the use of appropriate pain scoring tools and staff were aware of how to access guidance and how contact the pain team for support.
- The trust provided access to a wide range of pain relief and all patients interviewed indicated that there pain had been well managed. The approaches developed in services for children and young people were particularly impressive and included the use of technology to aid pain relief by distraction.

Summary of findings

- However, patients being treated in the cohort (corridor) area in the emergency department at RSCH did not have pain scoring tools completed or reviewed. This, in association with a lack of nurse rounding, meant that patients may not receive pain relief in a timely manner.
- In critical care we saw appropriate protocols for pain and delirium management. The service had audited the documentation of pain scores and the results had been poor. We could see no evidence of a subsequent action plan.

Patient outcomes

- Mortality and morbidity was reviewed in all the core services inspected. The trust also monitored Copeland's Risk Adjusted Barometer. The trust was not an outlier for any of the components of the composite indicators for mortality. However, there was marked variation in approach across the trust with some review meetings generating clear minutes and actions and others not.
- Across services we saw the use of national and local audit in the measurement of outcomes. For example stroke, critical care and end of life care all participated in national audit programmes.
- We saw positive outcome results in a number of audits including the management of sepsis and we saw an improvement in the rating obtained for the stroke unit at RSCH (from D to C), however services at PRH had declined (from C to D). Outcome measurement was well developed in services for children and young adults.
- In surgery the trust had introduced an emergency surgery team and this had a positive impact on patient outcomes. The centralisation of the fractured neck of femur pathway at PRH had also led to significant improvement in outcomes.
- The end of life care service was achieving excellent rates for attaining the patient's preferred place of death with this being achieved in 84% of referred cases.

Competent staff

- The trust had appropriate induction processes for both substantive and agency staff. The trust positively supported development, however staffing levels and the inability to create time to attend courses impacted on the ability for staff to remain up to date. Most notable were low training scores in adult life support.

Summary of findings

- Of particular concern was the skill base of nursing staff supporting the neurosurgery patients in critical care. Following reconfiguration this element of the workforce had lacked the support of a nurse practice educator, lack of updated training and a poorly managed rotation.
- To assist in maintaining a competent workforce the trust had initiated an overseas recruitment programme. However, feedback from staff indicated that this had been done with little or no consultation with ward senior staff. As a result, staff felt the trust had not developed robust methods of competency assessment and significantly underestimated the training burden being placed on wards. This placed ward staff under increased pressure and did not maximise the support available for vulnerable new recruits.
- During the inspection we saw evidence of the use of competency frameworks including for health care assistants. Programmes were largely supported by practice nurse educators.
- Allied health professionals registration was monitored and maintained.
- There was strong evidence of good multidisciplinary working with inclusive approaches to ward rounds. In some areas, notably critical care, this was impeded by availability of pharmacy and therapies staff.
- In services for children and young people there was excellent interaction with mental health services and charities.

Consent and Mental Capacity Act (MCA)

- Consent was guided by trust policy and was informed by Department of Health guidance leading to a standardised approach and with appropriate provision for child consent.
- However, a trust wide audit indicated that 68% of patients provide consent on the day of the procedure which is not best practice.
- Across the trust there was variable understanding of the mental capacity act (MCA), deprivation of liberty safeguarding (DoLS) and patient best interest decisions.

Are services at this trust caring?

Requires improvement

The trust was rated as requires improvement for caring. This was because:-

- Emergency care and outpatients at RSCH were rated as requiring improvement.

Summary of findings

- There was a poor level of privacy and dignity afforded patients in the cohort area of the emergency department at RSCH and in outpatients RSCH.

However,

- Services for children and young people were rated as outstanding.All other core services were rated as good for caring.
- Patient feedback was universally positive about the care provided by the trust and their involvement.
- Children and Young Peoples services had a clear ethos of compassionate care.

Compassionate care

- During our inspection we spoke to many patients. Almost all were exceptionally positive about the levels of care they had received from the trust. Since December 2015 the trust had seen via the Friends and Family Test an improvement in the percentage of patients who would recommend services .
- Our observations across most core services supported the views obtained from patients. In children and young people services we saw a well developed child friendly approach to obtaining feedback and a highly compassionate approach to support of end of life care and bereavement. In critical care we saw examples of maintaining communication with sedated patients.
- However, in the cohort (corridor) of the emergency department at RSCH we saw an environment and care that did not promote the provision of either privacy or dignity. This included frail elderly patients without call bells, patients being examined without the use of privacy screens and medical history discussions in close proximity of other patients.
- In outpatients at RSCH we observed a lack of respect for the privacy and dignity of patients by the continued consultation of patients with clinic doors open, little clear introduction a the first point of contact with the patient and no access to a chaperone service.

Understanding and involvement in patients

- Across all areas patients indicated that they had been involved in the planning of care and that they had received appropriate information.
- The trust had taken due consideration of children transitioning to adult care and developed a 'ready, steady, go' initiative so support patients.

Summary of findings

- In children and young people services we saw a comprehensive approach to understanding and involving patients that included pre admission tours, involvement of siblings and child friendly pre operative information.
- In a number of areas the trust had initiated 'you said, we did' to promote patient involvement. Unfortunately, this was undermined by the non implementation of the publicised' we did' in the outpatients department.

Emotional support

- Patients and carers had access to psychological support in the form of chaplaincy and bereavement. The trust had recruited a number of multi-faith volunteers to support patients.
- For children and young people services there was support from mental health and paly specialists.
- We saw evidence of good support to amputee patients and the trust was using a 'take home and settle' pack to support vulnerable patients when discharged.
- A number of staff commented about a lack of emotional support provided to them following difficult episodes of care.

Are services at this trust responsive?

Inadequate

We rated the trust as requires inadequate for being responsive to care needs. This was because:-

- Both ED and OPD at RSCH were rated as inadequate. Medical care, surgery and maternity and gynaecology were rated as requiring improvement. Services for children and young people and end of life care were rated as good.
- All services at PRH were rated as requires improvement with the exception of critical care and end of life care which were rated as good.
- Patients were not seen a timely manner in either emergency care or outpatient settings.
- As a result of patient flow issues critical care patients were not always discharged and cared for in the correct environment or in a timely manner.

However,

- Services for dementia patients and children were well designed to meet patients needs.

Summary of findings

Service planning and delivery to meet the needs of the local people

- Information provided before the inspection indicated that the trust is engaged with other stakeholders, including commissioners and the local authority, in the planning of services to meet the needs of the local people.
- The trust has, following a lengthy process, secured agreement for a major capital investment programme designed to address many of the issues relating to estate and design. However, it does not at this stage allow for major reconfiguration of the estate areas providing emergency services. However, the trust was due to commence a local works programme in the emergency department at RSCH.
- We saw little evidence of service planning across pathways. This was most notable in the matching of emergency care and surgical activity against critical care need.
- The trust is one of very few remaining NHS trusts that has not planned and developed midwifery led units for non complex deliveries.
- Cancer services were delivered through a network of trusts across Sussex and endeavoured to provide acre as close to the patient location as possible.

Meeting individual needs

- The trust had a dementia strategy which was written in May 2014 and was due for review in May 2016. We did not receive any documentation indicating further progress reports beyond 2014.
- The trust had made good provision for the support of dementia patients with the use of appropriate signage and colour coding. At PRH we also saw an excellent variety of activities designed to support dementia patients.
- However, we also found care being provided to frail and vulnerable patients on medical wards where balcony areas had been adapted to create bed spaces. There was no associated risk assessment for the placement of patients in balcony areas. These areas were not responsive to patients needs.
- Similarly , the cohort (corridor)area in the emergency department did not afford suitable accommodation for vulnerable patients and there was minimal support for patients with learning disabilities in the emergency department.
- The trust employed learning disability lead nurses and we saw evidence where due consideration of the needs for this patient group which included extended time for outpatients appointments.

