This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

**Facts and data about this trust**

Surrey and Sussex Healthcare NHS Trust provides emergency and non-emergency services to the residents of east Surrey, north-east West Sussex, and South Croydon, including the major towns of Crawley, Horsham, Reigate and Redhill. At East Surrey Hospital, Redhill there are 697 beds and provide acute and complex services. In addition, the trust provides a range of outpatient, diagnostic and less complex planned services at The Earlswood Centre, Caterham Dene Hospital and Oxted Health Centre, in Surrey, and at Crawley Hospital and Horsham in West Sussex.

(Source: Trust Website)
Is this organisation well-led?

Leadership
As part of the inspection process, we interviewed all the members of the board, both the executive and non-executive directors, and a range of senior staff across the trust. We looked at performance and quality reports, audits and action plans. We attended a board meeting, looked at previous board meeting minutes and papers to the board. We also spoke with staff about how they perceived the trust culture and their understanding of quality improvement initiatives. We attended a mortality and morbidity meeting and site management meetings.

We looked at investigations of deaths, serious incidents and complaints. We sought feedback from patients, local people and stakeholders. We spoke with a wide range of staff and asked their views on the leadership and governance of the trust.

The work of Surrey and Sussex NHS Trust was overseen by the trust board, which had a statutory responsibility for the trust. The trust board had the appropriate range of skills, knowledge and experience to perform its role. Both the Non-executives and executive board members were very well informed about trust performance and risks.

The board has significant healthcare and commercial expertise, with well-rounded capabilities making for an effective team. We observed numerous examples of good discussion and debate, with clear linkage made between quality of care, operational performance, finance and sustainability, evidencing that the board has a mature understanding of the complexities of managing a large NHS trust.

The board consisted of a chair (non-executive), four other non-executive directors (voting members) and two non-voting non-executive directors. One of these non-voting directors was awaiting confirmation of appointment to the board as a voting member. On the executive team were the chief executive officer, and five executive directors (voting members). Other directors (non-voting) also attended the board, and contributed to its decision-making.

The trust had a senior leadership team in place with the appropriate range of skills, knowledge and experience. There was a strong mix, amongst both board and senior staff, levels of those who had been in place a long time who provided stability and those who were newer in post and who brought a new perspective.

Michael Wilson has been the chief executive of the trust since October 2010. Prior to this he was Deputy CEO at another trust and had also worked at the Department of Health where he was Director for Commercial Solutions. He worked across a range of national projects and spent time in the Prime Minister’s Delivery Unit. In 2009, he completed an International Leadership programme at Harvard University and became an NHS IMAS Partner. Michael is a visiting Professor at the University of Surrey and Honorary President for the National Health Retirement Fellowship in Surrey. In 2016 Michael was awarded a CBE for services to the NHS.

Jane Dickson, is a registered nurse who qualified in 1987. Jane was appointed as chief nurse at Surrey and Sussex Healthcare in April 2018. Jane previously worked at the trust as deputy chief operating officer and associate director for cancer and diagnostics. Jane has led and reconfigured specialist nursing services across geographical boundaries with a constant focus on patient care, experience and outcomes. Whilst working in the complex field of deceased donation and transplantation Jane completed a postgraduate diploma in Health Care Ethics from Kings College London and then went on to complete an MSc in Care, Policy and Management from London Guildhall.

Professor Des Holden, the Medical Director was appointed in March 2012. Prior to this he worked as a consultant in Obstetrics and Gynaecology and as a Lecturer in Foetal Medicine for other NHS...
trusts. Des is a professor of Surrey University and he became an Honorary Clinical Senior Lecturer at the Brighton and Sussex Medical School in 2003. Des has held various managerial posts within other trusts, including Clinical Director for Women and Children, Divisional Director of Specialised services and, subsequently, Medical Director at another large trust.

Paul Simpson joined the trust in December 2007. Before this he worked as Deputy Director of Finance at another acute NHS trust. Paul has also worked at South East NHS Regional Office where he was a finance performance manager and at the Department of Health HQ in Leeds and dealt with the financial monitoring of NHS organisations nationally. Paul is a chartered accountant by training and is a Fellow of the Chartered Institute of Management Accountants. For most of the last 12 months Paul has acted as the Chair of the Finance Group for the Sussex and East Surrey Sustainability and Transformation Partnership.

Angela Stevenson was appointed chief operating officer for Surrey and Sussex NHS Trust in September 2015, having previously served as deputy chief operating Officer for 18 months. She was also the associate director of clinical services – medical division for five years at the trust a role which included work with the emergency department, where she played a pivotal role in the turnaround of the organisation. Angela has 26 years’ experience in clinical and general management roles across the NHS and private sector.

Ian Mackenzie, the director of information and facilities was appointed to the board of the trust in April 2009. He has worked in the NHS since 1983. In that time Ian has undertaken a wide-range of non-clinical roles and has lead a wide range of projects covering both IT and capital developments. Most immediately before becoming a Director he was a member of the senior leadership team at The Surrey Health Informatics Service.

Mark Preston, the director of organisational development and people joined the board on April 2016. He has previously worked in a variety of different healthcare settings over the past 25 years, including health authorities, tertiary centres and London teaching hospitals, as well as time working in an advertising agency. Mark has responsibility for the workforce directorate, which includes a diverse range of areas including resourcing, staff and organisational development, HR business partnering, employee relations, medical HR, occupational health and wellbeing and the staff nursery.

Gillian Francis-Musanu is a non-voting director of corporate affairs who was appointed in October 2012. She has over 25 years’ experience of working in the NHS in a variety of senior management roles at Acute Trust, Primary Care and at Health Authority level. As the Director of Corporate Affairs and Company Secretary at the trust she has responsibility for corporate governance, regulation, board assurance, legal affairs, corporate communications, patient and public engagement, the Council of Governors and advisor to the chair and chief executive

The Chair had been recently appointed but knew the trust well as he had previously been a non-executive director and was the chair of the Safety and Quality Committee.

Non-executive directors are members of the public who live in the area that the trust serves and who responded to advertisements for the posts. The Secretary of State for Health, via NHS Improvement, appoints the chair and the other non-executive members. Technically, they are not employees of the trust (and have no employment rights), and the terms of their appointment (including their remuneration) are set by NHS Improvement.

The board chair, Dr Richard Shaw, was appointed as chairman of the trust in September 2018. Prior to this he served the trust as a non-executive director for eight years. Prior to this, he has held the role of chief executive at both Surrey and Oxfordshire County Councils. Richard has worked in several senior Civil Service roles, and was responsible for establishing the new National Park Authority in the South Downs for three years from 2009. Richard has held non-executive roles with the University of Surrey, on its Council and Audit Committee.
The trust had six non-executive directors, two of whom are currently non-voting. They had a variety of backgrounds, which included previous experience as a finance director in an NHS trust, a chartered accountant, a director of business transformation, a director of business improvement and a healthcare professional with expertise in safeguarding.

The board had appointed a Senior Independent Director (SID) from the non-executive body. The specific duties of the SID include: Being available to the Council of Governors for any concerns which could not be resolved via contact with the chair or company secretary; attending members and governors meeting to gain insight into the issues which are important them, sharing any concerns raised with them with fellow board members, as appropriate. The SID also oversees the performance evaluation of the chair in line with NHS requirements and also supports the Freedom to Speak Up Guardian and has oversight of medical performance issues in relation to Maintaining High Professional Standards.

We spoke with the non-executive directors and were assured that collectively they had a clear understanding of their roles and responsibilities. All the non-executive directors were very well informed and engaged with the strategic development of the trust and had a strong grip on trust performance, areas of risk and the organisational culture.

We could see that they provided supportive challenge to the executive team. The executive team told us they had healthy challenge and debate from the non-executive directors. The Minutes of the Trust Board Meeting in Public dated 26 July 2018 showed that the non-executive directors had asked for an update on action taken in response to a patient story heard at the previous board meeting and also about the progress of a specific project.

The chair of the trust board and its non-executive directors are independently appointed by NHS Improvement. The chief executive and other executive posts serving on the trust board are appointed by the trust in liaison with NHS Improvement. All members of the trust board were subject to a performance framework which stipulates that: The chair of the trust board is appraised via a national framework operated by NHS Improvement; non-executive directors and the chief executive are appraised by the chair; executive directors are appraised by the chief executive.

We reviewed six of the executive and non-executive files and saw the administrative and employment processes to ensure fit and proper persons were employed were in line with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. All files were very well maintained, had good systems in place to ensure confidentiality was controlled and demonstrated oversight of the ongoing suitability of the directors.

Fit and Proper Person checks were in place. All the records referred to in the fit and proper person’s requirement and due diligence checks were retained within the individual files to indicate the checks had been undertaken.

The dates when appraisals were undertaken was noted on the fit and proper person’s requirement checklist for executive directors where they had been in post sufficient time for this to have taken place. In relation to the non-executives, the appraisal documentation was held on individual fit and proper persons requirement files which confirmed the appraisals were undertaken by the chair.

The non-executive directors were provided with training and support to fulfil the obligations of their roles.

The trust sub-board leadership was provided through a triumvirate structure that was clinically led. Reporting directly to the chief executive and the medical director were the chiefs of services who were all consultants in the service they led. The chief of services worked at divisional level with a
divisional chief nurse who reported to the chief nurse and an associate director who reported to the chief operating officer.

The four divisions at the trust were the surgical division, the medical division including emergency care, the women and children's division and the cancer services and diagnostics division.

There was a programme of board visits to services and staff fed back that leaders were approachable. Board members were encouraged to visit departments. We saw reports to the board which detailed visits by various board members to different areas of the trust, which indicated this was occurring. The non-executives that we spoke with could identify where their engagement and visits had led to changes or provided them with assurance that the information provided in the board papers was an accurate reflection of the services being provided.

The senior leadership team was highly visible and the chief executive was said to be “Omnipresent – in a good way”. Leaders knew their staff and the staff knew the leadership team.

Succession planning was in place throughout the trust. The workforce strategy incorporated leadership and talent management. Succession planning and talent management within the divisions was managed through the appraisal process and business planning and development opportunities were available dependent on individual need. We heard of many examples (including at executive level) where the trust had ‘grown their own’ staff.

We looked at 10 staff files and saw they were complete, contained job descriptions, qualifications, professional registration checks, disclosure and barring service checks, references, occupational health clearance, fitness to practice declarations and evidence of right to work. We saw examples where staff had undergone investigations and capability reviews and evidence all meetings were documented and clear processes followed.

The trust had invested in developing leaders including at deputy, divisional and non-executive director level, to enable the succession of senior leadership roles. This has been achieved as follows:

- Deputy executive directors were regularly involved in board committee meetings and report to the board and sub-committees to provide experience of the executive roles.

- The triumvirate clinical leaders regularly attended committee meetings with executives and non-executive directors to develop their skills further.

- There had been investment in the capability of leaders throughout the trust through the Lean for Leaders programme as part of ‘SASH+’, the trust's continuous improvement methodology.

- The trust has also introduced a designate non-executive director and an associate non-executive director who sat on the board as non-voting non-executive directors to develop their skills and capabilities as future voting non-executive directors. It was expected that the current designate non-executive director will become a voting non-executive director in due course and that this will mitigate against any perceived risks in relation to the departure of two long-standing non-executive directors.

The Medical director was also the Caldicott Guardian.

Dr Virach Phongasthorn is the Guardian of Safer Working and he reports to the Director of Education. Junior doctors spoken with were aware of this.
Board Members
Of the executive board members at the trust, 6% were Black Minority Ethnic (BME) and 19% were female.

Of the non-executive board members 6% were BME and 19% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
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<tbody>
<tr>
<td>Executive directors</td>
<td>6%</td>
<td>19%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>6%</td>
<td>19%</td>
</tr>
<tr>
<td>All board members</td>
<td>12%</td>
<td>38%</td>
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(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

The board was aware that diversity of the board was something that needed to be considered as posts became vacant.

Vision and strategy
The trust had a very clear vision underpinned by a set of known and shared values that included

- Safety and quality
- One team
- Dignity and Respect
- Compassion

The board were unanimous that patient safety and the patient experience was to be the key focus of the work of all staff. We saw many examples where the executive team and chiefs of service role modelled and upheld the trust values. The quality improvement initiatives used to create a learning environment and to bring about sustainable improvements had also driven the trust culture and empowered staff to deliver the high-quality care they wanted to provide.

All board and staff members that we spoke with were clear about the vision, highly engaged with the trust’s strategy and identified with the ethos of putting the patient first. Staff spoke of identifying current priorities for their particular areas or work.

The values and strategic priorities were promoted heavily in communications, for example through posters, reporting and through direct engagement with staff. The chief executive provided a weekly message to all staff that was uploaded on to the trust’s website and which reminded staff of the trust’s vision and values.

The vision was underpinned by strategic objectives that were aligned to the Care Quality Commission inspection domains. These objectives were to create an organisation that was safe, effective, caring, responsive and well-led. The strategy and objectives were challenging and innovative and were aligned to the wider environment and Sustainability and Transformation Plan for the local health economy.

The overarching strategy was driven by key enabling strategies (e.g. Workforce, estates and IT) which were being refreshed at the time of the inspection visit. The trust has a Director of Strategy
who was overseeing this process. The trust has held board seminars where the board had been involved in strategy development. Staff had been being engaged in the refresh of the strategy and had undertaken discussions on what was and wasn’t working for their particular areas.

Underpinning the strategic objectives was a priority for each objective. These were

- Reduce avoidable harm
- Improve discharge planning
- Create the best environment for patients
- Timely access to services
- Improve staff health, wellbeing and working lives.

Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy and service delivery, especially where there were plans to change services. Staff knew and understood the trust’s vision, values and strategy and how achievement of these applied to the work of their team. Staff we spoke with knew the trust’s values and felt they delivered their services in line with them. Some talked about their involvement in creating the values.

The vision and strategy on a page at team and ward level demonstrated how individual areas contributed to meeting the trust objectives.

The vision and values were embedded in business plans, divisional and team objectives and were aligned to annual achievement reviews.

The trust was committed to providing clinical services that achieved and demonstrated the best clinical outcomes. Leaders wanted every staff member to feel valued and respected. The leadership team had identified elements which would be key to developing a culture of quality improvement. They were:

- Providing quality and safety as the top priority
- Good leadership and culture throughout the organisation
- A clear clinical strategy to fulfil their role
- A commitment to meet all access and operational delivery targets
- Management of the trust finances and capital development.

The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans. The trust strategy had been designed to provide a guide as to how the trust would need to evolve over the next five years to fulfil its vision. The trust had aligned its vision with Five Year Forward View. The NHS Five Year Forward View was published in October 2014 and set out a new shared vision for the future of the NHS based around new models of care. This included the need for acute trusts to provide services with community based service providers.

The trust was an active participant in the Sussex and East Surrey Sustainability and Transformation Partnership (STP) which brings together 24 organisations involved in the planning and provision of health and care services across the region. This includes Surrey and Sussex Healthcare NHS Trust along with other acute hospital trusts; clinical commissioning groups, mental health; community services and local authorities. The STP is a partnership and a new way of working. It should ensure that all the health and care organisations in Sussex and East Surrey
work together in a joined-up way. The leadership team were actively involved in and regularly monitored and reviewed progress on delivering the strategy and local plans. It was apparent from the minutes of board meetings that the non-executive directors provided challenge and questioned elements of the strategy.

The trust had an Education Strategy (ratified in January 2018) that was closely aligned to the Clinical Strategy. There was a three-year plan for education across the trust and a very firm commitment that this was a learning organisation that invested in education and development of the staff. There were many innovative educational programmes that supported succession planning and partly addressed the challenges of recruitment difficulties. These included the growth of the apprenticeship scheme and a school of physician’s associates.

The trust also supported staff who needed help with literacy and numeracy. Working with other trusts, support was identified and over 100 staff were accessing additional learning in basic skills.

The nursing associates role was also being developed and the trust was leading across the STP on this, working with six trusts and hospices.

The trust also worked with numerous other agencies as strategic partners. This included partnerships with Surrey University where trust staff held joint professorships, the Kent Surrey and Sussex Academic Health Science Network, a buddying arrangement with the local ambulance trust who were in special measures, and joint work with Health Education England to provide the regional school for physician associates and junior doctors training in improvement methods.

The trust was supporting a specialist children’s NHS trust to develop a ‘Mini Mouth Care Matters’ programme for children during their stay in hospital. This was as a direct result of the success of the trust led Mouth Care Matters programme.

The trust had been selected to be part of a small cohort of five trusts working with the Virginia Mason Institute in Seattle, to develop their work on quality improvement.

There appeared to be a higher than expected turnover of staff from such a happy organisation. On investigation this was less about staff leaving and more about staff being encouraged and supported to train and to gain qualifications and then to return to the trust in a new role. This occurred at all levels with the Chief Nurse having previously been employed as the deputy chief operating officer and associate director for cancer and diagnostics. We also heard how the portering service lost staff as they moved on to other roles providing direct healthcare. In the year preceding inspection, 40% of all posts were filled by internal candidates and although the staff remained in the trust, they counted as having left.

Culture
The trust’s strategy, vision and values underpinned a culture which was exceptionally patient centred. Staff felt extremely positive and proud about working for the trust and about their teams. We found throughout the organisation an open and honest culture. Staff felt able to raise concerns amongst their peers and with leaders. Leaders and staff understood the importance of staff being able to raise concerns.

Staff spoke positively about the organisational local and trust leaders and felt them to be both recognisable and approachable. We observed interactions between all grades and disciplines of staff and noted they were consistently warm, respectful and supportive.

Staff referred to the CEO as “Boss”, “The Colonel” (although usually just Michael) and were clearly very fond of him. His presence around the hospital during the inspection was not seen as unusual and we were told very clearly that he often popped in to see staff. One nurse told us that he’d
known how busy they had been on the unit during a particularly hot day and had been out and bought them all ice lollies.

We observed the chief operating officer walking back from a site meeting that she had chaired quite robustly, setting a very clear expectation that staff in each area were aware of the movement of their patients. In the corridor she saw a porter struggling to open doors, keep an elderly patient’s belongings together and move the trolley at the same time. She introduced herself to the patient, picked up something that had dropped, tucked the blanket more firmly around the patient and then held the doors open. It felt like this was just something they did and reflected the culture and behaviours agreed by the board.

We spoke with chief of services who knew the names of healthcare support workers in their division and who could describe improvement work that was going on at ward level but which consultants would not usually be aware of or interested in. This included a trust wide focus on mouthcare.

There had been a strategic decision that the hospital would be clinically led. It was necessary to involve consultants in the wider leadership issues facing the trust and that the board was keen that they work together with the chiefs of service and all the consultants to achieve this.

Whilst the consultants provided clinical leadership and were strongly encouraged to become involved in the wider quality improvement and cultural initiatives, this was not a particularly hierarchical organisation. Respect for all was an absolute expectation and we saw friendly, collaborative and cross discipline working used effectively for the benefit of the patients. Staff at all levels and doing all jobs were encouraged to become involved in-service improvements and to work together for the benefit of the patients.

The trust reaction to a potential concern that had been raised with the commission prior to the core services inspection provided reassurance that any unwarranted behaviour or poor performance would be addressed both swiftly and effectively.

The trust had appointed a Freedom to Speak-up Guardian in November 2016, in line with the principles and role profile produced by the National Guardian and following recommendations of the Francis report. The Freedom to Speak Up Guardian is a mandatory role within all NHS and Foundation trusts. The National Guardian Office recommends that the board receive regular reports from the Speak Up Guardian.

The trust was part of the South-East Coast regional network of guardians which the trust guardian chaired. They had recruited and appointed nine speak up ambassadors across the organisation to support their work and also secured a slot on every induction programme to inform staff about their role.

The Speak Up Guardian was involved in work that included;

- Monitoring behaviours including bullying and harassment through the electronic incident reporting system and then working with HR to ensure a robust investigation and resolution.
- A review of incidents involving violence or aggression.
- Supporting staff returning to work with wellbeing concerns after a period of absence.
- Attending team meetings to ensure that staff are aware of the role and how to make contact if they have concerns.

The Freedom to Speak Up Guardian quarterly report Q1 2018/19 showed that the guardian was considering how to develop the service and had recommended areas to prioritise. These included;
• Continued promotion of Freedom to Speak Up
• Developing e-learning modules on reporting and responding to concerns for existing staff and managers
• Working to address barriers to speaking up
• Reviewing investigatory processes for timeliness and independence
• Seeking opportunities for sharing learning from speaking up activity.

The report showed that the guardian was reporting to the board and providing both quantitative and qualitative data for consideration. The record showed that the staff were supported to raise concerns and that the board acted appropriately when concerns were raised.

Staff we spoke with knew who the Freedom to Speak Up Guardian was, how to contact them and what their role was.

Most staff that we spoke with told us they felt the human resources team were very approachable and open. They felt employee relations were fair and consistent.

Staff had access to support for their own physical and emotional health needs through occupational health.

The trust had achieved 100% compliance with medical revalidation, which was better than other trusts. The nursing revalidation rates were also good with effective governance systems in place to ensure staff did not forget to revalidate.

The board has invested heavily in SASH+, the trust’s continuous improvement methodology which has been developed through a five-year partnership with the Virginia mason Institute in Seattle. This methodology supported staff to develop a culture of continuous improvement through lean principles which always put the patient first. Feedback from staff in all areas of the trust was that this methodology had a very positive impact on both culture and efficiency improvements. The methodology empowered staff to make practical changes to improve services for patients and continued to embed the culture of sustainable improvement at the trust.

The trust had invested significantly in training staff and supporting the roll out of SASH+. The trust aimed for 100 individuals per year to complete the ‘Lean for Leaders’ programme; as at July 2018 over 70 leaders have graduated. Further cohorts were planned with the programme open to all staff, from junior and non-clinical staff through to executive directors.

One of the non-executive directors was undertaking the programme to assess whether it is suitable for all non-executive directors.

All staff that we spoke with viewed SASH+ as a very positive programme for the trust. The culture of continuous improvement had become embedded and was largely seen as business as usual.

We tracked several value streams that were sponsored by executives and chiefs of services but which involved staff of all grades and disciplines across the trust. The process that was used to map the pre-improvement arrangements and highlight where changes could be made for the benefit of staff and patients was, “an inch wide and a mile deep”. This meant that a small area of practice was reviewed in real depth and involving all who might be considered a stakeholder in improvement. Once there was an understanding of the current practice, ideas were shared and changes made. These changes were then monitored carefully to see whether they had resulted in a change for the better and whether they were embedded, with formal review at 30, 60, 90 and 120 days.
We saw simple but effective changes that had made life better for patients and staff. A good example of this was the value stream and work that the trust had done on the management of diarrhoea. We visited several wards and departments where staff talked to us about their new ways of working. We were shown the diarrhoea packs that staff had created which brought all the necessary items for assisting someone to clean up after an episode of diarrhoea into a single pack. This meant less time for the patient to be sitting or lying in bed soiled and uncomfortable, it consequently reduced embarrassment and the risk of pressure damage and possibly the risk of falls as patients were less likely to become distressed and try to reach a lavatory. For staff it meant less time collecting all the items from different places on the ward, less frustration at finding you’d forgotten something and a calmer approach to the patient. For the trust it was also cheaper as less staff time was wasted searching for items. The process measured staff steps before and after the introduction and could demonstrate that for each episode of diarrhoea six minutes of staff time were saved.

Staff spoke highly about their engagement with SASH+. Many staff commented that the programme has made staff feel empowered to raise issues and improve processes. The methodology was designed to draw insight from all members of staff, irrespective of experience or seniority.

Stories from staff and patients provided evidence of trust wide culture that placed patient’s wellbeing at the heart of service delivery. Staff lived the trust values and there was a tangible positivity and compassion throughout the hospital.

We received an email that said, “On the same day as I was sitting in a CQC focus group meeting with inspectors asking us why we like to work at SASH I found myself becoming a patient’s relative. My 13-year-old child was rushed in to A+E with severe pains in their back. As the symptoms worsened and started becoming hard to control the staff in the children’s A+E were amazing, involving relevant staff, who quickly established where it was coming from and that diagnostic imaging would be needed urgently. The result was an emergency operation within hours of arrival. My child went straight from theatre to the ward where we were looked after with the most extraordinary attention and care. After an emotional 12 hours and lying next to my child the next morning, I found myself so grateful for so many people who helped make that happen and so proud of our trust and who we all are. We truly are ONE TEAM! I would like to thank so many who we met met from admission until they were discharged home, from the lovely nurse who was rushed off her feet in Paediatric A+E but still chased the right team knowing things were getting bad, the two from the specialist team who knew to get a consultant surgeon quickly, the consultant for their careful, safe hands, staff in theatre who kept us both calm, and all the amazing staff on the ward who were so rushed off their feet with sick children but nothing was too much. From bottom of our hearts thank you I’m so proud to work here amongst such amazing people”.

One patient, who was receiving end of life care, had lost their dentures. And was distraught at the thought of dying without them and was struggling to eat or speak. To alleviate the patients, distress the ward staff contacted the dental team who were able to arrange for another set to be made quickly.

The Clinical Nurse Specialist for Paediatric Epilepsy and Neurodisability won the national Young Epilepsy Award for best practice and outstanding nursing. In her spare time she organised fun days for children and young people on her caseload.

In the neonatal unit, staff used electronic tablets to promote bonding for mothers who has been separated from their babies because the mother was unwell in the maternity high dependency unit. Mothers could use a video link with their babies.
Where a twin had been lost, the staff used a butterfly cot card to signify the twin status of the surviving baby.

The mortuary staff had received a letter of thanks from a bereaved relative. The patient had died at home and been transferred from the emergency department to the mortuary. The relative was so impressed with the compassion and ongoing support from the staff who talked her through everything they needed to do that they wrote to the CEO.

**Staff Diversity**

Staff felt equality and diversity were promoted in their day to day work and when looking at opportunities for career progression.

The Director of Corporate Affairs chaired the BME staff network. This gave senior support and helped steer the group, which was launched six months prior to the inspection. The BME network was well supported by senior staff and consultants. The group actively promoted role modelling and job opportunities with support for individual staff to progress.

The trust had an inclusion steering group with terms of reference that was set up recently to oversee the action plan implementation from the annual equality report. The terms of reference were tested and agreed with the staff representative groups within the trust. This steering group had responsibility for review of the assurance and oversight of the implementation of the inclusion strategy.

The steering group set priorities and worked with other stakeholders to agree direction they needed to move in. There was an awareness of need and a conscious commitment to increasing public health into the strategy. Examples given of this were where people had mental health needs or who suffered loneliness.

One person who identified as LGTB reflected that “The culture of the organisation is one that is very accepting and I’ve been given a platform to be a role model in a very open and honest way”.

Demographically the local population has an average age of 40 years. The population is predominantly white British with between 85% and 90% of people living in the area served by the trust having been born in England (Some variation dependent on locality). The ethnicity of the trust staff was at least in line with these demographics and there was ethnic diversity at senior grades and on the board. The exception is Crawley, the second largest conurbation in Surrey and Sussex with an expanding population of, predominantly, working age residents. A slightly lower 78% of residents were born in the UK with a slightly higher number of people from India and Pakistan.

The board had recently approved a “One team” inclusion strategy that saw the establishment of an inclusion working group with the next phase of development. The strategy considered opportunities for broadening the reach of the trust with a focus on patients, engagement and the local community. We saw that the dental service had already begun working with the traveller community to provide services which traveller families felt more comfortable accessing.

Although the gender balance was good there were further opportunities to improve the diversity of the board to ensure that it mirrors the population that the trust serves. This was recognised by the trust and will feature in future succession plans.

The board had developed an action plan in response to their Gender Pay Report aimed at increasing the number of female applicants to the SASH Leaders Programme.

The trust worked in partnership with Surrey County Council through the Surrey Choices employability scheme to provide work placements for young adults with learning disabilities. Most of the placements had been with the SASH catering and library teams.
NHS Staff Survey 2017 – results better than average of acute trusts

The overall score for the National NHS Staff Survey were in the top 20% for the three years preceding the inspection. In some scores they ranked in the top 4 organisations nationally.

The focus on quality had tangible results; including improved performance in several quality metrics and changing the public perception of the trust to a positive one. The trust values resonated with all staff members we spoke to and many commented on the open and honest culture.

This was reiterated by the results of the 2017 NHS Staff Survey, which showed that the trust had achieved consistently higher percentages, compared to the national average for acute trusts, in relation to staff perceptions of the quality of care and the organisation encouraging staff to report incidents.

The trust has 25 key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
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<tbody>
<tr>
<td>KF12. Quality of appraisals</td>
<td>3.52</td>
<td>3.11</td>
</tr>
<tr>
<td>KF13. Quality of non-mandatory training, learning or development</td>
<td>4.10</td>
<td>4.05</td>
</tr>
<tr>
<td>KF21. % believing the organisation provides equal opportunities for career progression / promotion</td>
<td>90%</td>
<td>85%</td>
</tr>
<tr>
<td>KF28. % witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>28%</td>
<td>31%</td>
</tr>
<tr>
<td>KF29. % reporting errors, near misses or incidents witnessed in last month</td>
<td>93%</td>
<td>90%</td>
</tr>
<tr>
<td>KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.85</td>
<td>3.73</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.75</td>
<td>3.65</td>
</tr>
<tr>
<td>KF17. % feeling unwell due to work related stress in last 12 mths</td>
<td>30%</td>
<td>36%</td>
</tr>
<tr>
<td>KF18. % attending work in last 3 months despite feeling unwell because they felt pressure</td>
<td>42%</td>
<td>52%</td>
</tr>
<tr>
<td>KF19. Org and management interest in and action on health and wellbeing</td>
<td>3.86</td>
<td>3.62</td>
</tr>
<tr>
<td>KF15. % satisfied with the opportunities for flexible working patterns</td>
<td>58%</td>
<td>51%</td>
</tr>
<tr>
<td>KF1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>4.02</td>
<td>3.75</td>
</tr>
<tr>
<td>KF4. Staff motivation at work</td>
<td>4.02</td>
<td>3.92</td>
</tr>
<tr>
<td>KF7. % able to contribute towards improvements at work</td>
<td>74%</td>
<td>70%</td>
</tr>
<tr>
<td>KF8. Staff satisfaction with level of responsibility and involvement</td>
<td>4.02</td>
<td>3.91</td>
</tr>
<tr>
<td>KF9. Effective team working</td>
<td>3.85</td>
<td>3.72</td>
</tr>
</tbody>
</table>
The trust has three key findings worse than the average for similar trusts in the 2017 NHS Staff Survey:

### NHS Staff Survey 2017 – results worse than average of acute trusts

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF20. % experiencing discrimination at work in last 12 months</td>
<td>13%</td>
<td>12%</td>
</tr>
<tr>
<td>KF22. % experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>19%</td>
<td>15%</td>
</tr>
<tr>
<td>KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>32%</td>
<td>28%</td>
</tr>
</tbody>
</table>

In response to these results, the trust had taken action and was consulting on what the results meant in practice. In the emergency department there was ongoing work to capture data and review of all incidents reported where staff felt they had experienced bullying or harassment from patients, relatives or the public. The use of body cameras was being considered for some staff who were particularly vulnerable. The campaign, “It’s not OK” was strengthened and staff were encouraged to identify concerns and seek support.

(Source: NHS Staff Survey 2017)

**Workforce race equality standard**

Implementing the Workforce Race Equality Standard is a requirement for NHS commissioners and NHS healthcare provider. It provides information and data so that the trust can ensure employees from black and minority ethnic backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

Staff spoken to were keen to tell us they felt they had good opportunity for learning, development and promotion. There was representation of BME staff at all levels within the organisation. No
concerns relating to equality and diversity were raised with us during either the cores services or the well led inspections.

We saw the trust had completed the Workforce Race Equality Standard reporting template and had an action plan arising from it. This was included in the annual equality report and monitored by the director of workforce and through the workforce committee.

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

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

<table>
<thead>
<tr>
<th></th>
<th>Your Trust in 2017</th>
<th>Average (median) for acute trusts</th>
<th>Your Trust in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>White 33%</td>
<td>27%</td>
<td>32%</td>
</tr>
<tr>
<td></td>
<td>BME 32%</td>
<td>28%</td>
<td>25%</td>
</tr>
<tr>
<td>KF26</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>White 19%</td>
<td>25%</td>
<td>19%</td>
</tr>
<tr>
<td></td>
<td>BME 19%</td>
<td>27%</td>
<td>16%</td>
</tr>
<tr>
<td>KF21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>White 92%</td>
<td>87%</td>
<td>93%</td>
</tr>
<tr>
<td></td>
<td>BME 87%</td>
<td>75%</td>
<td>86%</td>
</tr>
<tr>
<td>Q17b</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>White 6%</td>
<td>7%</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>BME 9%</td>
<td>15%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Of the four questions above, the following questions showed a statistically significant difference in score between White and BME staff:

- KF21 Percentage of staff believing that the trust provides equal opportunities for career progression or promotion
- Q17b. In the last 12 months have you personally experienced discrimination at work from a manager/team leader or other colleagues?

(Source: NHS Staff Survey 2017)
Friends and Family test

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

The trust scored about the same as the England average for recommending the trust as a place to receive care from September 2017 to August 2018. The trust sustained very high scores in all divisions in the year preceding inspection; they were consistently above the England average.

In Quarter 1 of the staff FFT (April 2018 - June 2018), the trust was scored by staff as the best place in the country to work.

(Source: Friends and Family Test)
Sickness absence rates

The trust’s sickness absence levels from June 2017 to May 2018 were similar to the England average.

(Source: NHS Digital)

General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council Survey the trust performed in the middle 50% of all trusts for all 18 indicators.

The trust reported the best score regionally for clinical supervision for junior doctors. The trust was 8th out of 17 for the overall satisfaction levels which showed a year on year improvement.

The Medicine Division had a closed social media group that allowed junior doctors direct access to the chief of service and chief operating office as well as the support of their peers. The chief of service reported accepting messages for advice at 11pm and said they would prefer this to young doctors struggling to an extent where they ended up making a poor decision.

We spoke with seven junior doctors during the well led inspection and with both junior doctors and consultants during the core services inspection and focus groups. All were very positive about the trust and said they were well supported by their consultants and other staff and had opportunities for training and development.

We heard about a situation where one consultant went the extra mile to support a junior colleague. The junior doctor had been required to attend an inquest as a witness for a death at the trust where they had worked previously. The previous employer had not offered any support and the junior doctor was very anxious about the hearing so the consultant took the time to attend with them and provide support on site at the inquest.
Junior doctors were encouraged to become involved in the quality improvement programmes and had the opportunity to attend training in the methodology but they and the trust were limited a little by their training contracts and how they fitted with the project timelines.