- Prior to the inspection we had access to an extensive external report on services provided to patients with learning disabilities. The reported provided over twenty recommendations. We were not provided with evidence of an action plan in response to the report nor could we demonstrate that the board had sight of the content.
- In maternity services there was access to support systems for mothers with drug and alcohol dependency. Mental health support was also provided and there was a good awareness of female genital mutilation. There was further support for travellers, homeless and victims of domestic violence.
- The children's services were well designed to meet the needs of all age groups. Areas had customised art work and décor and access to age relevant leisure areas. The sensory area was seen as exemplary in it's use of technology and design.
- In critical care, although we found good evidence of hydration support and social assessment, rehabilitation was not managed proactively and there was a lack of mental health support.

Access and flow

- Access and flow throughout the trust was challenging, particularly at RSCH. However the trust had sought support from Emergency Care Improvement Programme (ECIP) who had been working with the trust for 8 months prior to our inspection.
- Patient flow issues were initiated within in the emergency departments. Patients experienced significant delays in handover when arriving by ambulance and this was further pronounced by long stays in the department before being admitted to an appropriate care environment. Performance against the four hour access target was weak.
- In critical care at RSCH we saw evidence of delays in patients being discharged of greater than 24 hours(37%) and that an above average number (12%) of patients being discharged outside normal hours.
- To address the pressures within the emergency department and critical care the trust has utilised the post operative recovery area in an unsuitable way. A number of patients have been both admitted from the emergency department and discharged from critical care into the recovery area when the trust is under pressure. this does not afford appropriate patient facilities (e.g. there was no patient toilet) or allow relatives and carers access. During the inspection staff expressed serious concern regarding the on-going practice of placing such patients in the recovery area.

Summary of findings

- Outpatients services were subject to significant late cancellations of appointments with 60% occurring with less than six weeks notice. In addition, the outpatients appointment call centre incurred a high number of abandoned calls. During our inspection 48% of all patient calls we abandoned without answer.
- The percentage of patients not being seen within the two week, 31 day and 62 day cancer pathways all exceeded the national standard. Waiting times for pathology results for patients on cancer pathways also exceeded national standards, however patients requiring diagnostic imaging (MRI and CT) were seen in a timely manner.
- The standard for general non- admitted patients referral to treatment within 18 weeks was also not being met. For admitted patients only one surgical specialty was meeting the 18 week standard in 2015.
- End of life care services were very responsive with 84% of patients on an end of life care pathway being cared for at their preferred place of death. The rapid discharge team supported this by attaining discharge within 48 hours in a high percentage of cases.

Learning from complaints

- Services across the trust largely had processes for the analysis of trends and the identification of learning from complaints. However, in medical services there was lack of themed analysis and in outpatients complaints did not feature in key meetings.

Are services at this trust well-led?

Inadequate

We have rated the trust leadership as inadequate. This is because:-

- Leadership was rated as inadequate in emergency care on both sites as was critical care at RSCH. All other services were rated as requires improvement with the exception of end of life care which was rated as good.
- Although the trust had a clinical strategy it had not been well communicated and as a result directorate strategies were not well developed and not explicitly linked to trust strategy.
- Risk management was weak across the trust with a lack of effective escalation and mitigation. The board assurance framework (BAF) was a reactive document and not predictive of strategic risk.

Summary of findings

- The culture of the trust was exceptionally challenging. This has been further exacerbated by inconsistent application of human resource policies. A fractured and damaged approach to equality and diversity had led to intense dissatisfaction and inequality across the workforce.
- The trust had not developed the capacity to manage service improvement and reconfiguration.

Vision, strategy and values.

- Prior to inspection we requested a number of documents including the current clinical strategy. The trust provided a document marked 'draft for Board approval' and was dated March 2014. This document provided a vision for unscheduled care, elective care, tertiary services, cancer, obstetrics, paediatrics and support services.
- Progress with the clinical strategy was reported at the trust board in August 2015 providing evidence of reconfiguration and strategic delivery. The key risk identified was the need for refreshing the strategy and the report did not indicate any resource implications.
- The clinical strategy had no further board level review at the time of the inspection.
- Interviews with senior staff within the directorates indicated that the overall trust strategy had not been well communicated throughout the organisation and was therefore poorly understood. The strategy was described as complex and creating conflicting tensions. We found little evidence of local directorate strategies being developed.
- The trust had introduced a values and behaviours programme in November 2014. This set out a framework around aligning people processes, developing teams and individuals and engaging for improvement. The trust web site does not currently feature the trust values.
- Our interviews with staff indicated a lack of recognition of any trust values.
- The trust had developed a five year safety, quality and patient experience strategy. This detailed document was based on six key questions relating to safe care, quality of care, compassion, involvement, feedback, and being treated fairly. It was not clear from board minutes how this strategy was being tracked. This document was not recognised or referenced to within the directorates.

Summary of findings

- In October, the trust obtained approval for a £485 million capital development programme for the trust. This significant achievement follows an extended period of planning and negotiation and aims to address the major estate issues on the RSCH site.
- The trust has an extensive programme office to support the delivery of this major capital programme.

Governance, risk management and quality measurement

- The trust completed a board assurance framework (BAF) and this was reviewed at board on a regular basis. However, there did not appear to be a clear link between the BAF and the trust quality and strategic objectives with it appearing as a function of escalated risk rather than proactive identification of strategic risk.
- At the last review in March 2016 the board added risks relating to capability and accountability of leadership and management and low levels of staff engagement. The previous review had added capacity to support achievement of access targets, non compliance with regulatory bodies (CQC),poor patient flow, inadequate approach to whistleblowing and inability to manage business change. In the past six months no risks had been managed to reduce the predicted likelihood.
- Risk management was not consistent across the trust. Directorates demonstrated the presence of risk registers. In some directorates, notably surgery, risk registers were well managed and escalated. However, in medical services we saw risks on the register for up to seven years, without note of mitigating actions. In the emergency department staff interviewed provided a lack of clarity regarding risk escalation.
- In September 2014 the trust redefined its organisational structure. The trust now operates 12 directorates that are clinically led and managed by a triumvirate of doctor, nurse and manager.
- All 12 directorates hold safety and quality review meetings and there are quarterly safety and quality forums with executive involvement. The quality and safety forums report to the executive safety committee which in turn reports to the trust board Quality and Risk Committee.
- This structure remains weak. Senior members of staff expressed concern about the lack of data quality and infrastructure to support performance management leading to a lack of assurance provided at board level.
- Safety and quality meetings at directorate level were of a variable standard. Whilst all departments indicated the

occurrence of meetings, some departments demonstrated a lack of escalation. It was also reported by staff in some directorates that the escalation of issues was futile, with little recognition, feedback or action from executive level meetings.
- The trust had a comprehensive complaints policy and supporting investigation documentation. Duty of candour requirements are identified within the complaints process. However, risk assessment was not formally documented in all the complaints investigations we reviewed. Overall trust performance against the 40 day response target was poor (56%).

Leadership of the trust including FFPR

- The trust chair had been in post for seven years and had had appropriate previous experience in such roles. The chair was supported by six non-executive directors.
- Subsequent to our inspection the trust chair resigned his position at the trust.
- The chief executive was newly appointed from outside the trust, arriving as an interim immediately prior to the inspection. This had followed a three month period of internal interim cover following the resignation of the previous chief executive in order to take up post at another trust.
- The executive team consisted of an experienced medical director and chief nurse, a relatively newly appointed chief operating officer and chief financial officer who was appointed in January 2014. The director of strategy (previously holding the acting CEO role and was also director responsible for human resources) was on extended leave. The trust did not have an executive director of human resources in post (and had not had one for 18 months) although the head of human resource had recently been designated director of workforce and people.
- The trust had appropriate policy and process to ensure requirements of the Fit and Proper Persons Act were met. However, storage of records was fragmented with some records on ESR and others held in files. A file for the newly appointed interim CEO had not been completed.
- Our interviews with board members gave a strong indication that the board was not operating in a unitary manner. The chair was clear in his view that the executive had lost grip but failed to acknowledge the board role in holding to account. As a result blame was afforded as opposed to accountability held.

Summary of findings

- Non-executive directors held appropriate positions on board sub committees but had significantly differing views as to the quality of assurance received by the board, with assurance being described from being totally absent to being of adequate content.
- During the inspection we could not identify a clear board development programme. In addition, newly appointed non-executive directors described a lack of induction into the role.
- Our contact with core services within the trust indicated that many staff had become frustrated with what was viewed as continual change amongst senior and middle management. Many staff indicated that there was a lack presence in terms of clinical leadership.

Culture and diversity within the trust

- In the 2015 national staff survey the trust was within the worst 20% of all acute trusts for a significant number of measures including bullying and harassment, physical violence from patients and the public and work related stress. In addition, quality of appraisals, staff satisfaction, action on wellbeing and support from immediate managers were also all in the worst 20% of trusts nationally. The only indicator above average was staff believing that their role makes a difference.
- Despite a trust action plan the 2015 results showed very little progress from 2014 with only the number of appraisals and staff motivation improving. Both these measures were still placed below the national average.
- We held a number of focus groups for all staff. Whilst feedback was not entirely negative many staff reported a number of concerns. These included lack of development opportunities due to work pressures, favouritism in terms of promotion and the use of appraisals, when completed, as a tick box exercise.
- The most common cultural characteristics described by staff were silo working, lack of accountability, acceptance of poor behaviour and performance and a lack of connection with the trust leadership. Many staff believed that the generation of concerns, ideas (including business cases) and risk are not acted upon by trust leadership.
- A number of staff indicated that human resource policies and processes were inconsistently applied. Further to that, some of the advice received served to further embed many of the negative aspects of the trusts culture and proved divisive in the management of equality.

Summary of findings

- In August 2015 the trust completed the NHS Workforce and Race Equality Standard report. This well structured report showed that BME staff constitute 15% of staff at the trust.
- The percentage of staff holding band 8-9 posts was lower at 6.6%. The report indicated that following job application the relative likelihood of white staff being appointed was 1.26 times greater than for BME staff.
- The report also showed comparative data that indicated that over the last two years the likelihood of white staff entering a disciplinary process had decreased whilst it had increased for BME staff. The relative likelihood had increased from 1.1 to 2.3 times more likely.
- In addition, the report also indicated that BME staff were less likely to access training and that although BME staff were more likely to apply for funding to support training they were less likely to be successful.
- Extracting data from the national staff survey showed that BME staff were more likely to report being subjected to bullying and harassment from patients and the public. The overall trust figure placed the trust in the worst 20% nationally.
- The most stark differentiation was seen in the percentage of staff who believe the trust provides equal opportunities for career progression and promotion. Results indicated that only 44% of BME staff believed that equal opportunities existed. Again the trust was in the worst 20% of acute trusts.
- Prior to the inspection we were provided with a board report regarding the WRES dated 21st December 2015. This is a significant delay from its completion and questions the trusts understanding of the significance of this report given previous reports to board and the contents of the previous CQC report. The WRES was discussed at the closed session of the board in December rather than in public. There is no evidence of significant discussion regarding the document at the meeting. There has been no further discussion of the WRES at the board up to and including May 2016.
- In 2015 the trust initiated a race equality workforce engagement strategy. This race equality programme was jointly chaired by the chief executive and the associate director of transformation (who is also chair of the BME network). The strategy had an innovative structure that afforded ownership of eight work streams between BME leads and senior managers and clinicians. A structure of meetings was initiated and a series of workforce analysis exercises completed.

Summary of findings

- Unfortunately this strategy has now fallen into disarray amidst a culture of disciplinary action and grievance placing any progress at significant risk. This risk does not appear to be have been acknowledged by the board.
- As part of our inspection we held BME staff focus groups. The most well attended of these was for BME Network members, at which over fifty staff attended. There was an overwhelming feeling that BME staff felt very undervalued and bullied.
- Of major concern within the group was the lack of equitable opportunities for promotion. Staff described incidents where, despite extensive experience, BME staff were not promoted and that staff acted into higher grade posts without either being successful in application or in some cases without appropriate re-numeration.
- BME staff also described reporting concerns only to be threatened with disciplinary action in addition to a lack of managerial support when under stress. Staff also indicated that the human resources department did not take the reporting of such incidents seriously and did not take action.
- BME staff also reported a lack of constructive appraisal process within the trust.
- The trust operated the governance of other organisational equality and diversity groups through a separate structure to that identified for race equality. Both groups report to the finance, people and performance sub- board committee.
- There was also a view from LGBT staff that staff with protected characteristics were not given support by the trust. Again a theme of poor appraisal and inequitable treatment was described. In addition, we also heard from staff with long term conditions who believed that the trust had not followed its policies on reasonable adjustments.

Staff and public engagement

- The trust used email and publication as means of communication and had recently issued a 'best of BSUHT' booklet to celebrate the good work of the trust.
- The trust held an annual staff and team awards ceremony.
- The trust had a patients and visitors section on the website providing supportive detail for those attending the hospital.
- The trust operated a 'patient voice' programme which gave feedback of patient views on service received. The information from these surveys was used to inform directorates.
- The trust was in the process of refreshing its patient experience panel.

Summary of findings

Innovation and sustainability

- The trust had a programme office and team for the management of the 3Ts programme.
- At our responsive inspection in 2015 of the emergency department we expressed concern regarding the capacity within the trust to manage the extent of change required within the trust. The trust lacked a dedicated programme office. We remain concerned about the capacity to manage change given the lack of progress in improving the emergency department and the issues our report has highlighted relating to the movement of neurosurgical services to RSCH.
- The trust faces significant financial challenge but has a programme of cost improvement plans that include equality and quality impact assessments.
- The trust has excellent links with research establishments and has been awarded funding for a National Institute for Health Clinical Research Facility for Experimental Medicine.

Overview of ratings

Our ratings for Royal Sussex County Hospital, Brighton

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate	Inadequate
Medical care	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Good	☆ Outstanding	☆ Outstanding	Good	Good	☆ Outstanding
End of life care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Outpatients and diagnostic imaging	Inadequate	N/A	Requires improvement	Inadequate	Requires improvement	Inadequate
Overall	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate

Overview of ratings

Our ratings for Princess Royal Hospital, Haywards Heath

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Brighton and Sussex University Hospitals NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate	Inadequate

Outstanding practice and areas for improvement

Outstanding practice

Royal Sussex County Hospital, Brighton

- The sensory centre in The Alex children's hospital had an under the sea themed room with treasure chests full of toys and a bubble tank. There was also an interactive floor where fish swam around your feet and changed direction according to your footsteps.
- The virtual fracture clinic had won an NHS award for innovation. It enabled patients with straightforward breaks in their bones to receive advice from a specialist physiotherapist by telephone.It reduced the number of hospital attendances and patients could start their treatment at home.
- We found that an outstanding service was being delivered by dedicated staff on the Stroke Unit (Donald Hall and Solomon wards). The service was being delivered in a very challenging ward environment in the Barry building. Staff spoke with passion and enthusiasm about the service they delivered and were focused on improving the care for stroke patients. The results of audits confirmed that stroke care at the hospital had improved over the past year.
- The children's ED was innovative and well led, ensuring that children were seen promptly and given effective care. Careful attention had been paid to the needs of children attending with significant efforts taken to reassure them and provide the best possible age appropriate care.