(Source: General Medical Council National Training Scheme Survey)

**Governance**

There were effective governance structures and processes in place at board and committee level. Roles and responsibilities were well understood and there were clear and explicit terms of reference for all committees.

The trust’s governance structure is in line with expectations for a high performing trust, with the appropriate board committees, sub-committees, and divisional governance groups in place. Although, the structure means that there are many governance forums, staff that we spoke to felt that this was right, discussion was not duplicated and that meetings were focussed.

Reporting into the board were the Nomination and Remuneration Committee, Finance and Workforce committee, Safety and Quality Committee, Charitable Funds and the Audit and Assurance Committee. The Council of Governors also had a direct link to the full board.

Sitting below the sub-committees were the Executive Committee and the Executive Committee for Quality and Risk. Feeding directly into these two committees were the Model Hospital and Divisional Performance reviews.

Below and feeding into the two executive committees were operational subcommittees for Patient Safety, Effectiveness, Access and Responsiveness, Patient Experience and Workforce.

The Divisional Governance fed into the five operational subcommittees.

The dynamic we observed between board members throughout the inspection visits was supportive, inclusive and challenging. We were given many good examples of debate and challenge from the non-executive directors and between executive directors. The relationships between the executives and the chiefs of services (and amongst the chiefs of services as a group) was also very strong with clear warmth and respectful. They clearly knew and understood each other well and felt comfortable challenging but also told us about the good work and ‘extra mile’ behaviours of their peers. There did not appear to be any professional jealousies or silo working.

The board operated in a unitary manner, with both non-executive and executive directors providing scrutiny and detailed questioning across all areas of financial, operational and quality performance.

The Board met monthly and the private board was held prior to the public board. The timing of the committees means that the Safety and Quality Committee met at the beginning of the month and therefore after the trust board whilst the Finance and Workforce Committee met at the end of the month prior to the trust board. However, this means that safety and quality information discussed at the board had not been scrutinised at the Safety and Quality Committee beforehand. This potentially reduced the ability of committee members to provide suitable challenge on the most recent performance across all areas.

Non-executive director membership at committees was in line with expectations, with three non-executive directors including the committee chair. Although all non-executive directors were invited to attend the Finance and Workforce Committee, there was little rotation of non-executive director membership across committees. The trust might consider rotating non-executive director
committee membership as part of forward succession planning. This will help to ensure non-executive directors obtain oversight of performance across all areas.

The trust had an Executive Committee, Executive Committee for Quality and Risk and five sub-committees that reported into these two committees.

The Executive Committee met weekly and was responsible for overseeing strategic priorities, operational issues, current divisional issues, divisional development plans and health and safety issues.

The Executive Committee for Quality and Risk met biweekly and was responsible for overseeing divisional governance, quality of care, Commissioning for Quality and Innovation (CQUIN) and compliance.

The Executive Committee provided periodic reports to the board and committees and the Executive Committee for Quality and Risk reported to the Safety and Quality Committee.

The executive directors also held a monthly performance review with divisions. This meeting was where the core business of the trust was discussed on a regular basis with quality, risk, financial and operational performance scrutinised directly through the committee structure without the need for additional Executive oversight.

We spoke with members of the board about the number of meetings and possible duplication: the overwhelming view was that the number of meetings meant that information flowed effectively throughout the trust and that the benefits of this outweigh the time commitment and administrative burden.

The division of responsibilities and accountability across the trust was clear. Divisions operated a triumvirate leadership structure with a chief of service, associate director and a divisional nurse, this ensured divisions were clinically led with operational and quality representation.

Each division had a monthly divisional board and a monthly performance review which was attended by executive directors. These meetings enabled strong oversight of performance.

Board oversight of divisional performance was through the Integrated Performance Report and minutes of sub-committee meetings. The trust wants to develop a more standard way of reporting divisional performance to the board to ensure the board has sufficient information about divisional performance to enable scrutiny and challenge over any poor performance.

All new business cases, projects and waste reduction schemes required a Quality Impact Assessment to be performed. The Quality Impact Assessment template required the user to describe and rate risks to patient safety, clinical effectiveness and patient experience. All Quality Impact Assessments were reviewed and approved by the Chief Nurse and Medical Director, providing a control to prevent financial goals being inappropriately prioritised over quality. We saw evidence that financial pressures were managed so that they do not compromise the quality of care.

There was a virtual team for governance instigated to consider patient experience and key areas of risk by and the management leads for governance areas. Each team member was responsible
for one of the following; patient safety, effectiveness, access and responsiveness, workforce and patient experience. The virtual team created links across areas where there was an overlap. The team acted as a safeguard for risk.

There was strong governance of child and adult safeguarding. Trust staff worked with external agencies to ensure the vulnerable were protected from the risk of abuse. Staff completed the appropriate level of safeguarding training and attendance rates were monitored to ensure they remained above the trust target.

**Board Assurance Framework**

The Board Assurance Framework (BAF) is a key mechanism which boards should be using to reinforce strategic focus and better management of risk. The Board Assurance Framework brings together in one place all of the relevant information on the risks to the board’s strategic objectives. The trust board had sight of the most significant risks and mitigating actions were clear.

Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance.

The assurance mapping process and the illustration of the results using the Board Assurance Framework gave confidence to management and the board that they had a broad and deep understanding of how the trust was performing and the key strategic risks.

The assurance mapping process identified and recorded the key sources of assurance. This informed board members of the effectiveness of how key strategic risks were being managed or mitigated, and of the key controls and processes that were relied on to manage risks. As a result, the Board Assurance Framework supported the achievement of the organisation’s strategic objectives.

The Board Assurance Framework was received by the board on a monthly basis, with an accompanying report that summarised any changes to the Board Assurance Framework and “the ask” of the board. The board formally reviewed the Board Assurance Framework annually to update the strategic objectives, key risks and risk appetite. The Minutes of the Board Meeting, dated July 2018 showed that there was detailed discussion on the 2018/19 strategic risks. The Board Assurance Framework was structured effectively with clear and concise content for the user.

Members of the board said the format and content of the Board Assurance Framework had improved and it helped them to understand the key areas of focus for the organisation.

(Source: *Routine Provider Information Request (RPIR)*)

**Management of risk, issues and performance**

There was an exceptional culture of data-driven continuous improvement and transformation at the trust, and this was supported by a comprehensive meeting structure and detailed performance reporting processes. The trust’s risk management policy, processes and tools were well designed, albeit there are areas where the format and content of risk registers could be improved.

There was evidence of meaningful risk discussion in key governance meetings. The trust had very strong processes for monitoring and addressing risks, including the use of innovative models to mitigate important strategic and operational risks. An example of this was the development of physician associate roles to alleviate workforce and capacity risks.
The Trust’s Performance Review Framework – 2018/19 set out the process for divisional performance reviews. The processes set out in the framework included:

- Monthly rotation of full performance review in one month followed by a shorter follow up meeting the following month
- Full review will include all executive directors and the full divisional team… Follow up review will be a reduced audience from the executive and divisional team.

There were other controls in place to manage performance that were not specified in the framework, for example: The Board receives a monthly Integrated Performance Report; the Finance and Workforce Committee received monthly Key Performance Indicator reporting against set finance and workforce metrics; and the Safety and Quality Committee received a monthly Quality Reports summarising performance on quality.

The structure of performance management meetings and level of reporting was comprehensive, providing sufficient opportunity for executive directors to hold divisions to account. The quality of performance reporting at trust and division level was high. The use of data to drive performance improvements was exceptional.

The Integrated Performance Report was clear and informative. Key issues with performance were clearly highlighted both in data dashboards and in the supporting narrative.

The trust’s Integrated Performance Report - entitled ‘Delivering our Vision’ - was presented at each board meeting. The report was structured in line with the trust’s five strategic objective categories: ‘Safe’, ‘Effective’, ‘Caring’, ‘Responsive’ and ‘Well-led’, with an additional section on ‘Finance and Use of Resources’.

Each section contained details of performance against set metrics for a rolling 12-month period, along with a supporting narrative. The format of the report was clear and easy to follow. It provided RAG ratings and trend information which highlighted areas where there were performance concerns, or the direction of travel for indicators. The commentary in the Integrated Performance Report was succinct and provided good context on actions being taken to address performance issues.

Weekly Divisional Board meetings provided a forum for monitoring activity levels against divisional activity budgets that have been set in 2018/19. The reports presented at these meetings included planned and actual data for activity and income by Point of Delivery (POD). The report showed variances in activity and income, and users could drill down into the data to investigate specific Points of Delivery.

There were also divisional dashboards that presented performance against set productivity and quality metrics. These include rag ratings for KPIs over a rolling 12-month period.

The Quality Board Report plotted the trust’s performance on quality and productivity measures against national performance, as well as a cohort of similar trusts. The structure was aligned to the Integrated Performance Report; the consistency in structure and flow of the trust’s performance reporting made them easy to read, and the use of graphical visualisations made the data accessible.

The trust had a Data Quality Policy in place - ‘An Organisation-wide Policy for Data Quality’ - which outlined trust-wide data quality principles as well as providing guidance to all staff on the collection, recording, storage and processing of data.
An internal audit on data quality was undertaken in 2017/18 and reported ‘substantial assurance’ (the highest assurance category) to the trust. Staff told us that they did not have any concerns over the quality or accuracy of the data they received.

The Model Hospital group is responsible for discussing, analysing and developing workplans associated with benchmarked data. This group discusses data from various sources, including: Model Hospital; Getting It Right First Time; Dr Foster; national pilots; etc.

The Director of Outcomes has performed analyses looking at the relationship between performance indicators and patient outcomes. This found relatively strong relationships between both the A&E 4-hour wait target and ambulance handover indicators, and patient mortality rates. The trust had subsequently focused on actions to improve these indicators to positively impact mortality rates.

We reviewed four sets of patient clinical records along with the mortality case records programme data review form for each patient. There was appropriate and correctly recorded use of Do Not Attempt Cardiopulmonary Resuscitation Forms with evidence of reversal of decisions when a patient’s condition improved. Each of the records showed that deaths were comprehensively reviewed by two independent clinicians.

The Mortality and Morbidity meeting we attended was also attended by 20 team members including the clinical leads for medicine, a respiratory consultant, the chief of service for medicine and three acute consultants. The meeting demonstrated an exceptional and effective approach to mortality. Presentation of clinical cases enabled learning and each death had been subject to independent senior clinical review and coding for the cause of death. The Royal College of Physicians Case Record Mortality Proforma was then completed and shared.

We walked the ‘waste management journey’ to observe how infection prevention and control risks were managed in practice. The trust had policies and guidance in place that were in date and which reflected the most recent national guidance and conformed to the Code of Practice. Staff spoken to were aware of the policies and knew how to contact the infection prevention and control team for advice on any matter. The Director of Infection Prevention and Control was the medical director, although the infection prevention and control team were line managed through the chief nurse.

On wards we saw staff following appropriate procedures for the disposal of waste with segregation into appropriate containers and good management of sharps containers, in accordance with trust policy. Externally waste was held in secure waste hub with locked, coloured bins which were all correctly tagged. The area was clean and tidy and free from evidence of vermin. The portering team was well regarded and seen as integral to maintaining high standards of patient safety.

The trust had a well-known and very effective dementia strategy, launched in 2017, that staff across the trust were very committed to. The strategy was overseen by a Dementia Strategy Steering Group which comprised of both trust staff and external stakeholders. The dementia lead was an Admiral Nurse. Admiral Nurses are mental health nurses specialising in dementia care, working collaboratively with health and social care professionals to improve the experiences of those affected by dementia. Examples of local initiatives included fast tracking patients with dementia in the x ray department. The trust used the Butterfly Scheme to enable staff to readily identify patients who had consented (or where a best interest decision was made in consultation with the families), to be included in the scheme which promoted personal choice.

The trust produced an Annual Dementia Report which provided data that demonstrated how well the strategy was working using performance indicators. These included the number of falls (there had been a 30% reduction in wards which reported a high number of falls), a review of
inappropriate discharges and the number of people with dementia being prescribed antipsychotic drugs.

The hospital resuscitation team met every morning at 9am. It had been recognised that the team coming together for the first time around a critically ill patient was not the best way to ensure everyone was clear about their roles and responsibilities. The team met for 10 -15 minutes to introduce themselves and describe the skills they brought the team and to decide how the team would work if there was more than one emergency call at any one time.

**Finances Overview**

The trust’s financial strategy was to establish the trust’s long term financial stability through short term and medium-term objectives as follows;

**Short term**
- stabilising the trust’s clinical services in the face of increasing emergency demand to provide sufficient capacity to deliver clinical and financial plans;
- recover the normalised position of the trust by 2017-18

**Medium term**
- become a financially sustainable organisation through continuous operational efficiency, improving health outcomes and working in fuller and more effective partnership with commissioners, local authorities and other providers
- creating a flexible and commercial organisation able to quickly and effectively respond to all the demands of the changing NHS environment

The trust delivered their first recurrent surplus in the financial year from April 2017 – March 2018.

The trust ended 2017-18 with a surplus of £13.6m. This is a notable achievement, which allowed the trust to invest in additional capital works during the year and improve its previously poor liquidity position.

The trust has achieved £6.2m of savings (meeting its planned savings target) in the financial year from April 2017 – March 2018 They received non-recurrent income of £8.2m from Sustainability and Transformation Funding from NHS Improvement. In conjunction with other non-recurrent items, the underlying position was a £2.6m surplus.

The trust had the lowest cost per weighted activity unit (unit cost) for any acute trust in England in the financial year from 2016-17 (national reporting of this data is one year in arrears). The cost per weighted activity unit (WAU) is a unit cost measure introduced as part of the NHS Improvement’s Operational Productivity work and recorded in the Model Hospital data portal.

The Trust’s 2016-17 cost per WAU is the lowest for any acute trust nationally - £2,930 per WAU. Their reference cost index, where 100 is the index level, was 83 – again the lowest in England for an acute trust. These values represent improvement on the previous year and described strong value for money.

The financial plan connection to the operational plan 2016-17 saw the delivery of a non-recurrent surplus that had become recurrent as the trust moved into 2017-18. Therefore, the trust had achieved the short-term objective to recover the normalised position of the trust.

The financial plan was supported by an operational plan, describing the activity changes that would allow the management of demand and the balancing of non-elective to elective activity.
Additional capacity for elective activity was created in 2015-16 (an additional elective ward and an additional theatre, plus additional day case capacity) but the level of emergency demand prevented its effective use. That problem continued through 2016-17 and into 2017-18.

This was despite better management of emergency work from the creation of new units and new ways of working. As a result, the trust did not deliver its elective income plan in 2017-18, particularly in the first half of the year. That also contributed to fluctuation of the delivery of the 18-week referral to treatment standard.

Surrey and Sussex Healthcare NHS Trust secured £56m working capital loan at the end of 2006-07 to cover debts from its poor financial performance up to that time. At that time, this was the largest loan allowed for any NHS Trust. The current position is that the trust has only £3m left outstanding. The trust is now making the scheduled payments required by its 25-year loan agreement against that balance.

The trust performed well on the model hospital indicators.

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£286.3m</td>
<td>£315.4m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>£3.4m</td>
<td>£13.6m</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£282.9m</td>
<td>£301.8m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>£282.5m</td>
<td>£301.9m</td>
</tr>
</tbody>
</table>

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

Trust corporate risk register

The Trust had a Risk Management Policy in place which was ratified by the Executive Committee for Quality and Risk in March 2018. The policy provided users with a clear framework for identifying, assessing, treating and monitoring risks.

The policy defined responsibilities and accountabilities for risk management, as well as the reporting/committee structure relevant to risk management. In line with good practice, the policy linked risk management to the trust’s strategic objectives.

The trust used a commercial electronic reporting system to log all identified risks. The different risk registers were derived from this system and this resulted in the use of a consistent format that is good practice.

The trust had developed the risk management tools including: A Board Assurance Framework (BAF); a Significant Risk Register to report risks with a score of 15 and above; and divisional risk registers.

The Significant Risk Register included the initial, current and residual risk rating. The residual risk rating was the trust’s target risk rating. There was a clear plan for each risk.

We saw several examples of a very reactive and proactive approach to mitigating risk.
In terms of immediate risk, we saw the trust approach in response to a trolley with unlocked liquids subject to the Control of Substances Hazardous to Health Regulations (2002). A cleaning trolley with a potentially toxic substance was left unattended in a public area for a considerable time. When informed of this, the trust took immediate action using a process called, “Stop the Line”. This is part of the lean methodology, developed initially by a car manufacturer in Japan but spread into other environments including healthcare and used at the Virginia Mason Institute that the trust is partnered with. There was an immediate response locally where the risk was identified and a wider local review and investigation to determine whether this was a truly local problem or whether there were wider implications and lessons.

In terms of a more proactive management of risks we saw that the trust used their patient flow database and site meetings to minimise the risk of delays of care to patients and also to ensure patients were cared for on specialist wards with staff who understood their specific needs. This reduced the risk of inappropriate care the risk of prolonged length of stay.

The trust provided a document detailing their eight highest profile risks. Each of these have a current risk score of 15 or higher.

<table>
<thead>
<tr>
<th>Date risk opened</th>
<th>ID</th>
<th>Description</th>
<th>Risk score (initial)</th>
<th>Risk level (current)</th>
<th>Next review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/02/2018</td>
<td>1918</td>
<td>Due to limited radiologist capacity radiology are no longer able to support triple assessment (physical exam, imagining and biopsy) in one visit for suspected cancer patients referred into the breast service.</td>
<td>16</td>
<td>15</td>
<td>31/07/2018</td>
</tr>
<tr>
<td>18/06/2014</td>
<td>1603</td>
<td>As described on the BAF (5.3)</td>
<td>15</td>
<td>15</td>
<td>31/08/2018</td>
</tr>
<tr>
<td>09/12/2014</td>
<td>1663</td>
<td>Risk of not achieving financial plan as a result of non-delivery of Cost Improvement Plans</td>
<td>15</td>
<td>15</td>
<td>31/08/2018</td>
</tr>
<tr>
<td>01/04/2015</td>
<td>1689</td>
<td>Risk the Trust short term financial stability if the annual income plan is not delivered.</td>
<td>15</td>
<td>15</td>
<td>31/08/2018</td>
</tr>
<tr>
<td>23/03/2015</td>
<td>1678</td>
<td>&quot;Due to demand exceeding capacity, on-going operational pressures and operational process issues, the Trust cannot offer all services within the 18 weeks standards set out in the NHS Constitution. Longer waiting times result in poor patient experience, potential avoidable harm and increase the number of formal and informal complaints&quot;</td>
<td>15</td>
<td>15</td>
<td>31/07/2018</td>
</tr>
<tr>
<td>01/04/2017</td>
<td>1838</td>
<td>Risk of delay in handover for ambulances arriving at ESH. No patient should wait over 30 minutes to be offloaded from an ambulance trolley into the Emergency Department.</td>
<td>15</td>
<td>15</td>
<td>01/10/2018</td>
</tr>
<tr>
<td>26/07/2010</td>
<td>1068</td>
<td>Description revised March 2017 to reflect current situation. Service demand (measured by number of samples received, number of blocks</td>
<td>20</td>
<td>16</td>
<td>05/10/2018</td>
</tr>
</tbody>
</table>
made per sample and proportion of samples requiring further work, in particular immunohistochemistry) has risen by at least 20% from 2012/13 to 2015/16. As a consequence, the department is failing to achieve the RCPath's quality standards relating to reporting turnaround times within 7 and 10 days. This is impacting on patient care by leading to delayed issuing of reports, and could impact on Trust performance relating to the cancer pathway targets.

<table>
<thead>
<tr>
<th>Date</th>
<th>Code</th>
<th>Note</th>
<th>Impacted</th>
<th>Awaiting</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/10/2016</td>
<td>1798</td>
<td>There is a chance of avoidable harm as a result of the Trust’s health record systems not being connected through one medium, be that electronic or paper</td>
<td>12</td>
<td>15</td>
<td>31/10/2018</td>
</tr>
</tbody>
</table>

(Source: Trust Corporate Risk Register)

Information management

The trust had appointed a Director of Outcomes. Their role was to look at information and regulation and how this impacted on patients.

Nationally available data and performance metrics were aligned to trust priorities. Data was used to map and demonstrate correlations between factors that impacted on patient outcomes. An example of this was worse outcomes for patients where ambulance handovers were delayed. Well-presented and accessible data enabled supported and enhanced conversations about quality.

The trust had a chief clinical information officer who guided the clinical informatics board which reports to the executive committee. Information technology was seen very much as an enabler to monitor and improve patient care.

Board and sub-committees had developed performance indicators which were scrutinised along with other data including the benchmarking report, comparing the trust with other high performing organisations and used to measure improvement.

Data systems were aligned and available at ward and speciality level enabling board not ward visibility.

The Model Hospital group was responsible for discussing, analysing and developing workplans associated with benchmarked data. This group discussed data from various sources, including: Model Hospital; Getting It Right First Time; Dr Foster and national pilots.

The Director of Outcomes performed analyses looking at the relationship between performance indicators and patient outcomes. This found relatively strong relationships between both the A&E 4-hour wait target and ambulance handover indicators, and patient mortality rates. The trust subsequently focused on actions to improve these indicators to positively impact mortality rates.

At the July 2018 board meeting the members identified that urinary tract infections was flagging as an issue on the Quality Board Report. A deep dive into the root causes was carried out. Through the Quality Board Report, benchmarking had become another source of assurance on quality and performance for the board.
One exceptional use of information was the control centre patient information dashboard. This was used by staff, led by the Chief Operating Officer and site managers, to ensure that patients were “in the right place to receive the right care”. The dashboard was a live tool that continuously updated where every patient was in the hospital and showed any plans to discharge or move them from one department to another. It enabled all staff from ward to the control centre to see at a glance where beds were available, whether any patients were allocated to those beds but not yet moved, whether the bed was ready and how far along the discharge process patients going home were. It allowed the organisation to think ahead about the number of beds likely to be needed over the next few hours and which was the most appropriate ward for them to be moved to. In general, patients requiring specialist care were accommodated on wards for that speciality. Respiratory patients went to respiratory wards and cardiac patients went to cardiology wards. This improved patient outcomes and reduced the length of stay because patients received the right treatment quickly. Staff time wastage was reduced as there were fewer outliers on inappropriate wards. It also resulted in significantly less bed moves overall and improved the patient experience.

The trust was considering the best electronic patient record system to invest in at the time of the inspection and was clear they wanted to ensure they had the most efficient and user-friendly system that reduced duplication. They wanted one system that supported all information across the system. Electronic Patient records were in use but the trust wanted to extend the scope of the systems they used.

Engagement

We found an ethos and culture of staff engagement at the trust which led to staff feeling empowered to lead improvement in their teams. The trust had a number of key strategies including patient and public engagement, patient experience, dementia, mental health and also a patient experience committee. The trust Strategy on a Page was a key enabler of staff engagement.

Staff surveys highlighted a recurring issue relating to staff harassment by patients, which the board was taking action on and where there was clear intent by the board to ensure all staff felt safe at work. When we spoke to staff, the particular concern reported related to the security service which was provided through a third-party contract. Actions had been identified to address the issue of staff harassment, specifically a renewed focus on the ‘It’s Not Okay’ campaign. The most recent Staff Friends and Family Test survey identified that 54% of staff were aware of this campaign.

The trust has increased the level of patient engagement to a good level via investment in different approaches to involve patients.

Many of the key risks and issues the trust faced (e.g. ‘super stranded’ patients, pressure on A&E, workforce, etc.) required a collaborative system solution. The trust’s clinical staff were encouraged to increase their involvement in the regional Sustainability and Transformation Plans but the progress of the Sustainability and Transformation Plans was not entirely within their sphere of control.

The trust’s chief executive performed the Sustainability and Transformation Plans lead role for the first 16 months, and trust staff continue to contribute to various meetings and working groups. Trust leaders expressed some concerns about the formation of the Sustainability and Transformation Plan including;

• A lack of clarity over the remit of the STP and its committees.
• Staff reported not having the capacity to deliver their trust role and effectively contribute to the Sustainability and Transformation Plan such that they could bring about timely progress of the plan.

• Clinical teams have not been sufficiently engaged to improve pathways. There had not been the clinical benefits realised and whilst the trust welcomed wider partnership opportunities the Sustainability and Transformation Plan could provide; the board was very clear that their main focus had to remain on delivering high quality healthcare for their patients.

Board members undertook a series of “NED Walks” to meet staff and discuss their concerns or make positive comments. Staff considered the board to be very visible, supportive and approachable.

The trust had developed several mechanisms for staff to be engaged. We were told that staff feel empowered to identify and implement changes to improve quality and efficiency of services. Staff expressed a strong sense of ownership over their work and pride in their teams.

Regular safety and trust community newsletters were sent out by the chief nurse to all staff. Safety Pin was the publication sent out each week to share lessons learned and improvements to patient care. The format was to report patient stories and the lessons learned. The edition dated 15 October 2018 shared a story from another trust where a patient had become very ill because they had used contaminated liquid medicine that had decomposed as the patient had kept it so long. The lessons learned resulted in pharmacy staff adding expiry labels to bottles that assumed the opening date was the dispensing date.

The trust engaged patients in the following ways:

• A Council of Governors was maintained and met regularly although this is not a Foundation Trust and there is no requirement to have a council.

• Two patient governors sit on the Patient Experience Committee.

• Governors have represented patients on Lean for Leaders.

• Two patient representatives sat on the Patient Information Review Group, which reviews communication to patients.

• Patients had been included in focus groups (e.g. endoscopy) and workshops (e.g. Chronic Obstructive Pulmonary Disease) where design of services is discussed.

• The trust had adopted the ‘Harvey’s Gang’ programme to engage with children with long term or life limiting conditions and allowed children to have a better understanding of the necessary tests and treatment they needed.

• Individual frail elderly patients were encouraged to engage with staff through the use of strolling musicians from the Wishing Well Music in Healthcare initiative. We watched a beautiful moment when one person who was completely contained in their own world gradually responded to the two strolling musicians playing and singing ‘I’m forever blowing bubbles’ very gently. This person engaged and responded with a huge smile and meaningful conversation just as their family arrived.

• Maternity User Engagement focus group.

• Community dental services for the traveller community.

• Patient stories were heard at the board and sub-committees.
The paediatric dental team at the trust worked in partnership with the 0-19 Homeless Health Team in Surrey to address the dental health needs of vulnerable children in Surrey. This service had been used to provide care to many families from the traveller community, from sheltered housing, from refuges. It also provided care to child refugees. This work has resulted in a local CIC nominating this service for a staff ward as external partners. The final results were not known at the time of the inspection.

The trust had an e-midwife called Sasha, an experienced, senior midwife available for women and their families to contact via email. Messages were responded to within three days and there had been over 450 emails received over a 12 month period.

In discussions we found staff to be very positive about the benefits of patient engagement, and about the trust’s current levels of patient engagement. Patients were also very positive about the level of interaction and how staff engaged with them on a personal level.

The trust has developed a feed on its website to draw in patient comments about the trust on Care Opinion - an online forum where patients can share their experience of health services.

Trust staff engaged with patients directly and included patients in investigations or lessons learned processes. This level of transparency in dealing with issues in a public forum enhanced the open and honest environment at the trust.

In March 2017 the trust launched a patient experience platform which captured patient experience information. Patient satisfaction surveys could be accessed online, via telephone or smart phones, or via 50 electronic tablets in East Surrey Hospital. The trust’s investment in different mechanisms to receive patient feedback was indicative of the patient-centred and continuous improvement culture.

Executives spoke of a much-improved relationship between the trust and the local Clinical Commissioning Groups, and considered the reasons for this to be improved relationships at board level. The two-year contract with the Clinical Commissioning Groups had also reduced disputes and increased collaborative working.

There were strong external partnerships and relationships with other trusts, the third sector and educational institutions. There was a strong commitment to partnership working to improve the patient experience and to support innovative practice. Examples of this included:

- The Lane Fox Respiratory Centre in partnership with a London trust and a commercial provider of therapeutic oxygen.
- A joint venture with another trust to provider pathology services
- Formally supporting an ambulance trust that is in special measures.
- Work with a regional medical school
- Work with the Virginia Mason Institute in Seattle and the other four involved trusts
- Work with an outstanding trust within the region.

The trust maternity service had an active Maternity Voices Partnership, which had evolved from the Maternity Services Liaison Committee. The group was chaired by a service user and meets bi-monthly with representation from minority and hard to reach groups such as teenagers, fathers and bereaved parents.
Learning, continuous improvement and innovation

Through SASH+, Lean for Leaders, the procedures in place for benchmarking and reporting of incidents and complaints the trust had developed robust processes for learning, improvement and innovation. The “tone from the top” from the trust’s board had embedded an ethos of continuous improvement. The investment in SASH+ and Lean for Leaders had proved to staff the organisation’s commitment to developing staff and improving the way the trust worked. This had won the “hearts and minds” of the workforce and as a result staff embraced the trust’s continuous improvement journey.

“Continuous quality improvement” was a consistent theme in discussions with trust staff. The trust’s SASH+ programme was the well-publicised mechanism by which the organisation formalises quality improvement.

The Lean for Leaders training had been a significant investment of resources for the trust, including £14m over the five years as well as significant staff time away from their day job. This level of investment was indicative of the trust’s focus on improving efficiency and patient experience. Staff spoke very positively about SASH+ and Lean for Leaders, including how the programmes have improved staff relationships within and across teams, as well as empowered staff to implement change where they saw quality or patient experience could be improved. Staff were able to provide examples of changes that had been made to improve patient experience and/or efficiency of process.

The trust held discussions to consider ‘The ward of the future’, and the workforce that will be required. As a result, new roles were being developed, including apprentices, physician associates and nurse associates, which also links to the trusts own workforce issues. The trust hosts the Kent Surrey and Sussex School of Physician Associates, a first of its kind nationally.

There were ‘Innovation Huddles’, as well as staff away days, to discuss potential process improvements. The trust also has an ‘Ideas to Innovation’ portal for staff to share ideas that will improve efficiency, quality of care or patient experience. The medical director and an evaluation team considered the ideas and fed them to the relevant team for implementation.

Staff were able to provide examples of changes they had made to improve processes, and spoke of how the trust celebrated such stories.

In 2017 NHSI invited the trust to provide support to an ambulance trust in special measures. In 2018, a formal “buddying” relationship was developed via a memorandum of understanding. The trust has successfully used this relationship to improve ambulance handover times.

Several groups of staff and executives told us about the “stopping the line” process, where a process is stopped to investigate when an incident occurs. During the core service inspection, we saw the process in use. The process is only recommenced once the team are happy that the risk of re-occurrence has been adequately mitigated. Staff spoke of a ‘no blame’ culture and were able to provide examples where they felt supported by the trust to stop procedures or change processes to prevent harm or improve quality.
There is a Serious Incident Review Group that is responsible for investigating and monitoring action plans through to completion. There was a real focus on learning lessons from incidents and escalating/cascading these through the organisation.

An example of the learning following a serious incident was the introduction of the close care observation badges for specific bays or wards. Where a patient bay had a close observation badge, there was a requirement that there was always a member of staff in the bay. The minutes of the Serious Incident Review Group dated 9 August 2018 showed that another ward already had a local scheme in place called ‘Baywatch’. The trust was reviewing both to see which was the most effective.

There were daily safety huddles across the trust where learning was a key theme and outcome.

The trust led the innovative ‘Mouthcare Matters’ campaign which has then rolled out regionally and subsequently nationally by Health Education England. The Mouth Care Matters programme, set out to improve oral health. Oral health is an important part of general health and wellbeing. It allows people to eat, speak and socialise without discomfort or embarrassment. Research shows that oral care is often lacking in hospital and community care settings, especially to those patients who may be unable to carry out their own personal care and rely on others for support; Mouth Care Matters seeks to address this.

The trust had more Darzi Fellows either directly awarded by HEEKSS, or doing their projects within their services over the last two years than any other acute NHS trust. One of the fellows co-designed some work in the respiratory outpatient’s department and found that patients wanted peer support (advice from people with the same COPD diagnosis as them who were experts by experience and facing similar challenges) rather than always having to turn to healthcare professionals. They also wanted more support from their partners to improve their knowledge and prevent burnout. They set up an on-line forum for them that is reported to be working very well.

The trust had been approached by the University of Surrey who have a strong and growing digital health interest, with quite a few faculty and senior post-docs with little actual health care experience. They approached the trust to see if they could work in partnership to describe and provide a programme of clinical experience and exposure. The trust executive report being very keen to to do this and say that they will work through the practicalities to enable them to take advantage of this golden opportunity.

The trust was concerned for patients with suspected cancers waiting for appointments and introduced a system where patients could make an urgent/soon appointment that suited them. This reduced the need to rearrange appointments and missed appointments and in many cases meant patients could have their scans on the same day. This was so successful that the trust is rolling it out to other modalities.

The multidisciplinary team education about ageing (MDTea) produced podcasts as a means of providing accessible education about the specific healthcare needs of older people. These podcasts could be accessed by staff in primary and secondary care. The scheme won the best technology enhanced learning presentation as the Association for the Study of Medical Education conference in 2017. Active engagement with social media was used to develop an online community via the #MDTeaClub – a social media based journal club linked to the podcasts. There have been over 85,000 downloads of the first 50 episodes.
As part of the Lean for Leaders programme the orthopaedic team instigated a virtual fracture clinic where all new patients were assessed virtually one week in advance of the clinic by a consultant. This resulted in 75% of patients being discharged and being sent a letter for self-management which was copied to their GP. Very few of these patients have chosen to have face to face consultations. The virtual clinic has had a significant impact on efficiency and costs with clinics taking a quarter of the time and allowing consultants top see appropriate urgent referrals more quickly.

Using the lean methodology, the endoscopy team reduced the time between a patient being referred and them receiving an appointment from 4-7 weeks to 10 days initially and this had further improved to 24 hours by March 2018. The hidden benefit of this was a revenue increase of £120,000 and saving 27 reams of paper by not duplicating letters.

The trust took a proactive stance regarding research. Dermatology was a very good example of this with a whole team approach which allowed research to be fully integrated into the unit as part of normal clinical care. This has had a direct, positive impact on the care of patients and their outcomes. Examples of this include a one-stop psoriasis clinic set up to accommodate a small research study and which evolved into monthly clinics which streamlined the review process for patients.

The trust was a high performer against the National Institute of Health Research Studies performance metrics and were one of the best performers in the regional clinical research network in terms of research delivery timelines and data quality.

The trust was a high-level recruiter of patients to studies. They were within the top 20 for the DALES study – a programme considering Drug Allergy Labels in the Elective Surgical population and the 5th nationally for the National Institute for Health and care Excellence Fit Study. This is a study looking at the use of a faecal immunochemical test to exclude bowel cancers.