Princess Royal Hospital

- Excellent support to stroke patients including the development of creative activities to stimulate patients.
- Reconfigured fracture neck of femur pathway leading to improved clinical outcomes.

Areas for improvement

Action the trust MUST take to improve

- Ensure that there are sufficient numbers of staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of patients using the service at all times.
- Ensure that all staff have attended mandatory training and that all staff have an annual appraisal.
- Ensure that newly appointed overseas staff have the support and training to ensure their basic competencies before they care for and treat patients.
- Must undertake an urgent review of staff skill mix in the mixed/neuro ICU unit and this must include an analysis of competencies against patient acuity.
- Establish clear working guidelines and protocols, fully risk assessed, that identify why it is appropriate and safe for general ICU nurses to care for neurosurgery ICU patients. This should include input from neurosurgery specialists.
- Must take steps to ensure the 18 week Referral to Treatment Time is addressed so patients are treated in a timely manner and their outcomes are improved. The trust must also monitor the turnaround time for biopsies for suspected cancer of all tumour sites.
- Must ensure that medicines are always supplied, stored and disposed of securely and appropriately. This includes ensuring that medicine cabinets and trollies are kept locked and only used for the purpose of storing medicines and intravenous fluids. Additionally the trust must ensure patient group directives are reviewed regularly and up to date.
- Implement urgent plans to stop patients, other than by exception being cared for in the cohort area in ED.
- Adhere to the 4 hour standard for decision to admit patients from ED, ie patients should not wait longer than 4 hours for a bed.

Outstanding practice and areas for improvement

- Ensure that there are clear procedures, followed in practice, monitored and reviewed to ensure that all areas where patients receive care and treatment are safe, well-maintained and suitable for the activity being carried out. In particular the risks of caring for patients in the Barry and Jubilee buildings should be closely monitored to ensure patient, staff and visitor safety.
- Ensure that patient's dignity, respect and confidentiality are maintained at all times in all areas and wards.
- Stop the transfer of patients into the recovery area from ED /HDU to ensure patients are managed in a safe and effective manner and ensure senior leaders take the responsibility for supporting junior staff in making decisions about admissions, and address the bullying tactics of some senior staff.
- Review the results of the most recent infection control audit undertaken in outpatients and produce action plans to monitor the improvements required.
- Ensure its governance systems are embedded in practice to provide a robust and systematic approach to improving the quality of services across all directorates.
- Urgently facilitate and establish a line of communication between the clinical leadership team and the trust executive board.
- Undertake a review of the HR functions in the organisations, including but not exclusively recruitment processes and grievance management.
- Develop and implement a people strategy that leads to cultural change. This must address the current persistence of bullying and harassment, inequality of opportunity afforded all staff, but notably those who have protected characteristics, and the acceptance of poor behaviour whilst also providing the board clear oversight of delivery.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect 10.—(1) Service users must be treated with dignity and respect. (a) Ensuring the privacy of the service user.and staff must respect people's personal preferences, lifestyle and care choices.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staffing 18-(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part.(a) receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out duties they are employed to perform.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medicines management 12(2)(g) Appropriate arrangements must be in place for the safe keeping, dispensing, administration and disposal of Medicines Safe Care and treatment 12-(1) Care and treatment must be provided in a safe way for service users (b) doing all that is reasonably practicable to mitigate any such risks. Safe Care and treatment 12-(1) Care and treatment must be provided in a safe way for service users (h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Safety and Suitability of premises 15 The provider must ensure that service users and others having access to the premises where regulated activities are carried on are protected against the risks associated with unsafe or unsuitable premises. In particular address the risks from infection and the risk of fire from poor environmental maintenance, design and layout in the Barry and Jubilee buildings.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Good governance 17-(1) Systems or process must be established and operated effectively to ensure compliance with requirements of this Part. (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
1.Your systems to assess, monitor, and mitigate risks to people receiving the care as inpatients and outpatients are not operated effectively. 2. Your systems to assess, monitor, and improve the care and, privacy and dignity of people attending your hospitals as inpatients and outpatients are not operated effectively. 3. Your systems to ensure patients are seen in line within national timescales for treatment are not operating effectively. Start here...	1. Your trust board of directors receives conflicting and inaccurate evidence of assurance about the risks to patients using your services; we saw little or no evidence of robust discussions and challenges at board level to the risks posed to patients using services. We reviewed Trust board minutes from April 2015 – April 2016. There were frequent occasions during our inspection (April 4th- 8th 2016) when the number of patients requiring treatment exceeded the number of cubicles available in the emergency department (ED) at RSCH. This meant that patients spent long periods of time waiting in the 'cohort' area at RSCH, a corridor immediately adjacent to the ambulance entrance and handover bay. There was a lack of assessment of patients' conditions before they were placed in the 'cohort' area in the emergency department at RSCH and a lack of clinical ownership of patients in the 'cohort' area. We raised concerns following a focussed inspection in June 2015; however the actions taken by the trust since our last inspection remain insufficient to mitigate the risk. Between 1st January 2016 – 31st March 2016, 6623 patients waited in the 'cohort' area and, from information provided by the trust, the most time a patient spent in the corridor was 12 hours 53 minutes. We found that the risk assessments used for placing people in the 'cohort' area were not sufficient and patients sometimes received nursing care from a combination of ambulance paramedics and ED staff without appropriate monitoring. The responsibility for ongoing care was arbitrarily allocated and confusingly signposted, as described to us, by an informal system of either leaving or taking gloves off the bottom of the respective trolley, to identify wither ED staff or ambulance staff were responsible for the care.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

There were no systems in place for the management of overcrowding in the 'cohort' area. Staff were not able to provide satisfactory details of "full capacity" protocols or triggers used to highlight demand exceeding resources to unacceptable levels of patients in the area.
· There was an incident where a patient who had suffered a cardiac arrest whilst in the 'cohort', area reported in February 2016.The nurse in the cohort area had escalated her concerns regarding the patient to the coordinator but there was no space available elsewhere for the patient. The patient then suffered a cardiac arrest and had to undergo cardiopulmonary resuscitation (CPR).
· Patients presenting with a mental health illness were not adequately risk assessed prior to being placed in the 'cohort' area, one patient in May 2015 tried to self-harm whilst in the 'cohort' area. One patient in the September 2015 absconded from the hospital and was found collapsed and unresponsive on the road outside the hospital. Three other patients absconded from the department in August 2015, July 2015 and 10 May 2015, one patient was found safe and well the other two patients had no outcome recorded.
· At PRH there was only an emergency medical consultant (EMC) present in the department from 9am until 5pm Monday to Friday and no cover during evenings or weekends. We were unable to determine the status on Bank Holidays. This breached the Royal College of Emergency Medicine recommendations of having an emergency medicine consultant (EMC) presence from 8.00am until midnight seven days a week.
· There was a governance framework in place in ED with responsibilities defined that monitored the outcome of audits, complaints, incidents however it was unclear how this fed into the wider governance structure within the trust.
· The recovery area at RSCH in the operating theatres was being used for emergency medical patients due to having to reduce the pressure on an overcrowded ED and to help meet the emergency department's targets such as 12 hour waits. Some patients were transferred from the HDU to recovery to allow admission to HDU and some patients were remaining in recovery when there was no post-operative bed available. We were told and saw evidence in records that some patients were discharged home directly from the recovery area.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