The acute medical consultants had introduced Point of Care Ultrasound throughout the acute medical unit and ambulatory emergency care unit. This had resulted in the more rapid diagnosis and treatment of several conditions including heart failure, embolisms and effusions. The use of the ultrasound at the point of care was supported by an education programme and new ultrasound devices.

There was a defined complaints handling process which is set out in the Complaints Policy and administered by the Complaints Team. The Complaints Review Group met monthly and was chaired by the Chief Nurse. This group was responsible for monitoring responses to complainants and ensuring remedial actions plans were robust.

The trust responded to concerns that were raised with them even when they were not formalised as a complaint. Feedback on the Patient Opinion site suggested a patient had felt very uncomfortable having to sit a hospital gown in an open area within the imaging department. The trust invited the person in, understood the concern and developed a solution. New gowns which were longer and which were a wraparound style, for better coverage, were purchased. They then secured funding to build a more suitable cannulation and waiting environment closer to the imaging room.

We reviewed four complaint files. All had clear documentation with a process checklist attached to the front of the file. The investigations were comprehensive and involved the clinicians in the area
which the complaint was about. The response to the complainant was personalised, detailed and had the complaint investigation response template attached so that complainants could see which staff had contributed to the investigation and what actions the trust was taking.

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

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>25 days, or a timescale agreed upon with complainant</td>
<td>92%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>25 days, or a timescale agreed upon with complainant</td>
<td>92%</td>
</tr>
</tbody>
</table>

| Number of complaints resolved without formal process in the last 12 months? | 527 | June 2017 – May 2018 |

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

The trust received 542 complaints from June 2017 to May 2018. Outpatients core service received the most complaints with 141.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC - Outpatients</td>
<td>141</td>
</tr>
<tr>
<td>AC - Medical care (including older people’s care)</td>
<td>113</td>
</tr>
<tr>
<td>AC - Surgery</td>
<td>96</td>
</tr>
<tr>
<td>AC - Urgent and emergency services</td>
<td>85</td>
</tr>
<tr>
<td>AC - Maternity</td>
<td>37</td>
</tr>
<tr>
<td>AC - Gynaecology</td>
<td>27</td>
</tr>
<tr>
<td>AC - Services for children and young people</td>
<td>16</td>
</tr>
<tr>
<td>AC - Diagnostics</td>
<td>11</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
</tr>
<tr>
<td>AC - Critical care</td>
<td>3</td>
</tr>
<tr>
<td>AC - End of life care</td>
<td>2</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)
From June 2017 to May 2018, the trust received a total of 19,113 compliments. A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC - Outpatients</td>
<td>4,487</td>
</tr>
<tr>
<td>AC - Surgery</td>
<td>4,374</td>
</tr>
<tr>
<td>AC - Urgent and emergency services</td>
<td>3,928</td>
</tr>
<tr>
<td>AC - Medical care (including older people’s care)</td>
<td>2,865</td>
</tr>
<tr>
<td>AC - Maternity</td>
<td>1,200</td>
</tr>
<tr>
<td>AC - Diagnostics</td>
<td>597</td>
</tr>
<tr>
<td>Other</td>
<td>588</td>
</tr>
<tr>
<td>AC - Gynaecology</td>
<td>574</td>
</tr>
<tr>
<td>AC - Services for children and young people</td>
<td>420</td>
</tr>
<tr>
<td>AC - Critical care</td>
<td>80</td>
</tr>
</tbody>
</table>

The data in the table above shows the volumes of SenSASHional comments by month, which is the trust’s own feedback initiative.

Currently these comments are not themed for analysis but the trust advise that the overwhelming feedback is around quality of care and compassion.

The trust also receives compliments via other channels but not all these mechanisms make counting feasible;

- Social Media
- Letters & thank you cards
- Phone calls into patient experience team
- Express feedback button on website

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

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

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Next accreditation due November 2018</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and it's successor</td>
<td>Microbiology UKAS ISO15189 awarded 28/10/15 and retained.</td>
</tr>
<tr>
<td>Medical Laboratories ISO 15189</td>
<td></td>
</tr>
<tr>
<td>MacMillan Quality Environment Award (MQEM)</td>
<td>MQUEM assessment last year and achieved the quality mark in August 2017</td>
</tr>
</tbody>
</table>

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

Outpatients

Facts and data about this service

Surrey and Sussex Healthcare NHS trust offers outpatient appointments for all specialties where assessment, treatment, monitoring and follow up are required. These include medical, nurse or therapy led clinics and are delivered from a number of locations, including East Surrey hospital, Crawley hospital, Earlswood, Horsham, Oxted and Caterham. At East Surrey hospital, clinics are available until 8pm Monday to Friday and 6pm at weekends.

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

The graph below represents how this compares to other trusts.

The trust had 380,040 first and follow up outpatient appointments from June 2017 to May 2018.

(Source: HES - Outpatient)

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from June 2017 to May 2018.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Surrey Hospital</td>
<td>385,547</td>
</tr>
</tbody>
</table>
The chart below shows the percentage breakdown of the type of outpatient appointments from June 2017 to May 2018.

### Number of appointments at Surrey and Sussex Healthcare NHS Trust from June 2017 to May 2018 by site and type of appointment.

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crawley Hospital</td>
<td>123,829</td>
</tr>
<tr>
<td>Horsham Hospital</td>
<td>49,085</td>
</tr>
<tr>
<td>Earlswood Community Diabetes and Endocrinology Centre</td>
<td>9,994</td>
</tr>
<tr>
<td>Caterham Dene Hospital</td>
<td>4,559</td>
</tr>
<tr>
<td>This Trust</td>
<td>575,629</td>
</tr>
<tr>
<td>England</td>
<td>106,785,632</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

The outpatient department at the East Surrey Hospital is part of the Surrey and Sussex Healthcare NHS trust.

Between June 2017 and May 2018 there were 385,547 appointments at East Surrey Hospital, which equated to 67% of the overall appointments across the trust during the same period.

Outpatient services at East Surrey Hospital were located throughout the site, with the main outpatient department located on the ground floor.

As part of our announced inspection we visited the main outpatients' department; ophthalmology outpatients; the therapies department; the fracture clinic; phlebotomy (taking blood for testing); the breast clinic; the ear, nose and throat clinic; maxillofacial; dental clinics; the Kaizen (Kaizen means continuous improvement in business) office; cardiology; medical records; and, the booking office.

The hospital provides outpatient services covering a range of specialities including but not limited to: medicine, cardiology, neurology, rheumatology, diabetes, respiratory and dental.
The service provided both consultant and nurse led outpatient clinics across a range of specialties. Outpatient clinics were held between 08:00am and 8:00pm with some additional clinics on a Saturday and some ad hoc clinics on a Sunday.

During our inspection we spoke with nine patients and one carer. We spoke with 35 members of staff including nurses, health care assistants, consultants, therapists, phlebotomists, divisional leads and managers. We reviewed three patient records and three complaint records. We reviewed performance information about the department and the trust.

The service was previously inspected in 2016. That inspection also included diagnostic imaging services. Diagnostic imaging services are now inspected separately and have a separate report and therefore we cannot directly compare ratings. During this inspection, we only looked at services provided within outpatients.

The last inspection rated the service as requires improvement overall. On this inspection we rated this service as good.

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

Staff received effective training in safety systems, processes and practices. The service provided mandatory training in key skills to all staff and made sure everyone completed it. General outpatient services operated within the surgical division of the trust and mandatory training figures were reported on this group of outpatient staff. This included outpatient nursing, allied healthcare professionals and administrative staff working in the general outpatient department. The trust target of 80% compliance for all mandatory training was met or exceeded in the general outpatient department.

The trust did not have dedicated medical staff working within the general outpatient department. All medical staff running clinics were assigned to different specialities within the trust and mandatory training was reported within those specialities.

Staff we spoke with told us the online training resource was easily accessible and up to date. The system flagged when staff were approaching their refresher date and some of the training sessions were also available as face to face sessions.

Mandatory training covered a variety of topics including fire safety, medicines management, conflict resolution, information governance, manual handling and safeguarding adults and children.

The trust set a target of 80% for completion of mandatory training.

**Trust level**

A breakdown of compliance for mandatory training courses as of May 2018 at trust level for qualified nursing staff in outpatients is shown below:

Please note the training modules have been merged to give overall figures for each module as the raw data included multiple entries of the same modules with training renewal dates.
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Safety - 2 Years</td>
<td>19</td>
<td>23</td>
<td>83%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local Data Security Awareness - 1 Year</td>
<td>19</td>
<td>23</td>
<td>83%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS Conflict Resolution (England) - 3 Years</td>
<td>20</td>
<td>24</td>
<td>83%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control - Level 2 - 1 Year</td>
<td>21</td>
<td>23</td>
<td>91%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic Life Support (Adults &amp; Paeds) Level 2</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>23</td>
<td>23</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, Safety and Welfare - 3 Years</td>
<td>23</td>
<td>23</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>In Hospital Basic Life Support (Adults &amp; Paeds)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - Clinical Update</td>
<td>8</td>
<td>8</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - MaST Clinical Update</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management – Update</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management Core Update</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Level 2 - 2 Years</td>
<td>23</td>
<td>23</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - Basic Life Support</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital BLS (Adults &amp; Paeds) - BLS/ILS</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus In Hospital MaST BLS &amp; AED Awareness Training</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation ILS</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In outpatients the 80% target was met for all mandatory training modules for which qualified nursing staff were eligible.

**East Surrey hospital:**

A breakdown of compliance for mandatory training courses as of May 2018 for qualified nursing
Qualified nursing staff in outpatients at East Surrey hospital met the 80% target for all mandatory training modules for which they were eligible.

**Crawley hospital:**

A breakdown of compliance for mandatory training courses as of May 2018 for qualified nursing staff in outpatients at Crawley Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Safety - 2 Years</td>
<td>8</td>
<td>9</td>
<td>89%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control - Level 2 - 1 Year</td>
<td>8</td>
<td>9</td>
<td>89%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local Data Security Awareness - 1 Year</td>
<td>8</td>
<td>9</td>
<td>89%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS Conflict Resolution (England) - 3 Years</td>
<td>9</td>
<td>10</td>
<td>90%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic Life Support (Adults &amp; Paeds) Level 2</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, Safety and Welfare - 3 Years</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>In Hospital Basic Life Support (Adults &amp; Paeds)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - Clinical Update</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management Core Update</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Level 2 - 2 Years</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - Basic Life Support</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital BLS (Adults &amp; Paeds) - BLS/ILS</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation ILS</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Name of course</td>
<td>Number of staff trained (YTD)</td>
<td>Number of eligible staff (YTD)</td>
<td>Completion rate</td>
<td>Trust Target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>------------------------------</td>
<td>-------------------------------</td>
<td>-----------------</td>
<td>--------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Local Data Security Awareness - 1 Year</td>
<td>5</td>
<td>7</td>
<td>71%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety - 2 Years</td>
<td>6</td>
<td>7</td>
<td>86%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS Conflict Resolution (England) - 3 Years</td>
<td>6</td>
<td>7</td>
<td>86%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, Safety and Welfare - 3 Years</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>In Hospital Basic Life Support (Adults &amp; Paeds)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control - Level 2 - 1 Year</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - Clinical Update</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - MaST Clinical Update</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management – Update</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Level 2 - 2 Years</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital BLS (Adults &amp; Paeds) - BLS/ILS</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation ILS</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Qualified nursing staff in outpatients at Crawley hospital met the 80% target in all but one of the mandatory training modules for which they were eligible. Local data security awareness was the one module they didn’t meet the target for with 71% compliance.

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

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it. All the staff in the general outpatient department had received safeguarding adult training. Staff working in more specialist areas of outpatients, where children may be treated routinely were trained to safeguarding children level three. For example, nurses we spoke with working in the fracture clinic where children would regularly be seen were trained to level three.
According to the Safeguarding children and young people: roles and competencies for health care staff Intercollegiate document, all non-clinical and clinical staff who have any contact with children, young people and or parents and carers require level two safeguarding children training. In addition to this, staff should be able to access a level three trained professional at any time during their work.

There were no adult safeguarding referrals made in the 12 months between June 2017 and July 2018 by outpatient staff. However, there were more than 8000 child safeguarding referrals made in the 12 months between June 2017 and July 2018 by outpatient staff working across the trust. For example, a staff nurse working in the fracture clinic told us they routinely referred children to the safeguarding team for follow up if they failed to attend an appointment. Staff told us that ‘did not attend’ appointments accounted for a high proportion of referrals to the safeguarding team.

Staff we spoke with had a good understanding of who the named safeguarding lead for the trust was and they could describe how they would raise concerns. For example, one member of staff told us of a referral to the safeguarding team of a child that was identified as regularly missing school. Another had made a referral because of suspected abuse. Information on safeguarding was visible throughout the department for staff, patients and visitors to see. This included the details of who to contact to raise concerns.

The trust set a target of 80% for completion of safeguarding training.

**Trust level**

A breakdown of compliance for safeguarding training courses as of May 2018 at trust level for qualified nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults - Level 2 - 3 Years</td>
<td>22</td>
<td>23</td>
<td>96%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In outpatients the 80% target was met for the one safeguarding training module for which qualified nursing staff were eligible.

**East Surrey hospital**

A breakdown of compliance for safeguarding training courses as of May 2018 for qualified nursing staff in outpatients at East Surrey hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults - Level 2 - 3 Years</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Qualified nursing staff in outpatients at East Surrey hospital met the 80% target for the one safeguarding module for which they were eligible.
Crawley hospital

A breakdown of compliance for safeguarding training courses as of May 2018 for qualified nursing staff in outpatients at Crawley hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults - Level 2 - 3 Years</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Qualified nursing staff in outpatients at Crawley hospital met the 80% target for the one safeguarding module for which they were eligible.

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

Cleanliness, infection control and hygiene

Standards of cleanliness across the department were generally maintained, with systems to prevent healthcare associated infections. Staff kept the environment, premises and most of the equipment clean, however we did view an accumulation of dust on the resuscitation trolley in the main outpatient clinic.

Cleaning schedules were maintained in all clinical areas. For example, schedules for each consulting room were stored on the back of the door. Those we viewed included details of the frequency and extent of cleaning within the room and were signed off as completed. Nursing staff took responsibility for monitoring the cleanliness of the rooms.

Toys used within the ear, nose and throat clinic for children in the waiting area were not subject to routine cleaning schedules. We raised this with staff during our inspection and as a result this was discussed in a safety huddle. The matron told us that because most children take their own toys with them a decision had been taken to remove the toys and offer colouring materials for children instead. Toys within the trauma and orthopaedic outpatient department were subject to a weekly cleaning schedule.

Monthly cleaning audits were undertaken and showed high levels of compliance, with the general outpatient department achieving scores between 92% and 100% between January 2018 and September 2018. We observed re-usable privacy curtains in treatment areas which had been changed in the last six months in line with national guidance. Records showed that all outpatient areas, including specialty clinics had records of six monthly curtain changes. This complied with Hospital Building Note 00-09, infection control in the built environment. This demonstrated that staff regularly changed the curtains to minimise the risk of the spread of infection.

We observed staff following national guidance on infection control. For example, staff with long hair had tied it back and all staff were ‘bare below the elbows’ at all times to enable effective hand hygiene and minimise the risk of contamination. We observed staff following National Institute of Health and Care Excellence (NICE) QS61: Statement 3: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of...
direct contact or care. Alcohol hand sanitiser was seen throughout the department and staff and visitors were observed using it.

In the phlebotomy department we observed staff taking blood without the use of gloves. Staff we spoke with told us that this was a decision for individual phlebotomists, however this was not in line with trust policy that clearly stated gloves should be worn when handling sharp or contaminated devices. Spill kits were available throughout outpatient clinics for the cleaning of body fluid spillages.

Patient feedback in the general outpatient department had included that patients did not always report seeing staff wash their hands. As a result, hand washing had been identified as an area for improvement within the department. As part of the outpatient team annual priority to reduce avoidable harm a team objective included the adoption of good hand hygiene techniques. Staff told us they had received hand hygiene training as part of their infection control training. Results of monthly hand hygiene audits showed that compliance was between 96% and 100% between September 2017 and September 2018.

There was sufficient personal protective equipment (PPE) available in line with trust policy. There were sufficient hand washing facilities available with sinks with lever arch taps in clinical/treatment areas. This was in line with Health Building Note (HBN) 00-09: Infection control in the built environment. Soap and hand towels were available next to hand basins to facilitate effective hand washing. Information was displayed by hand washing sinks, demonstrating the World Health Organisation (WHO) guidance (2009) ‘Five moments for hand hygiene’.

Waste was seen to be handled in line with national guidance. Waste bins were emptied regularly and seen to not be overfilled. Sharps bins included completed labels with the signature of staff and the date they were assembled. Sharps bins were available in treatment rooms and areas where sharps may be used. Sharps bins were not overfilled and were managed in line with Health and Safety Regulations 2013 (the sharps regulations), 5 (1) d. This requires that appropriate and secure sharps containers for the safe disposal of medical sharps, be placed close to the work area where sharps are being used.

We spoke with staff in the ear, nose and throat clinic who could describe a process of decontamination of reusable medical equipment in accordance with Department of Health Decontamination of surgical instruments (CFPP 01-01) (chapter 6) and trust policy. We observed labelled and packaged equipment waiting to be collected for decontamination by the central sterile services department (CSSD).

Infection control improvements were identified. For example, in the breast clinic we were told that a review of issues and teaching around the cause of post-operative infections had led to improved scrubbing techniques and ventilation within theatres.

Infection control risks were identified and action taken to mitigate them. For example, the service’s inability to meet the Department of Health’s CFPP 01-06 gold standard guideline on the decontamination of nasal endoscopes was on the surgical risk register. Essential quality requirements were met through the cleaning of endoscopes between patients and regular audits to ensure that cleaning procedures were adhered to. However, the trust’s infection control team had recommended the implementation of the gold standard guideline. This required a six-hour turnaround time from the central decontamination service which would necessitate the purchase of an additional 20 nasal endoscopes to meet the current demand on the service. A business case was due to be submitted to the capital bid group within the trust by April 2019 to address this issue and purchase additional nasal endoscopes.
Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. The outpatient service was provided from a range of areas throughout the hospital. Space was seen to be limited in some areas. For example, staff working within the Speech and Language Therapy (SALT) service told us that a lack of clinic rooms impacted on waiting times for patients. Specialist staff working in Chipstead clinic told us there was limited space for breaking bad news to patients which had sometimes resulted in them having to use rooms that were not suitable to have the privacy required. Staff working in the general outpatient department told us they were unable to accommodate trolleys in outpatients for any length of time. Wheelchairs were also difficult to manoeuvre in some areas.

Capacity issues within the ophthalmology clinic were identified as a risk on the surgical division risk register. The risk included issues around patients manoeuvring around the department as well as the impact on patient waiting times. Action to address issues within the environment included the development of additional clinic space, more efficient use of existing space and external capacity solutions. Pathology and haematology risks were also on the risk register. Waiting areas for haematology and pathology patients were separated by a partition to mitigate risks to immunocompromised haematology patients. There were long term plans to separate haematology and pathology. Risks were additionally mitigated by severely neutropenic patients being offered appointments at quieter times. Patients also advised to avoid public areas. We were told that a business case had been approved but waiting for ventilation issues to be resolved in pathology. However, staff working in phlebotomy told us they were concerned about space as the longer-term plans did not include the development of additional space for patients. Staff told us that some phlebotomy patients had to wait standing up as there was not enough space in the waiting areas. Staff working in the cardiology clinic also told us that patients would sometimes have to stand in the waiting area.

We viewed control of substances hazardous to health (COSHH) risk assessments within the outpatient department. We found the COSHH risk assessments and safety data sheets pertaining to all the cleaning chemicals used within the department.

Resuscitation trolleys were available in all areas of the outpatient department and in all outpatient clinics throughout the hospital. The trolleys included tamper resistant seals on each of the drawers for additional security while ensuring that the emergency medicines and equipment were easily accessible to staff. Emergency equipment and medicines stored on the resuscitation trolleys were subject to regular checks. This included daily checks that included ensuring that the seals were secure and that oxygen cylinders were sufficiently full. Weekly checks of the trolleys included expiry dates of medicines and a detailed check of all equipment and single use items that may be required in a medical emergency.

We checked resuscitation trolleys in general outpatients, the fracture clinic and cardiac clinic. All resuscitation medicines and consumables kept on the trolley were in date. Oxygen cylinders next to the trolleys were in full and there were both child and adult masks easily accessible. Daily and weekly checks of the resuscitation trolleys were consistently clearly recorded in general outpatients and the fracture clinic and there were no gaps in checks. However, within the cardiac clinic there were a number of gaps in checks in the months of September and October 2018, sometimes for two or three days in a row.

Medical devices maintenance was carried out by the in-house medical engineering team. Medical devices were registered to an equipment management database where planned maintenance and demand maintenance work was recorded. We checked three items of equipment in general
outpatients and found that all had up to date maintenance stickers attached, indicating they had been appropriately serviced as part of a preventative maintenance schedule. We saw four electric fans that had been taken out of service and had red stickers on them indicating they needed to be tested before they could be used.

Disposable items were in use throughout the outpatient services. All disposable equipment was seen to be in date with arrangements for stock replenishment clear.

**Assessing and responding to patient risk**

There were systems and processes to assess, monitor and manage risks to patients. Staff had a good understanding of how to respond to risk and had clear pathways and processes to follow, including the use of urgent referrals if required.

Reception staff had sight of patients sitting in the waiting area and reported to the nursing staff if anyone appeared to be unwell or needed support. We also saw nursing staff monitoring the waiting areas. Reception staff had a good understanding of how to manage risks in relation to patients, including how to call for help and alert staff to an emergency. They were also aware of the location of the resuscitation equipment should they need to access it and the emergency call number to use in this situation.

Nursing staff had received training in sepsis management, managing low blood sugar levels and basic life support, with some additional nursing staff having received intermediate life support training.

Staff were made aware of processes for escalating concerns about deteriorating patients as part of their induction. Clinicians working in various outpatient clinics had access to information on the wall in clinic rooms on how to put out a cardiac arrest (or other emergency) call.

Safety huddles were held every morning in general outpatients and briefly again at lunchtime. All staff working in the outpatient clinic met at the same time every day to discuss current safety issues relating to the premises, patient care and other relevant issues that could impact on patient safety.

We saw evidence of learning from safety discussions and changes to practice. For example, staff reflected on the previous day's clinic as part of the daily safety huddle. This included discussions when things have gone wrong or situations where patients had been unwell or at risk. Staff told us of situations where patients had deteriorated while in clinic. We were told of situations where patients had been transferred back to ward areas or to the accident and emergency department and in some cases fast tracking patients through clinic.

Nursing staff told us they would support patients around specific monitoring of their health while in clinic. For example, using blood sugar monitoring where patients were diabetic. Staff could access refreshments quickly in the case of patients having episodes of low blood sugar.

Staff had a good understanding of referral pathways for use in situations where patients were displaying signs of mental ill health. They had access to a mental health liaison team.

An outpatient procedure care plan was in use that incorporated the principles of the World Health Organisation (WHO) five steps to safer surgery checklist. We reviewed records that showed the safety checks were carried out and recorded for patients undergoing minor surgical procedures within the outpatient department.

**Nurse Staffing**
The trust reported the following qualified nursing staff numbers as of December 2017 and May 2018 for outpatients:

<table>
<thead>
<tr>
<th>Location</th>
<th>December 2017</th>
<th>May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned WTE staff</td>
<td>Actual WTE staff</td>
</tr>
<tr>
<td>Trust level</td>
<td>21.9</td>
<td>17.3</td>
</tr>
</tbody>
</table>

The staff fill rate in May 2018 has improved since December 2017 with 1.1 more WTE staff in post.

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

From June 2017 to May 2018 the trust reported a vacancy rate of 20.0% for qualified nursing staff in outpatients. This was higher than the trust target of 12%.

- East Surrey hospital: 27.1%
- Crawley hospital: 1.7%

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

At the time of our inspection the vacancy rate at East Surrey Hospital had significantly reduced and we were told there was just one vacancy. Senior staff were shortlisting for the post at the time of inspection and told us they would then have met their nursing establishment within the department.

From June 2017 to May 2018, the trust reported a turnover rate of 14.8% for qualified nursing staff in outpatients. This was higher than the trust target of 12%.

- East Surrey hospital: 21.3%
- Crawley hospital: 19.8%

Turnover at Horsham (which is not an independently-registered site), was zero.

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

From June 2017 to May 2018, the trust reported a sickness rate of 5.6% for qualified nursing staff in outpatients. This was higher than the trust target of 3%.

- East Surrey hospital: 6.8%
- Crawley hospital: 1.8%

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

Senior staff told us there was no agency nurse usage within the general outpatient department and data provided by the trust showed that the last time agency staff had been used was in December 2017. We were told that bank staff were used to cover specific shortages in clinics and that these staff were sourced from a pool of bank staff with relevant experience.
Medical staffing

Medical staff working within outpatients were employed within different divisions based on their speciality areas. There were no medical staff directly employed within general outpatients. Some clinics we visited had experienced medical staffing difficulties that were impacting on areas such as appointment waiting times. We were also told of areas where improvements had been made. For example, the recruitment of additional respiratory medicine consultants had seen an increase from three to six in recent years.

Vacancy rates

The trust has provided the information, but it did not include details of any medical staff for outpatients. This was because medical staff were not directly employed to work solely within the outpatient department.

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

Turnover rates

The trust has provided the information, but it did not include details of any medical staff for outpatients. This was because medical staff were not directly employed to work solely within the outpatient department.

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

Sickness rates

From June 2017 to May 2018, the trust reported a sickness rate of 0.8% for medical staff in outpatients. This was lower than the trust target of 3%.

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

Bank and locum staff usage

It should be noted that the trust has said that it is “unable to provide the data in the requested format for medical staff bank and locum usage”. This was because medical staff were not directly employed to work solely within the outpatient department.

(Source: Routine Provider Information Request (RPIR) – Medical agency locum)

Records

People’s individual care records, including clinical data was written, stored and managed in a way that kept people safe. Recent upgrades had been made to the medical record service, resulting in improved flow of medical records across the trust. In the year before our inspection less than 0.1% of patients were seen in the outpatient department without their full medical record. Medical records were tracked via electronic sensors around the hospital. Staff told us they could locate records anywhere within the trust using a bar code scanner. Senior staff within the medical records department told us there had been a focus on transforming the service to make it more patient centred. Specific actions to develop this had included collaborative improvement meetings with representatives from different departments. Staff feedback about the changes to the record system was positive. Staff told us they had clear work plans to access records one to two days ahead of schedule and that this had led to improved efficiency and greater role clarity for staff.
morning huddle within medical records was held to ensure records were prepared in a timely way. Data seen at the time of inspection showed that medical records had been obtained for clinics within the two-day advanced target. The trust told us that since 2015 there had been a significant reduction in the use of temporary notes within outpatient clinics. For example, this had reduced from 100 a week to less than five a week.

When the full medical record was not available, staff could access most of results such as radiological and haematological results on electronic systems, and referral letters could be printed from other electronic patient information systems. Staff told us that access to patient’s full medical record was consistent and that they rarely had incidents where notes were unavailable. Staff consistently told us that access to records had improved. However, at the time of our inspection there was a patient in the department whose records had not been accessed prior to their appointment. This led to an extended wait for the patient as without their record the staff working within the clinic were unaware that they were waiting.

Staff we spoke with in outpatients told us that access to electronic information systems was consistent and they reported having few problems with them. As part of our inspection we reviewed three sets of patient’s notes all of which were legible, contained appropriate demographic information, consent documented where appropriate (circled on template) and signed and designated.

Patient records were stored securely and were easily accessible. This had improved from the previous inspection where there had been issues with medical records regularly not being available for clinics in a way that was timely. Notes were stored within a medical records store with a tracking system in place. All notes we saw in the clinic areas were in secure cabinets within consulting rooms. The majority of those we viewed were locked securely; however, there was one unlocked cabinet in general outpatients that could have been accessed without authority. This was raised with senior staff at the time of our inspection. We saw that this was then raised as a safety issue within the daily safety huddle and that staff were reminded of the importance of security and confidentiality. Staff told us this would be raised as a reminder to all staff at safety huddles over the coming days.

**Medicines**

Medicines in outpatients were managed safely. Medicines were kept in a treatment room that was locked when not in use. Cupboards containing medicines were locked, and the keys for these were held by a registered nurse.

FP10 and hospital prescription pads were stored securely in locked cupboards with serial numbers recorded within pharmacy so that all forms could be tracked throughout the department. This was in line with NHS Counter Fraud Authority Management and control of prescription forms: A guide for prescribers and health organisations, March 2018. FP10 prescription pads were not in use within the department as medicines were generally issued using hospital prescriptions, however FP10 pads for issue to outlying outpatient clinics were stored there ready for staff from those clinics to collect when needed.

Not all outpatient areas had pharmacy input for stock control. For example, in the general outpatient department stock control was the responsibility of nursing staff. Monthly stock audits were undertaken and records maintained of who carried them out. All medicines viewed at the time of our inspection were stored securely and in date.

Fridge temperatures were monitored to ensure that medicines were stored within the correct temperature range. We reviewed temperature monitoring records in general outpatients and saw
that these were within range and that records were completed including checks of minimum and maximum temperatures. Staff were clear that any issues with the cold chain were to be escalated to pharmacy and advice sought about the storage of medicines.

Patient Group Directions (PGDs) were not used in general outpatients, PGDs are written instructions to administer medicines to patients in planned circumstances in place of an individual named patient prescription. Medicines for patients being seen in clinic were prescribed to take home or by prescribing clinicians in the patient’s notes if medicines were to be administered in clinic. Patients were prescribed medicines to take home using a hospital prescription that could be filled at the outpatient pharmacy that was located opposite the outpatient department. Controlled drugs were not in use within the department.

Incidents

Lessons were learned and improvements made when things went wrong. Staff understood their responsibilities to raise concerns, record safety incidents and report them internally and externally.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From July 2017 to August 2018, the trust reported no incidents classified as never events for outpatients.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in outpatients which met the reporting criteria set by NHS England from July 2017 to August 2018.

(Source: Strategic Executive Information System (STEIS))

The serious incident related to a treatment delay meeting SI criterion in the ophthalmology outpatient’s clinic. The trust provided us with additional information about a further four ophthalmology SIs that were under investigation or with the Clinical Commissioning Group for closure. Staff told us it had been identified that patients were not always returning their outcome forms to reception following their appointment. This meant that follow up appointments had not always been made. Action taken to prevent further repeat incidents included closer daily monitoring of outcome forms within outpatients so that patients without a clear recorded outcome following an appointment would be identified and action taken to address this. In addition, within the ophthalmology department action had been taken to review their database on a weekly basis to identify all patients with a deteriorating sight who may not have completed treatment as planned.

Staff we spoke with demonstrated a good understanding of their responsibilities for reporting when things went wrong. Staff were aware of the reporting system and knew how to use it. Daily safety huddles every morning included time for staff to discuss any incidents and how to ensure improvements as a result. We viewed summaries of huddle meetings and staff gave examples of changes to practice as a result. For example, at the time of our inspection staff had discussed ways to remind clinicians to lock consulting room doors and ensure that medical records are always stored securely in their locked cabinets. We also observed nursing staff monitoring and reminding other staff about the security of medical records.
Data provided by the trust during inspection showed that between April and September 2018 there had been 102 incidents reported under the outpatient category. Themes identified included appointments, clinical documentation, staffing and transport to and from the hospital. Data provided by the trust following inspection identified that the top issues were cancelled appointments, booking errors and incorrect filing. Thirty-one incidents resulted in no harm to patients, three resulted in moderate harm to patients and the rest resulted in no harm. In order to address issues with booking errors and cancelled appointments the trust had progressed a clinic utilisation programme and improved booking management.

Staff told us that transport issues had been an issue within outpatients. We were told that these were reported and that changes had been made as a result. For example, due to limited space patients being transported on a stretcher were unable to be accommodated within the department for any length of time. As a result, a decision was taken to ensure that patients on a stretcher would be seen in clinic straight away and that transport staff were asked to wait with them. Staff told us there continued to be issues with transport, generally relating to patients in wheelchairs having to wait for several hours. Action taken to minimise the impact on patients included transferring them to the discharge lounge where they could wait more comfortably and be given a hot meal. However, staff told us that delays in transport were an ongoing issue and they were not aware of action being taken to improve this.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. There were no incidents in general outpatients that were scored as causing moderate harm and therefore triggering the duty of candour.

Is the service effective?

Evidence-based care and treatment

The department provided care and treatment based on national guidance. Policies and procedures were available and accessible to staff via the trust intranet. Policies we viewed as part of our inspection were in date. Clinical guidance was also available as part of the trust intranet and some via smartphone apps for use at the point of care.

Staff in the outpatient department participated in external audits as part of divisional reviews and assessments of compliance against relevant guidance. Audits were developed against the quality standards and clinical guidelines from the relevant guiding body, for example The National Institute for Health and Care Excellence (NICE). The clinical effectiveness committee monitored where guidance was not fully complied with. In ophthalmology an audit into wet age-related macular degeneration identified that the appointment system did not meet the standards set for a small group of patients and subsequently this subset of patient’s visual outcomes were poorer than those in patients who were seen at predetermined intervals. As a result, the service explored ways to reduce the length of time between follow up appointments for these patients.

We spoke with an osteoporosis nurse specialist who told us that the trust followed guidance from the National Institute for Health and Care Excellence (NICE) and the National Osteoporosis Society. For example, the service had implemented components of a fracture prevention pathway that included identifying those at risk, assessing the risk, providing information and support, interventions, follow up and service developments.
Staff working in the breast clinic followed National Institute for Health and Care Excellence quality standard (QS12) for breast cancer treatment and care, and NICE guideline NG101 for diagnosis and management.

**Nutrition and hydration**

Patient’s nutrition and hydration needs were identified and met. Water machines and free tea and coffee were available in the waiting areas. Patients could also access refreshments from a café close to the outpatient clinic. Staff told us that patients who were waiting for a long time or delayed due to transport issues were offered lunch boxes which could be accessed via the catering department. In addition, patients who were transferred to the discharge lounge while waiting for transport were offered a hot meal.

**Pain relief**

Patients’ pain was assessed and managed. As part of outpatient assessment processes staff told us they would assess patient’s pain level as appropriate depending on their condition and symptoms, or procedures they were having done. Staff told us that pain was assessed as part of holistic assessments, however one patient told us they had tried to talk to the doctor about their pain as part of their consultation and was told it was unrelated to the appointment.

Stocks of simple analgesia such as paracetamol were available in general outpatients. Staff told us that if a patient was in pain they were assessed and a one-off prescription was issued by a medical practitioner and analgesia supplied. Pain clinics were held within the general outpatient service.