· Some patients at were kept in the recovery area for anything between four hours and up to three days with some patients being discharged home directly from the recovery area.
· Whilst staff working in the recovery area were highly trained in looking after patients recovering from an anaesthetic they were not trained to look after emergency high dependency medical patients and ventilated patients when they were transferred directly to the recovery area.
· In out-patients (OPD) at RSCH we found a store cupboard in the eye hospital that contained medical records, a fridge, a toaster, a microwave and a kettle. We asked staff if a fire risk assessment had been carried out but none had.
· In the Sussex Eye Hospital a shutter which divided the reception area from the office where medical records were kept was broken and could not be closed. Staff told us they had reported this in August 2015, but was yet to be repaired.
· The wards in the older buildings at RSCH were extremely difficult environments for staff to provide safe and effective care. Some of the most challenging and vulnerable patients were being cared for in premises that were no longer fit for purpose. Although the trust had a strategy for managing this, this was not carried out in practice. Risk assessments were poorly completed or out of date and did not provide assurance that risks to patients, staff and visitors were identified and managed appropriately.
· Patients were not always protected from avoidable harm because there was no system to ensure trust wide learning from incidents or take action where poor infection control practices were identified.
· We were told and saw that all the environmental issues for the older buildings were on the risk register and had been "fed up the line." Staff were told by senior managers and the executive team that all the issues would be resolved during the rebuilding of the hospital. In the meantime staff and patients remained at risk from care and treatment being undertaken in an inappropriate environment.
· Managers told us that the acuity of patients in the Barry Building at RSCH was closely monitored as it was acknowledged the environment was inappropriate. However staff told us that due to pressures on beds their guidelines for admitting patients to these beds were

Enforcement actions (s.29A Warning notice)

frequently overridden by the bed managers. We saw examples where staff had completed incident reports due to inappropriate patients being admitted to these beds without any additional resources being put in place.

· We had particular concerns that the risk of fire was not being managed appropriately. We found that the Barry and Jubilee buildings were particular fire safety risks as they were not constructed to modern safety standards and had been altered and redesigned many times during their long history. They were overpopulated, overcrowded and cluttered with narrow corridors and inaccessible fire exits. We found flammable oxygen cylinders were stored in the fire exit corridors. We found fire doors with damaged intumescent strips which would not provide half an hour fire barrier in the event of horizontal evacuation. We found fire exits which had not been tested to ensure they provided safe, easy and immediate evacuation for the number and acuity of patients accommodated. We raised this with the executive team and requested action to be taken.It was unclear that the executive were aware of this risk to patient and staff safety.

· In the OPD at RSCH a doctors' hand written prescriptions could only be dispensed in the hospital pharmacy. The pads were stored in unlocked clinic rooms. We saw three pads in examination room four in the diabetic outpatient area. The pads did not have serial numbers on. No record was kept of how many prescriptions were issued each day. This was not in line with NHS Protect security of prescription forms guidance (2013).

· We saw records in outpatients at RSCH kept in unlocked trolleys and not constantly attended by staff. We found patient identifiable data which included clinical diagnoses, in an unlocked, unattended area, which related to 203 patients. This indicated records were consistently being kept securely.

· Staffing levels on the mixed intensive care unit (ICU) and cardiac ICU units were frequently and significantly short of enough nurses to provide safe care. This unit also frequently breached the minimum staff to patient standards set by the Intensive Care Society and the Royal College of Nursing.

Enforcement actions (s.29A Warning notice)

The skill mix of nurses on the mixed ICU unit was often insufficient to provide specialised care to neurosurgery patients. The trust had systematically failed to respond to staff concerns about this and mitigating strategies had failed.

· There was a lack of team working and skills competence in the mixed ICU unit that meant patient risks were not adequately assessed. This situation occurred when the nurse in charge overruled more junior neurological ICU nurses about specific treatment for high acuity neurosurgical patients. Several neurological ICU nurses raised this with us and told us they felt it was a dangerous precedent to set. For example, one individual said a nurse in charge, who was not trained in neurosurgery, disagreed with them about the ventilator settings used for a ventilated neurological patient. When the bedside nurse was not present, the nurse in charge changed the settings without a discussion. The patient's condition deteriorated and the bedside nurse then returned the settings to their original level. Staff told us this was a common occurrence but the department did not monitor such events we found no evidence on the risk register.

2.

Your trust board of directors receives conflicting and inaccurate evidence of assurance about the care and needs of patients, and we saw little or no evidence of robust discussions and challenges at board level of the care given or the responsiveness to people's needs. We reviewed Trust board minutes from April 2015- April 2016.

· We saw that people attending both RSCH and PRH did not always receive care in line with best practice, nor care that always met individual needs and protected their privacy and dignity.

For example :

During the inspection we saw a patient with a fractured ankle who was using a pain relieving gas arrive on a trolley, however because the 'cohort' area was already busy, a nurse wanted to re direct the patient to the unscheduled care centre (UCC). We witnessed the patient experiencing severe pain when trying to transfer to a wheelchair as patients on trolleys are not accepted in UCC. The patient was crying and obviously unable to transfer to a wheelchair, at this point a member of the inspection team voiced their concerns that this was subjecting the patient to unnecessary pain. The patient

Enforcement actions (s.29A Warning notice)

was then kept on the trolley in the 'cohort' area. We considered this interaction uncaring even though the action was taken because of the activity in the department but did not take into account the needs of the patient.
We observed an elderly patient who was left on a urine saturated sheet on a trolley for over an hour in the 'cohort' area.
We observed frail elderly vulnerable patients left in the 'cohort' area without call bells for extended periods of time and without any interaction with staff.
Some of the patients we spoke to in the 'cohort' area felt they were "on a conveyer belt" waiting to be placed in a cubicle.
We saw that there was constant moving of patients within the 'cohort' area and the inspection team felt this could disorientate and confuse patients.
We heard staff make assumptions and judgements about patients depending on their presenting condition; this indicated that they did not consider patients' individual needs.
We did not see interactions where staff apologised to those waiting in the 'cohort' area.
We observed poor levels of privacy and dignity for patients throughout the outpatient department. We saw a non-clinical member of staff knock and enter a clinic room without waiting, despite being told there was a patient in the room. Clinic doors were left open when patients were having their consultation, with waiting patients observing. Confidential patient information was clearly heard at reception desks. We heard a staff member discuss a patient's condition in a waiting room, whilst other patients were waiting in that area.
In the Sussex Eye Hospital, we saw clinic doors were left open, whilst patients had examination. Patients waiting in corridors outside the rooms ould see patients being examined. We observed eye examinations being carried out and overheard patient-doctor conversations. Some eye tests performed in corridors due to a refurbishment programme.
AT RSCH patients were being kept in the recovery area of operating theatres for significant periods of time due to the trust attempting to reduce its target of moving a patient within 12 hours out of the emergency department (ED), lack of beds on the high dependency unit (HDU) and lack of beds in other areas of the trust.,

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Some patients could be kept in the recovery area for over four hours and up to three days with some patients being discharged home directly from the recovery area. Patients did not have their privacy when they needed it and 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.
3.
Your trust board of directors receives conflicting and inaccurate evidence of assurance about the Referral to Treatment Time (RTT) target of 18 weeks and the 12 hour breach target (decision to admit) in ED across the Trust services. We saw little or no evidence of robust discussions and challenges at board level of the need to meet these targets and strategies to achieve this. We reviewed Trust board minutes from April 2015- April 2016.
The trust had failed to meet the England standard of 95% for referral to treatment (RTT) times since September 2014. At the end of February 2016, one out of 18 specialities had met the standard. Overall 85 % of patients were seen within 18 weeks which remains below the standard.
The trust had failed to meet cancer waiting and treatment times. The percentage of cancer patients seen by specialist within 2 weeks of an urgent referral varied between from April 2015 to December 2015 and in four out of the seven quarters was below the national average. The most recent data indicated 92% of patients were seen in two weeks. This was below the England average of 95% and the standard of 93%.
The percentage of patients within two weeks with suspected lower gastrointestinal cancer was 67%. The most recent cancer meeting minutes indicated this had reduced further to 38%. The percentage of patients seen within two weeks with suspected upper gastrointestinal cancer was 87%. The most recent cancer meeting minutes indicated this had reduced to 76%. This indicated the performance in these two areas was worsening.
The percentage of patients waiting less than 31 days for treatment for cancer was below the England average from April to December 2015. The most recent data indicated 95% of patients were seen within 31 days, which was below the England standard of 96% and England average of 98%.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

· The percentage of patients waiting less than 62 days for their first treatment for cancer was below the England average from April to December 2015. The most recent data indicated 82% waited less than 62 days which was below the standard of 85% and England average of 84%.
· The pathology department was not providing diagnostic results for suspected cancer in a timely way. It had met the target time for suspected breast cancer results, but not others.
· Data indicated 82,873 patient appointments were cancelled by the hospital in the last year 2015/16. Sixty percent of appointment cancellations were done with less than 6 weeks' notice. This was not in line with the patient access policy which states; a minimum of 6 weeks' notice is required if a Consultant or Clinician needs an outpatient clinic or inpatient theatre list cancelled or reduced. We requested the reasons for short notice cancellations but did not receive this information. We saw booking centre staff cancelling appointments with less than 24 hours' notice during the inspection.
The percentage of patients whose operations were cancelled and not treated within 28 days was 20% which was consistently higher than the England average of 5% from quarter four 2013/2014 to the first quarter 2015/2016. In the most recent data quarter 2015/2016 the service was three times higher than the national average at around 15% and had been as high as six times above the average at one point during the whole time period. Cancelled operations as a percentage of elective admissions had been variable over the time period, and been above the England average for four quarters between quarter four 2014/15 to quarter three 2015/16. Average theatre utilisation rate was 81% which was below the trust standard of 85%.
Between March 2015 and February 2016 24% of operations were cancelled with an average of 32 patients cancelled every month. Of these cancellations 40% were due to the patients cancelling themselves.
The percentage of patients waiting four hours from "decision to admit" to being admitted through the ED were consistently worse than the England average for the period January 2015 - to December 2015. During this period 3,926 people waited between 4 to 12 hours from the time of "decision to admit" to hospital admission.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

52 breaches for exceeding the 12-hour target were reported on the incident computer system between October 2015 - January 2016, however post inspection we have received incident reports for at least 15 breaches between 8th April 2016 and 31st May 2016
The percentage of patients seen within four hours in ED were consistently lower than the England average and lower than the 95% target set by the trust throughout the period from September 2013 - to December 2015
Start here....

Brighton and Sussex University Hospitals NHS Trust

Health Overview and Scrutiny Committee

Wednesday 05 October 2016

Brighton and Sussex University Hospitals NHS Trust

CQC report and ‘special measures’

What does it mean?

How we got to where we are…

May 2014

Full CQC inspection – **Requires improvement**

June 2015

CQC focussed inspection on urgent and emergency services – **Inadequate**

April 2016

Full CQC inspection

June 2016

Warning Notice - ‘significant improvement’ by 30 August

August 2016

CQC publish report – **Inadequate**

NHS Improvement put Trust in ‘Special Measures’

Brighton and Sussex University Hospitals NHS Trust

Summary response to Warning Notice

Failure to ensure systems to assess, monitor and mitigate risks to patients are operating effectively

- Complete review of corporate governance systems and processes
- Complete review of corporate risk management, including
  - creation and implementation of Risk Committee
  - re-drafting / re-scoring of existing risks
  - thorough revision of risk management strategy (for approval by Board in September)
  - presentation of revised risk register to Quality & Performance Committee of Board in July and August
- Allocation of executive responsibility for risk function to newly created Director of Clinical Governance role
- All Practice Group Directions (PGD) now reviewed, revised as required and up to date
  - Plan in place to ensure PGDs managed in timely manner in future
- Plan to ensure fire risk assessments remain up to date now in place

Brighton and Sussex University Hospitals NHS Trust

Summary response to Warning Notice

Failure to ensure systems to monitor and improve care, privacy and dignity of patients are operating effectively / to assess, monitor and improve patient treatment times

- ICT: CIO appointed, three key areas of focus identified
  - Improvement / extension of electronic patient records
  - Alignment of IT resource to clinical and organisational priorities
  - Addressing risks associated with IT infrastructure
- Performance management: Director of Performance Management appointed
  - Trust wide and Directorate (inc for ED) scorecards in use and under discussion at relevant meetings (eg, SMT, Quality & Performance Committee, Board)
    - Exception reports / action plans required for red items reported at Board
    - New format for Directorate Performance Review meetings from 19.09.16
  - Ward scorecards produced for use from 19.09.16
  - Subject specific (including Clinical Governance) scorecards drafted and under consideration
  - Independent review of 18 week RTT position started 14 Sept
- Structure: Executive Portfolios redefined; responsibilities re-stated

PMO created and aligned to support of key Recovery Plan priorities

Brighton and Sussex University Hospitals NHS Trust

Summary response to Warning Notice

Clinical governance failures across trust; learning from incidents, complaints etc

- Creation of, and appointment to, Director of Clinical Governance role
- Creation of Clinical Governance Directorate in hand, to include introduction of Clinical Governance Partners to ensure rigour and quality of clinical governance activity and sharing of information and lessons
- Planned overhaul of clinical governance function to include standardised terms of reference and standing agenda for directorate clinical governance meetings

Volume of patients in RSCH ED corridor area

- Reduction in use of corridor area:
  - June 2016: 15% of all ED pts spent time in corridor, ave LoS: 52 mins
  - July 2016: 14% of all ED pts spent time in corridor, ave LoS: 55 mins
  - Aug 2016: 9% of all ED pts spent time in corridor, ave LoS: 45 mins
    - NB: some deterioration in this performance during Sept acknowledged
- Standard Operating Procedure in place re: escalation if more than 5 patients in the corridor at any given time

Brighton and Sussex University Hospitals NHS Trust

Summary response to Warning Notice

Failure to assess and act on risks to safety in RSCH ED corridor

- NEWS score assessments of patients in corridor completed in 100% of audited records since mid-August (although 95% week ending 16.09.16)
- Patients in corridor limited to those with NEWS score of 4 or more 100% since mid-August)
- Mental health risk assessments completed in 100% audited records of patient placed in corridor since mid-August
- All suitably experienced staff now trained in triage
- Emergency care checklists in place for patients placed in corridor; completed in majority of cases (100% of audited records since 17 August, apart from week ending 2 Sept (97%) and week ending 16 Sept (75%). Dept returning immediately to methods in use during previous weeks
- Average time to initial assessment reduced (acknowledged not at required standard)
  - 43 mins in August 2016
  - 26 mins in September 2016
- PAT system introduced (although not 24/7)

Brighton and Sussex University Hospitals NHS Trust

Summary response to Warning Notice

Failure to protect patients' privacy and dignity in RSCH ED corridor

- Four new assessment cubicles opened
- Three privacy screens purchased for use in corridor; three more on order
- Comfort rounds completed for 100% of audited records of patients placed in corridor since 17 August, apart from week ending 2 Sept (97%) and week ending 16 Sept (65%). Returning immediately to methods in use during previous weeks)