**Patient outcomes**

Outpatient services had processes in place to record patient outcomes after each clinic appointment. The service used an outcome form which medical and clinical staff completed at the end of each appointment. The outcome recorded whether the patient required another appointment and whether this should be with a consultant, middle grade or junior doctor, nurse or allied health professional. Other outcomes recorded included any blood tests, scans, further investigations or discharge and was used to monitor patient follow up from consultation.

Staff told us there had been some issues with the outcome forms, generally due to patients not taking them to reception staff at the end of their appointment. This had resulted in a serious incident relating to a delay in treatment for an ophthalmology patient. As a result, staff were in the process of reviewing the format and processes relating to the outcome forms. There were plans to digitalise forms in the new year where actions relating to future appointments and follow up tests would be automatically populated by the clinician at the end of the consultation. In the meantime, administrative staff working in the outpatient department were undertaking daily monitoring of the forms to identify any that were missing. This meant that any outcomes that had not been processed would be identified and followed up by staff.

The outpatient service had a number of one stop clinics in operation where patients could receive tests alongside their consultation rather than having to make additional appointments. For example, the one stop breast clinic enabled patients to receive their consultation, ultrasound scan and mammogram in one appointment. In addition, there were one stop clinics within the fracture clinic and for osteoporosis. One stop pilot clinics were in operation within endoscopy, pre-assessment clinics, phlebotomy and bowel preparation. Plans were in place for a one stop glaucoma clinic in 2019.
Follow-up to new rate

From June 2017 to May 2018 the follow-up to new rates for East Surrey, Crawley, Horsham and Caterham Dene hospitals were all lower than the England average.

Earlswood community diabetes and endocrinology centre’s follow-up to new rate was highly variable throughout the period but was lower than the England average in all months in the period except, October 2017 to December 2017 and in April 2018.

Follow-up to new rate, Surrey and Sussex Healthcare NHS Trust.

(Source: Hospital Episode Statistics)

Competent staff

Staff had the skills, knowledge and experience to deliver effective care, support and treatment. Staff had access to appraisals, ongoing training and assessments of competency.

Appraisal rates

Trust level

From April 2017 to March 2018, 97% of all staff within outpatients at the trust received an appraisal compared to a trust target of 90%.

The trust has provided the data for the following staff groups, but it did not include details of any medical staff for any core service.

All three staff groups met the 90% appraisal completion target.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals completed</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Clinical Services</td>
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<td>15</td>
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<tr>
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</table>
East Surrey hospital

From April 2017 to March 2018, 93% of staff within outpatients at East Surrey hospital received an appraisal compared to a trust target of 90%.

Administrative and clerical staff were the only group that did not meet the 90% appraisal completion target.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals completed</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Clinical Services</td>
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<tr>
<td>Nursing and Midwifery Registered</td>
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<td>90%</td>
<td>Yes</td>
</tr>
<tr>
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<td>16</td>
<td>14</td>
<td>88%</td>
<td>90%</td>
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</table>

Crawley hospital

From April 2017 to March 2018, 100% of staff within outpatients at Crawley hospital received an appraisal compared to a trust target of 90%.

All three staff groups had 100% appraisal completion.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals completed</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Clinical Services</td>
<td>6</td>
<td>6</td>
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<tr>
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<td>Yes</td>
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<tr>
<td>Nursing and Midwifery Registered</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

All new staff and volunteers attended a trust induction programme and were provided with additional role specific training as needed. The trust induction included mandatory training and an introduction to the trust as a whole as well as the individual hospital sites. The outpatient department had local induction processes in place for new staff, student nurses and bank and locum staff.

Staff consistently told us they received support with their professional development within the service. One healthcare assistant working in ophthalmology told us they had opportunities to develop their skills, for example in relation to vision tests and eye measurements and access to fully funded ophthalmology courses relevant to their work.

Sisters working within the outpatient department had attended a leadership course in the use of lean methodologies, developing their skills through project based scenarios to ensure the department ran as efficiently as possible. Clinical staff had access to clinical skills training. This included supernumerary time to learn essential skills and meet competency assessments. Examples of competency assessments included phlebotomy skills, use of specific equipment, wound care and the administration of intravenous medicines.
Monthly audit meetings were held within the outpatient department and included training elements relevant to practice. This included internal and external specialist speakers, for example in relation to Parkinson’s disease.

Medical staff told us that consultants supervised trainee doctors in specialist clinics and that time was allowed for teaching and case discussions. Nursing staff working in the outpatient department had been identified as speciality champions. For example, in relation to breast care, dermatology, infection control, dementia, neurology, safeguarding and disabilities. Staff were given time to access training in their specialist area and to provide teaching for other staff as relevant.

Clinical supervision was available to all clinical staff. Access to this varied across different specialities and included group and one-to-one formats.

**Multidisciplinary working**

All necessary staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. There were one stop clinics in operation within some speciality areas such as the breast clinic, osteoporosis and the fracture clinic. The one stop approach allowed patients to have their consultation, diagnostic tests and some results on the same day. This meant that care was coordinated and patients could see a range of professionals in one appointment.

Staff working within other areas of the outpatient clinics also told us there was a multidisciplinary approach to care across the different specialities. For example, a weekly multidisciplinary meeting was held within the breast clinic where care and treatment plans were discussed. We observed an oncology multidisciplinary meeting that was attended by multidisciplinary coordinators, a chest physician, clinical nurse specialists, radiologists and radiographers. Discussions centred around referral processes and cross team working. We observed open discussions where consensus was sought and the best options for the patient considered. The meeting was structured and staff had a good knowledge and understanding of the patients.

Weekly multidisciplinary meetings were held to review cancer patients. We were told that treatment and cancer wait times were discussed at these multidisciplinary meetings and that patient tracking lists were used.

We observed multidisciplinary working in outpatient clinics where specialist staff worked with outpatient staff to provide care for patients. This included specialist nurses in cancer and osteoporosis working with staff within outpatients to review patients.

We were told of plans to further develop multidisciplinary working across the trust. For example, in the fracture clinic there were plans to develop a multidisciplinary virtual clinic where imaging results would be reviewed virtually by multidisciplinary team members and the patient contacted to attend in person when necessary.

Daily outpatient safety huddles in a range of clinics were multidisciplinary where all staff were involved in the review of safety within the clinics.

**Seven-day services**

General outpatient clinics were in operation between 8.00 and 8.00pm Monday to Friday. Additional clinics were also run regularly on a Saturday and sometimes on a Sunday. Phlebotomy and x-ray services were provided across the seven-day week.
Health promotion

National priorities to improve the population’s health were supported by the service. Information about issues such as stopping smoking and improving heart health were available.

There was educational literature for patients, placed around different parts of the outpatient department. Information based on national guidance and best practice was provided by clinics and given to patients as part of their consultation.

For example, there were comprehensive patient and carer resources for cancer and other long-term health conditions such as Parkinson’s and diabetes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The trust includes training for the Mental Capacity Act and Deprivation of Liberty within the mandatory level 1 and level 2 safeguarding training modules.

Please see the “Safeguarding” section for details of training compliance.

(Source: Routine Provider Information Request (RPIR) – Quality statement)

Staff had a good understanding of the Mental Capacity Act and Deprivation of Liberty and the presumption of capacity. There was information displayed within the department to remind staff to undertake capacity assessments and best interest decision making as appropriate. We observed the use of a clear mental capacity algorithm to guide staff on the action they should take through the process of capacity assessments.

Consent was sought prior to care and treatment. For example, in the breast clinic staff sought the patient’s consent prior to a breast examination and treatment and patients were given copies of their consent forms. In the minor operations procedure room within the outpatient department patients were asked for their consent once in the procedure room. This meant that the patient was only asked for consent immediately prior to a procedure at a time when they may feel vulnerable.
Is the service caring?

Compassionate care

People were treated with compassion, kindness, dignity and respect, when receiving care. Feedback from people who used the service, those who were close to them and stakeholders was positive about the way staff treated people.

Staff understood and considered people’s personal, cultural, social and religious needs. We observed patients arriving in the department and being supported by reception and nursing staff. Staff were observed to greet patients with kindness and respect. We also witnessed staff identifying and introducing themselves and asking patients if they needed help with anything when being collected from waiting areas. This is in line with NICE QS15 Statement 1: Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.

Staff interacted with patients and those close to them in a respectful and considerate manner. Patients throughout all outpatient areas consistently reported that staff were kind and respectful and that the service offered was good. We observed staff within the department providing support and advice to patients and their families whilst using the automated check-in service and providing guidance on where to wait for their appointment.

Staff were sensitive and supportive towards people using their services and those close to them. Patients reported that staff had been patient and kind and had taken the time to fully explain things to them.

Staff understood and gave good examples of how they would raise concerns about disrespectful, discriminatory or abusive behaviour. Staff were familiar with safeguarding policies and conflict resolution procedures. Staff had been trained in dealing with conflict and we were given examples of when these skills had been used to diffuse situations.

Staff ensured people’s privacy and dignity was always respected. Outpatient appointment letters explained what the appointment was for, what time and date it was happening and what the procedure consisted of. In the appointment letter, there was a contact number to ensure any queries or personal preferences may be addressed prior to the appointment. During each appointment, a nurse or healthcare assistant accompanied the patient and acted as their advocate during appointments. The trust’s chaperone policy set out the requirement for all patients to have access to a chaperone of the same sex if required. Nurses or healthcare assistants acted as chaperones when necessary and they told us they had received training in this. Where a patient had a personal preference with regards to the sex of the person that was accompanying or examining them staff would make every effort to accommodate the patient’s request.

Staff demonstrated the need to respond in a compassionate, timely and appropriate way to people’s experience of physical pain, discomfort or emotional distress. Patients with a life changing diagnosis were offered specialist support from trained nurses. This was in line with NICE QS15 Statement 2: Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills. However, in some outpatient areas there was limited space for such conversations to be held. For example, in the Chipstead outpatient service we spoke with specialist cancer nurses who told us that they struggled to find space to meet with patients privately and that this made difficult conversations, including those where bad news was being shared, even more difficult.

The NHS friends and family test is a nationwide initiative to gain feedback from patients about the care and treatment they receive in hospital. Patients were asked whether they would recommend NHS services to their friends and family if they needed similar care or treatment. Test results
recorded and displayed within the outpatient department showed percentage of patients who would recommend the service was 90%. Survey data provided by the trust between July 2017 and July 2018 showed that 92% of patients had trust and confidence in the staff treating them in the outpatient department.

Since our previous inspection the service had developed a room where patients could have their height and weight measured in privacy rather than in a public area.

**Emotional support**

Patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. Staff communicated well with patients so they understood their care, treatment and condition. A healthcare assistant or nurse was present with patients during their appointments. This ensured that the patient had an advocate during their appointment who would check that they understood what was being said. Staff we spoke with told us they would always check patient’s understanding at the end of the appointment before they left the department. Staff told us they would try and take patients to a different area if they needed extra support or time, however this was sometimes limited by a lack of space within the department.

Written information was available for patients about their condition and the support services available to them. Staff we spoke with demonstrated an understanding of the need to assess and support patients from a psychological and social perspective as well as a physical one. We saw that assessment processes in the breast clinic included the assessment of patient’s general health and wellbeing and that support was available for psychosocial issues in addition to physical ones. This was in line with NICE QS15 Statement 10: Patients have their physical and psychological needs regularly assessed.

Staff told us they could signpost patients to psychological services for support. Sometimes these services were accessible within one stop clinics and other times staff would give information about support services and how to access them to the patient.

There was a team approach evident to supporting patients in the clinics. Reception staff told us they were vigilant in looking out for patients who were struggling or in distress.

**Understanding and involvement of patients and those close to them**

Patients we spoke with told us they felt involved in their treatment and care. They told us that clinical staff were open in their approach and that information was readily available, both verbally and in written formats to help them understand their condition and treatment plans.

Speciality clinics had different approaches to supporting patients throughout their journey. For example, patients in the breast clinic had a named nurse for consistency and to ensure their involvement. This meant that all patients had a named nurse to contact with concerns and that relationships were developed over time to ensure that trust was built. Patients were given care and treatment plans within the breast clinic to take away. The care plan had been developed by staff working within the breast service and included contact details, information about the multidisciplinary team, information about the specific condition and treatment plan and details about follow up appointments and additional support available.

In a glaucoma clinic within ophthalmology, the consultant wrote letters addressed to the patient with the GP copied in. This meant that the language used was easy to understand and the patient had access to the information shared when they needed it.
Patients told us they had the time and opportunity to talk to staff about any concerns or treatment options. This was in line with NICE QS15 Statement 5: Patients are supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences.

Patients were supported by staff who had the communication skills to ensure effective interactions with patients in line with NICE QS15 Statement 2: Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills. For example, a patient visiting the glaucoma clinic told us they had received a good explanation of their treatment and care. They also told us that staff checked their understanding before the end of the consultation.

There was information in the waiting area about safeguarding from abuse and this was displayed where patients and people accompanying them could see it.

Staff could communicate with patients by using their own preferred methods of communication. Patients were asked to alert the department to any communication issues prior to their appointment so that staff knew in advance. Referral forms included information about the accessible information standard.

Patients we spoke with told us they felt listened to and respected by the staff working in the outpatient department. Patient feedback was displayed within the department, for example, the topic of the month related to waiting times and staff were seen to be openly communicating delays and the reasons for them.

Is the service responsive?

Service delivery to meet the needs of local people

Outpatient services ensured people’s needs were met through the way services were organised and developed.

The outpatient department environment was appropriate to the needs of patients and provided comfortable seating, sufficient toilets, free tea and coffee and a water dispenser. There was also a café located near to the department which served a variety of refreshments.

General outpatient clinics operated between 8:00am and 8.00pm Monday to Friday. There were some additional clinics run on Saturday mornings and ad hoc Sunday's which staff told us were usually run by the specialities staff although one member of the outpatient nursing team was scheduled to help coordinate.

Patients had two options to check-in for outpatient appointments. One option was an outpatient check-in booth with administrative staff completing the check-in process. The second method was an automated self-check-in system. The automated system presented patients the options in a variety of different languages and included the option for patients to identify if they had additional learning needs. Reception staff were also nearby and could provide support if needed. The service had plans to develop the booking in area to make it easier for patients.

Patients told us that car parking had not been an issue. Public transport to the hospital was good and there was information about this in the hospital and on the hospital website. Information included a downloadable transport information leaflet and online and telephone journey planning support.
The department was clearly signposted and we observed staff helping to direct patients to where they needed to go. We observed staff interacting with patients in a way that was supportive and helpful. Signposting within the department had improved since our previous inspection, with clear signage in a colour that was more visible to patients with impaired vision. All areas within the hospital, including outpatient areas, were colour coded. These colours corresponded to the hospital site map to make it easier for patients and visitors to navigate the site.

The service made use of telemedicine appointments via telephone and video link appointments as an alternative to face to face appointments. This included a virtual fracture clinic where all new fracture clinic patients were assessed virtually by a consultant orthopaedic surgeon. In addition, patients were signposted to video links about self-management. This had an impact of reducing routine face to face appointments and increasing capacity for patients who require face to face consultations.

There were notice boards in clinic waiting areas advising who the relevant nurse and healthcare assistant attached to that clinic was. The notice boards all had standard text printed and displayed advising patients of the potential for delays in clinics and apologised for this.

Patients received text message reminders of their appointments. Patients told us the reminders were helpful and two-way texting meant that patients could personalise their queries and receive a personalised response.

A phlebotomy service was available in the main outpatient department for patients being seen in clinic. This was a recent development, designed to reduce the waiting times for patients who required blood tests alongside their clinic appointment.

A patient paging system was in use within the fracture clinic so patients could wait elsewhere in the hospital, such as restaurant areas, without missing the call for their appointment.

**Did not attend rate**

From June 2017 to May 2018:

- The ‘did not attend’ rates for East Surrey, Crawley and Caterham Dene hospitals were all generally lower than the England average.
- The ‘did not attend’ rate for Horsham hospital was higher than the England average in June and July 2017, but was then reduced to below the England average for the rest of the period.
- The ‘did not attend’ rate for Earlswood community diabetes and endocrinology centre was consistently higher than the England average.

The chart below shows the ‘did not attend’ rate over time.
Proportion of patients who did not attend appointment, Surrey and Sussex Healthcare NHS Trust

(Source: Hospital Episode Statistics)

While the ‘did not attend’ rate at East Surrey Hospital was lower than the England average there were some clinics where the rate was higher. For example, staff working in an osteoporosis clinic told us that the ‘did not attend’ rate was around 20%. They told us that this was due to patients who did not attend their appointment being automatically given a further appointment by the booking office. Senior staff told us that this was a clinical decision rather than one made by booking office staff. We were told that the booking team was contacting patients to ask why they did not attend to reduce the rate.

Meeting people’s individual needs

The service took account of patients’ individual needs. The trust had a dementia strategy with the aim of becoming a dementia friendly organisation. There were clear objectives identified around improving the patient experience, training for staff, better engagement and improving the environment. At the time of our inspection there were no dementia friendly signs within the outpatient department. However, a working group was in place reviewing how the environment within the outpatient department met the needs of a variety of patients including those with physical and learning disabilities and those with dementia. Staff told us that dementia friendly signage had been discussed and would be in place in due course. All staff working within the trust received dementia training as part of their induction. A member of outpatient staff had been identified as the dementia lead and those in this lead role had access to additional training. For example, one member of staff working in the fracture clinic had received training in being a ‘dementia friend’. The trust used a symbol in patients’ medical records that identified them as someone with dementia.