Long waits for mental health patients in ED

- Significant engagement with CCG and Mental Health Trust, but limited impact on experience or outcomes for patients
- Royal Coll Emergency Medicine mental health audit completed August/September – improvements in all eight indicators since previous audit
- Mental Health assessment of patients allocated to corridor completed in 100% of audited records from mid-August

Brighton and Sussex University Hospitals NHS Trust

Summary response to Warning Notice

Failure to comply with RCEM guidelines re: Consultant cover at PRH

- Business case for increased senior presence at PRH agreed
- Given national shortage of ED consultants and existing local vacancies, alternative approach to provision of senior cover under development
- Additional SHO in place at PRH most evening shifts (currently locum provision, aiming for consistency and all shifts filled)

Failure of 4 hour ED access standard

- April 2016: 84.2%
- May 2016: 86.3%
- June 2016: 85.1%
- July 2016: 84.1%
- Aug 2016: 81.27% (closure balcony beds at RSCH, reduced performance at PRH)
- Sept 2016: 82.4% (86% week ending 16.09.16)

Brighton and Sussex University Hospitals NHS Trust

Summary response to Warning Notice

High number of 12 hour breaches

- April 2106: 11
- May 2106: 4
- June 2106: 2
- July 2016: 0
- August 2016: 1
- Sept 2016: 1

Inappropriate use of recovery area at RSCH

- ICU Escalation Policy in force
- Inappropriate use of recovery area almost eliminated
  - Two incidents since policy introduced mid-July
- Each incidence of inappropriate use reported as an incident on Datix and discussed at SMT

Brighton and Sussex University Hospitals NHS Trust

Summary response to Warning Notice

Failure to maintain full range of fire risk assessments

- 100% of fire risk assessments now complete
- Programme for maintaining compliance in place
- Action planning for identified issues underway
- Remediation of highest risk items underway, and complete in many areas

Failure to maintain required standards of fire safety practice

- Highest risk beds in Barry Building (“balcony beds”) closed
- Ski-sheets purchased and fitted to all beds
- Checking of fire exits part of all ward visits by SMT, Execs etc

Brighton and Sussex University Hospitals NHS Trust

Summary response to Warning Notice

Failure to maintain patients' privacy and dignity in Sussex Eye Hospital / out-patient department

Lack of respect for patient confidentiality in Sussex Eye Hospital / out-patient department

- Snellen charts removed from corridors and provided in appropriate manner in clinic rooms
- Building temperature reduced to obviate need for doors to be propped open in hot weather
- "Knock and wait" signs applied to clinic doors
- IG training amongst OPD staff increased from 63% in June to 83% (acknowledged still below required 95%, trajectory for full compliance in place)
- Lockable storage room provided to improve security of records

Summary response to Warning Notice

Brighton and Sussex University Hospitals NHS Trust

Failure to act on risk assessments prior to allocating pts to Barry Building

- Highest risk beds ("balcony beds") closed
- Risk assessment process reviewed and revised
- Escalation Policy revised
- Full review of incidents associated with allocation to Barry wards – no harm identified
- Monthly review of all apparent incident of inappropriate allocation started 09.09.16

Failure to comply with hand hygiene standards

- Hand hygiene audit compliance now at 97% at RSCH site
- Apparent deterioration in performance at PRH (91% - 77%) under investigation
- No MRSA bacteraemia cases since 15.07.15, c. diff at annual trajectory +2

Summary response to Warning Notice

Brighton and Sussex University Hospitals NHS Trust

Poor patient environment in Barry Building

- Highest risk beds ("balcony beds") closed
- Works commenced on key wards to ameliorate layout etc
- Revisions to housekeeping and estates practice and governance completed
  - Patient Environment Committee (agreed for establishment by end of Sept)
- Quality checks on housekeeping now unannounced
- Approach to calculating and publishing performance against national environment standard introduced
- Revised checklist for ward managers introduced
- Programme of 1000 hours of SMT visits to all areas per annum commenced – areas of focus to include patient environment

Summary response to Warning Notice

Brighton and Sussex University Hospitals NHS Trust

Failure to comply with NHS Protect required standards of security re: prescription pads

- Now compliant
  - Un-numbered prescription pads removed from use
  - Warning to all staff issued jointly by Chief Medical Officer and Pharmacy Lead
- Numbered prescription pads now kept in safes in OPD when not in use

Failure to maintain safe levels of neuro-trained staffing in Neuro-ICU

- Safe level of service provision calculated in line with availability of neuro-trained, experienced staff
  - service temporarily reduced to seven beds to match staffing
  - capacity to increase only in line with increases in numbers of specialist trained staff (resumption of previous level expected around end of November)
- Neuro-surgery / ICU education strategy developed and out for consultation
- In-house training programme developed and in use

Summary response to Warning Notice

Brighton and Sussex University Hospitals NHS Trust

Failure to meet 18 week RTT 95% standard

- 18 week trajectory developed and in use as indicator of improvements
  - 16.09.16: performance 75.12% against trajectory of 72.35%
- Reduction in backlog of patients waiting more than 52 weeks
  - 16.09.16: 7063 patients who have waited more than 52 weeks against plan of 9363

Failure to meet cancer 2ww standard – met since mid August

Failure to meet breast cancer 2ww standard – met since mid-August

Failure to meet lower GI cancer 2ww standard – met since mid-August

Failure to meet cancer 31 day wait standard – met since mid-August

Summary response to Warning Notice

Brighton and Sussex University Hospitals NHS Trust

Failure to meet cancer 62 day wait standard

- Trajectory to deliver national standard (85%) in place
- Current deviation from trajectory (70.54% performance vs. 80.3% plan) to enable focus on longest waiters

High numbers of cancelled appointments

- 82,873 appts cancelled 2015/16
- Annual performance based on 19.09.16 data: 11,336 appointments cancelled

Poor performance in respect of cancelled operations not completed within 28 days

national average 5% - last data at time of inspection: 15%

- August performance: 1 cancelled operation not completed within 28 days
- Sept performance: 0 cancelled operations not completed within 28 days

CQC inspection reports

Brighton and Sussex University Hospitals NHS Trust

Published 17 August

- One for each main registered location
  - Princess Royal Hospital, Haywards Heath
  - Royal Sussex County Hospital, including Sussex Eye Hospital, Royal Alexandra Children's Hospital

Focussed on the five standard CQC questions about any healthcare service:

- Is it safe?
- Is it caring?
- Is it effective?
- Is it responsive?
- Is it well-led?

Services grouped by usual CQC approach rather than BSUH service lines

Rated according to CQC standard scale

Inadequate	Requires improvement	Good	Outstanding

CQC report – how we rated

Overall

Safe	Effective	Caring	Responsive	Well-led	Overall
Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate	Inadequate

Royal Sussex County Hospital

Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate

Princess Royal Hospital

Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

CQC report – how we rated

PRH only	Safe	Effective	Caring	Responsive	Well led	Overall
Urgent & Emergency Servs	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate
Medical care	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Surgery	Good	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Critical Care	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Maternity and Gynae	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
End of Life care	Good	Requires Improvement	Good	Good	Good	Good
Outpatients and diagnostics	Requires Improvement	Not rated	Good	Requires Improvement	Requires Improvement	Requires Improvement

RSCH only	Safe	Effective	Caring	Responsive	Well led	Overall
Urgent & emergency Servs	Inadequate	Requires Improvement	Requires improvement	Inadequate	Inadequate	Inadequate
Medical care	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Surgery	Good	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Critical Care	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate
Maternity and Gynae	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Children and Young People	Good	**Outstanding**	**Outstanding**	Good	Good	**Outstanding**
End of Life care	Requires Improvement	Requires Improvement	Good	Good	Good	Good
Outpatients and Diagnostics	Inadequate	Inspected but not rated	Requires improvement	Inadequate	Requires Improvement	Inadequate

CQC report – musts and shoulds

- 67 requirements attached to the three reports – combination of "must" and "should" directions
  - Trust approaching all requirements in same way

- Wide variety in detail and scope, eg:
  - Review and improve major incident storage facilities and replenish stock
  - Review analgesia authorisation for Band 5 nursing staff (PGD)
  - Ensure that patients' dignity, respect and confidentiality are maintained at all times in all areas and wards
  - Ensure that there are sufficient numbers of staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of patients using the service at all times

- Evidence of underlying rationale for musts and shoulds set out in report
  - Each item of evidence also being treated as a requirement

CQC report – “outstanding practice”

- Children’s services rated as ‘outstanding’ overall
- Royal Sussex County Hospital ‘outstanding practice’
  - The sensory centre in The Alex children’s hospital
  - The virtual fracture clinic
  - Outstanding service and dedicated staff on the Stroke Unit (Donald Hall and Solomon wards)
  - The children’s ED was innovative and well led
- Princess Royal Hospital ‘outstanding practice’
  - Excellent support to stroke patients
  - Reconfigured fracture neck of femur pathway
- *Staff were **caring and compassionate** to patients’ needs and patients and relatives said they received good care and felt **well looked after***

CQC report – consequences

A guide to special measures – Monitor/CQC/TDA, 2015

- If CQC makes finding of inadequate re: “well led?” and one or more other key question, CQC will normally recommend to NHSI that the trust is placed in special measures

- NHSI considers CQC’s evidence, plus other relevant evidence, including information from other stakeholders and its own regulatory activity

- On the basis of the full range of information, NHSI will make a decision whether the trust or foundation trust will be placed in special measures.

What now?

Special measures – usual response

- NHSI gives Trust additional support in making the necessary improvements
    - Improvement Director identified and senior staff from NHSI deployed
    - Integrated recovery plan developed
    - Review of the Trust Board takes place

BSUH response to Warning Notice

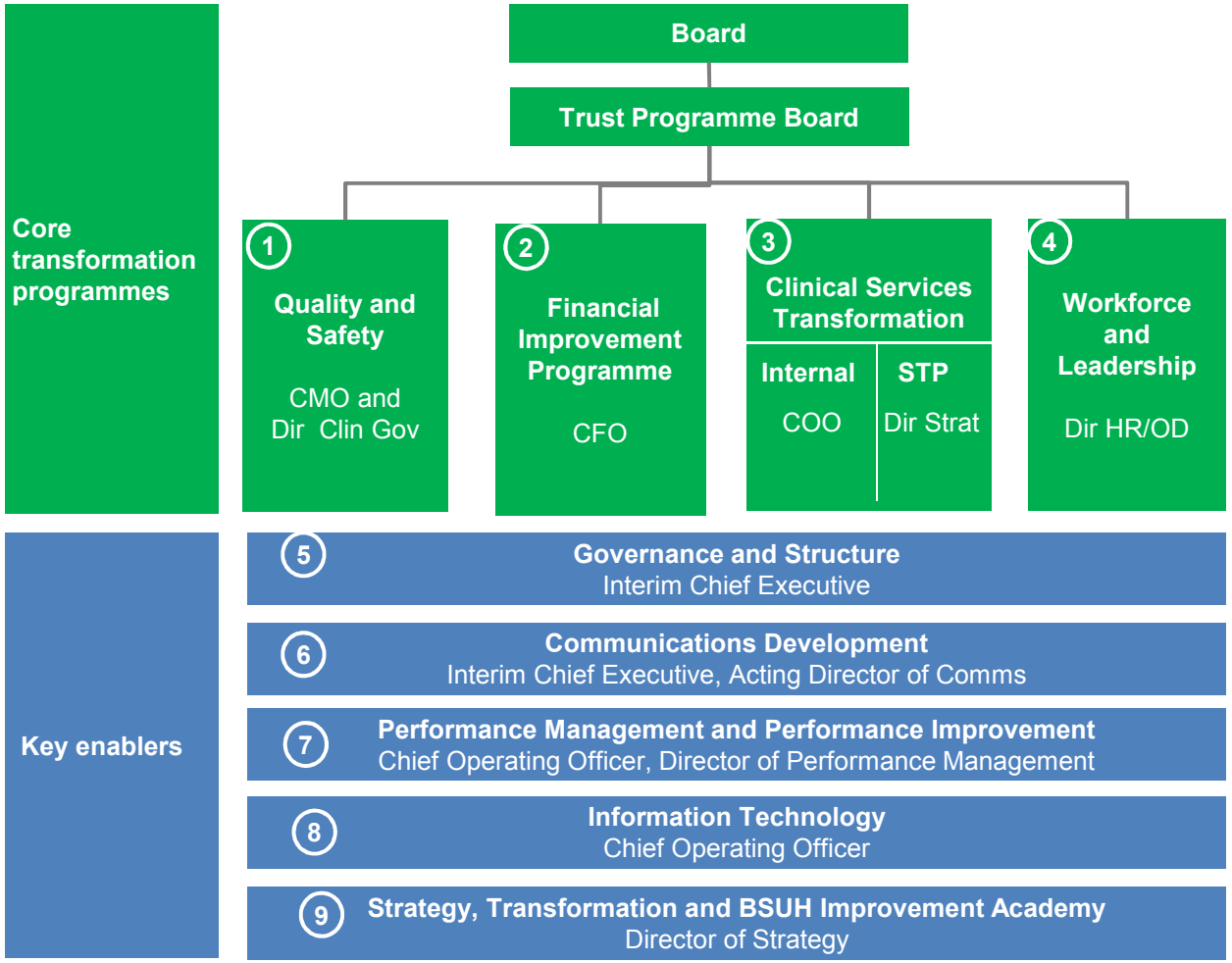
- Review of the Trust Board undertaken
- Revision of Trust corporate governance completed
- Action plan developed and implemented to address priority areas identified in Notice
  - now substantially delivered

BSUH response to special measures

- Integrated recovery plan developed
- Approved by Trust Board, CQC and NHSI last week
- Reporting framework agreed

Brighton and Sussex University Hospitals NHS Trust

BSUH recovery programme structure



Recovery / improvement programme

Quality & Safety Improvement Programme

- Not a “CQC action plan” – phase one of a continuous programme of improvement
- Seven projects currently, focussed on CQC requirements, but to be supplemented by Trust projects once CQC concerns resolved
- Monthly highlight reports to Trust board, CQC, NHSI, and others
- Focus on delivery of required improvements, not just completion of identified actions
- Regular review of whether planned actions are delivering the required improvements, and revision of plans as required

What now?

CQC unannounced inspection in near future

- Focus on what we have achieved since April
- Review of how our Quality & Safety Improvement Programme is helping us give better care and meet national standards

Maintaining momentum vital

- Support from our patients, their carers/families, colleagues in Healthwatch and other friends of the Trust much appreciated

What now?

Some improvements can be addressed immediately with the help from our staff

Other requirements need input from our stakeholders:

- Clinical Commissioning Groups
- NHS England
- NHS Improvement
- Other healthcare providers
    - Sussex Partnerships NHS FT
    - Sussex Community NHS FT
- Social care providers
    - Brighton & Hove City Council
    - ESCC
    - WSCC

Questions or feedback?