The trust was aware of the Accessible Information Standard. The Accessible Information Standard came into effect in 2016 and requires that all NHS trusts offer reasonable adjustments to help support people with disabilities or sensory loss to fully understand the information given to them. Referrers were asked to complete Accessible Information Standard information as part of referral processes so that staff were aware of patients with additional needs. Staff had access to communication resources and the use of a trust wide communication book and communication prompts. The service had access to multiple language and British Sign Language (BSL) interpreting for appointments, listening devices, and braille for patients with visual impairment.
Staff told us they could access interpreters on the same day if needed. Staff knew about translation services for patients who did not speak English as a first language and interpretation services could be arranged either to be face to face or via a telephone device.

A disabled access toilet was located opposite the outpatient department. The service had adjusted the environment within the outpatient department to better meet the needs of patients with disabilities. For example, a panel had been removed from the reception desk in main outpatients to make it easier for reception staff to communicate with patients in wheelchairs.

There was no bariatric equipment held in general outpatients, however, staff told us they could access equipment from other departments as needed.

Staff working in outpatients had access to a learning disability liaison nurse. They would contact the liaison nurse for advice and input about how best to support the patient. There was a learning disability resource folder for staff reference within the department. A task group for outpatients was looking at how patients with disabilities could access services and identify areas for improvements.

Access to the department for patients with physical disabilities was difficult due to limited space. Patients on stretchers were prioritised to be seen straight away due to limited space in waiting areas. Staff requested that transport staff waited with the patient so that they could take them home immediately following the appointment. Patients in wheelchairs would be transferred to the discharge lounge where they could wait in a more comfortable environment and where they would be given refreshments if there were delays transporting home. Waiting area facilities was an area being reviewed by the task group with the aim of improving access for these patients. Improvements to one part of the waiting area had been made because of this work by removing a table to create better access for patients in wheelchairs.

As part of a trust wide initiative to improve the care of patients with Parkinson’s disease the service had reviewed the information available to patients who attended neurology clinics. This included a stock of booklets produced by Parkinson’s UK that included information about the disease, treatments and additional resources available. Feedback from patients with Parkinson’s had helped to inform the staff of areas for improvement, this included a talk from a patient to staff to help them better understand patient’s needs.

Access and flow

From 1 October 2018 all outpatient referrals nationally were to be received via the NHS e-Referral System (ERS). Senior staff told us they had worked with clinical commissioning groups (CCGs) to improve the uptake of e-referrals. This work had involved senior staff attending local practice manager forums and engaging with GPs to improve relationships and team working on referral processes. Local GPs had been invited to participate in a working group and the trust had worked with NHS Digital to improve uptake. Prior to this work e-referrals uptake had been at zero. Following the work and prior to the October 2018 deadline uptake had increased to 80%.

Improvements had been made to the booking office to improve key performance indicators relating to appointment bookings. For example, huddles were held in the department twice daily to review booking statistics, waiting times and outstanding issues. The booking office had received input from clinical staff around these improvements and to make the booking centre more patient focused. Specific action included the implementation of text reminders for patients, a patient feedback survey and patient reminders in the days leading up to their appointments.

Other action that the trust had taken included using a company to provide support to specialities with short term workforce constraints that had affected the 18-week pathways. Insourcing
services had been used in areas such as ophthalmology and neurology. In addition, the trust had
outsourced for some cataract surgeries and were using locum doctors in ophthalmology to
address waiting times. Different specialities met weekly to discuss their referral to treatment times
(RTTs) and identify action to address them.

Staff working in speech and language clinics told us that waiting times for assessment were an
issue. This involved patients waiting for more than seven months to see a specialist and for
between four and six weeks for an initial assessment. The service had appointed locum staff to
help with capacity issues but ongoing issues with space continued to have an impact. The
concerns had been escalated to managers and were on the risk register.

The trust monitored the percentage of cancelled clinics. At our inspection in 2014 32% of clinics
had been cancelled with short notice. At this inspection data from the trust showed that the rate
of hospital cancelled clinics was between 14% and 17%.

Staff told us that overbooking of clinics was sometimes an issue, particularly in ophthalmology
clinics. However, this was generally undertaken with the agreement of relevant clinicians and
senior outpatient staff. Senior sisters told us they took responsibility for late running clinics and
worked to identify ways of improving the patient flow throughout the department.

Waiting times in some departments were long. For example, in the cardiology clinic patients and
staff reported lengthy waiting times. Staff told us that a lack of consulting rooms meant that even
when they had the staff to manage the clinics they did not always have the space. Action taken to
address this issue included trying to identify alternative rooms to use and running some Saturday
clinics. The improvement of cardiology and ophthalmology waiting times formed part of the
outpatient improvement programme and we saw that this was routinely reviewed and discussed at
outpatient board meetings.

The service was exploring the use of virtual clinics to improve patient access and flow. For
example, in the fracture clinic a business plan had been developed to increase the use of virtual
clinics for patient assessments. This involved a review of images with the patient contacted by
phone or signposted to alternative support when a face to face medical review was not required.

An independent pharmacy service was located opposite the outpatient department. The pharmacy
dispensed all hospital outpatient prescriptions from a range of clinics. The pharmacy monitored the
amount of time patients had to wait for their prescriptions. Between January 2018 and May 2018,
the average waiting time for outpatient prescriptions was 12 minutes. Patients and staff reported
that waiting times for prescriptions was satisfactory and that staff were helpful. Pharmacy opening
times were between 8 a.m. and 8.30 p.m. on a Monday to Saturday and between 10 a.m. and 4
p.m. on a Sunday.

Patients could access the service when they needed it. Overall waiting times from referral to
treatment had seen an improvement since April 2018 with performance improving for non-
admitted pathways. June 2018 data showed that the trust was 3% above the national average for
non-admitted pathways. June 2018 data showed that the trust was 2.5% above the national
average for incomplete pathways.

From July 2017 to June 2018 the trust’s referral to treatment time (RTT) for non-admitted
pathways was below the England overall performance. The trust has seen an improvement in
performance from April 2018 onwards.

In the latest month, June 2018, 91.4% of this group of patients were treated within 18 weeks
compared to the England average of 88.5%.
Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Surrey and Sussex Healthcare NHS Trust

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

Seven specialties were above the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic surgery</td>
<td>100.0%</td>
<td>91.0%</td>
</tr>
<tr>
<td>General medicine</td>
<td>94.7%</td>
<td>91.7%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>93.6%</td>
<td>87.5%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>93.5%</td>
<td>86.5%</td>
</tr>
<tr>
<td>ENT</td>
<td>93.2%</td>
<td>86.6%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>89.3%</td>
<td>88.7%</td>
</tr>
<tr>
<td>Urology</td>
<td>89.3%</td>
<td>87.6%</td>
</tr>
</tbody>
</table>

Eleven specialties were below the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynaecology</td>
<td>90.7%</td>
<td>92.9%</td>
</tr>
<tr>
<td>Other</td>
<td>89.0%</td>
<td>91.1%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>87.5%</td>
<td>95.6%</td>
</tr>
<tr>
<td>General surgery</td>
<td>85.9%</td>
<td>89.0%</td>
</tr>
</tbody>
</table>
Referral to treatment (percentage within 18 weeks) – incomplete pathways

From July 2017 to June 2018 the trust’s referral to treatment time (RTT) for incomplete pathways performance was below the England average for the first half of the period. December 2017 to April 2018 saw the trust’s performance improve to higher than the England average.

In the latest month, June 2018, 90.0% of this group of patients were treated within 18 weeks compared to the England average of 87.4%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Surrey and Sussex Healthcare NHS Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Nine specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>97.3%</td>
<td>93.2%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>92.7%</td>
<td>89.4%</td>
</tr>
</tbody>
</table>
Eight specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>93.5%</td>
<td>96.2%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>92.5%</td>
<td>92.9%</td>
</tr>
<tr>
<td>Other</td>
<td>88.9%</td>
<td>90.3%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>87.6%</td>
<td>88.5%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>86.6%</td>
<td>89.9%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>86.5%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>84.1%</td>
<td>85.4%</td>
</tr>
<tr>
<td>Neurology</td>
<td>64.9%</td>
<td>87.5%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

**Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)**

The trust has performed in line with the England average and better than the 93% operational standard for people being seen within two weeks of an urgent GP referral from Q3 2017/18 to Q1 2018/19. Performance in the first quarter of the period had been below the operational standard and the England average.

Action taken to improve performance around two-week cancer waiting times included the recruitment of additional respiratory physicians with an increase from three to six employed by the trust. The trust was also reviewing how they addressed patients on the two-week pathways booking themselves into appointments that fell outside of the two weeks.
The performance over time is shown in the graph below.

Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Surrey and Sussex Healthcare NHS Trust

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

The trust has consistently performed better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat), and has been similar to the England average throughout the period.

The performance over time is shown in the graph below.

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Surrey and Sussex Healthcare NHS Trust

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust performed better than the England average and the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral from Q2 2017/18 to Q4 2017/18. In the latest quarter trust performance fell below the operational standard but was similar to the England average.

The performance over time is shown in the graph below.
Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Surrey and Sussex Healthcare NHS Trust

(Source: NHS England – Cancer Waits)

**Learning from complaints and concerns**

From June 2017 to May 2018 there were 18 complaints about outpatients. The trust took an average of 34 calendar days to investigate and close complaints. This is in line with the trust’s complaints policy. Their complaints policy states that under current legislation trusts have six months to resolve complaints, but that a response time is agreed for each complaint and is usually 25 working days, (35 calendar days).

Appointments was the subject with the most complaints, accounting for 72% of all complaints about outpatients.

East Surrey hospital received the most outpatient complaints with 16 (89%).

A breakdown of complaints by subject and site is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Crawley Hospital</th>
<th>East Surrey Hospital</th>
<th>Horsham Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointments</td>
<td>1</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Communications</td>
<td></td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Facilities</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1</strong></td>
<td><strong>16</strong></td>
<td><strong>1</strong></td>
</tr>
</tbody>
</table>

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

From June 2017 to May 2018 there were 4,487 compliments within outpatients.

A breakdown of the number of compliments by ward and site is shown below:

<table>
<thead>
<tr>
<th>Ward/team</th>
<th>Crawley Hospital</th>
<th>Earlswood</th>
<th>East Surrey Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main outpatients/Chipstead</td>
<td></td>
<td></td>
<td>3,041</td>
</tr>
<tr>
<td>Outpatients</td>
<td></td>
<td></td>
<td>572</td>
</tr>
<tr>
<td>Fracture clinic and orthopaedics</td>
<td></td>
<td></td>
<td>331</td>
</tr>
</tbody>
</table>
During our inspection we reviewed three complaints relating to the outpatient services. Two of these related to waiting times. We saw that apologies were given and that learning and action was identified. Responses were timely and in line with trust policy.

A further complaint related to a patient who had been seen in the breast clinic who was distressed after being sent home with a drain. Because of this complaint staff reviewed the processes for patients being sent home following interventions. As a result, patients were then routinely given information about community staff available to support them and contact numbers should the patient or their family need to get in touch.
Is the service well-led?

Leadership

The outpatient services had the leadership capacity and capability to deliver high-quality, sustainable care. Leaders had the skills, knowledge, experience and integrity needed and there were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership.

The outpatient department at East Surrey Hospital was managed by a general outpatient matron who worked across the trust-wide outpatient services. Staff reported there had been an increase in nursing leadership in recent years and that there was a band seven senior sister and band six sisters working within the department. A reception appointments manager had been recently appointed to provide direct management support to reception staff. Senior sisters were available at each outpatient location across the trust and were available to provide support across site as necessary. Staff we spoke with told us they were supported operationally by the lead staff and that operational leaders were approachable and supportive. For example, nurses working in the breast clinic reported that the matron was supportive and communicated openly with them. Staff working in the fracture clinic reported that senior staff were helpful and encouraging and always accessible.

Staff told us they had consistent contact with divisional leads who visited the department on a regular basis, undertaking walkaround visits as well as being available to respond to situations. Staff told us they felt well informed about trust and divisional level decisions. Executive leaders communicated well and were visible to staff. Staff reported that senior managers had an open-door policy and that communication was transparent. Staff received regular updates on plans through e-bulletin updates. A non-executive director visited the department on a regular basis to listen to staff and focus on quality improvement.

Staff were consistently positive about the leadership of the trust, the division and the department. For example, a specialist nurse working in an outpatient clinic told us that there was strong leadership across the trust and this had resulted in better consistency and everyone pushing in the same direction.

Vision and strategy

There was a clear vision and set of values, with quality and sustainability as the top priorities.

There was a trust wide vision to ‘pursue perfection in the delivery of safe, high quality healthcare which puts the people of our community first’. Staff had a good understanding of the trust values of safety and quality, one team, dignity and respect and compassion. The outpatient service had developed their own local priorities which were aligned to the trusts vision and values and objectives using a structured planning process in collaboration with staff. Strategic objectives and annual priorities were aligned across the trust. For example, in relation to reducing avoidable harm, improving discharge planning, creating the best environment for patients, improving efficiency of elective care and staff health and wellbeing.

There were clear objectives identified for the outpatient department. These included improving handwashing and the use of patient outcome forms, addressing patient delays and improving the security of medical records, maximising opportunities for patient feedback and customer care training and ensuring that staff took regular comfort breaks and participate in feedback questionnaires.
The outpatient ‘strategy on a page’ was visible within the department and included in departmental communications. Staff demonstrated a good understanding of the priorities and we observed team objectives being monitored throughout the department.

**Culture**

The culture within the outpatient department was centred on the needs and experience of people who use the service and staff felt supported, respected and valued.

Staff reported there had been a change in culture under the current leadership of the trust and the outpatient department as a whole and that staff morale had improved as a result. Senior staff told us there had been a particular focus on improving the culture in order to develop a more cohesive and collaborative atmosphere.

We observed staff focusing on the experience of patients and striving to make this as positive as possible. There was a patient focus across all departments we visited, including the booking hub and medical records departments.

Staff told us there were increased opportunities for reflecting on their practice and development and that the team objectives were used to structure daily huddles so that everyone had a clear focus. This had helped to improve the culture within the department and ensure that all staff were focused on learning and improvement.

Staff we spoke with reported that they felt valued and that the team was a happy one. There was evidence of cross divisional working and strong team dynamics. Leaders told us that improved communication within teams and across the trust leadership had resulted in the improvements to the culture.

**Governance**

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. Staff at all levels were clear about their roles and understood their accountabilities.

The outpatient service sat within the surgical divisional structure. The outpatient matron reported to the divisional chief nurse. The medical records and outpatient booking service sat within the cancer and diagnostics divisional structure. The head of medical records and outpatient booking office reported to the divisional deputy chief operating officer/associate director.

There was an outpatient board in operation with membership from across the trust that was chaired by the chief operating officer. This included the medical director, chief nurse, associate directors, divisional chiefs of service, director of information technology and facilities and the director of corporate affairs. There was also attendance from a range of senior staff including the chief executive officer, Kaizen, outcomes, education, service development, finance and strategy and clinical informatics.

The outpatient board were responsible for delivering the outpatient strategy and key performance indicators and the provision of a governance framework. The governance framework included safety and quality, access and responsiveness, performance and productivity, patient experience and information, risk management and regulatory compliance.

Weekly divisional board meetings were attended by the outpatient matron. At these meetings areas such as health and safety, infection prevention and control, policies, updates, good practice
and case reviews were discussed. Minutes from these meetings were cascaded to senior outpatient sisters who would share information with outpatient staff in monthly audit meetings and daily huddles as appropriate.

Weekly senior sister’s meetings were held where all the senior outpatient sisters from across all locations within the trust would meet. Monthly audit meetings were held where performance and quality improvement issues were discussed with all outpatient staff and where specific education events would be held.

We reviewed minutes of daily huddle meetings and saw that discussions were structured around the team objectives and that communication was shared with staff around issues of governance and performance.

**Management of risk, issues and performance**

There were processes to manage current and future performance and robust arrangements for identifying, recording and managing risks, issues and mitigating actions.

Senior outpatient staff were clear about the areas where improvements needed to be made and improvements were demonstrated. There was a systematic programme of internal operational audit to monitor quality and operational processes. Monthly performance reporting was conducted. An outpatient performance scorecard showed data collated for many areas of activity and performance. This included data relating to referral to outpatient cancellations, clinic utilisation and telephone call statistics. Performance was reported to the outpatient board.

There were environmental risk assessments, including those for control of substances hazardous to health (COSHH). A band six sister was the health and safety lead and represented the outpatient department at health and safety committee meetings.

An identified area of risk within the outpatient department was a lack of space to accommodate patients waiting on stretchers in the department. Action to mitigate the risk included ensuring the patient was seen in clinic straight away and arranging for transport staff to wait so they could transfer the patient as soon as their appointment ended. Within ophthalmology outpatients a risk had been identified on the risk register relating to insufficient space within the department. There was a risk of patients with restricted mobility being harmed due to the lack of space available and the area being utilised not at times having enough seating for the numbers of people attending. The potential for harm was increased due to tight spaces and the number of people attending who were elderly with impaired eye sight. Action taken to mitigate the risk included revising clinic times and relocating some clinics and exploring external capacity solutions. The risk had initially been rated as red on the risk register with a residual amber rating with mitigating actions implemented.

A serious incident in ophthalmology where a patient had a treatment delay due to their outcome form not being processed was not identified on the risk register. However, the service had acted to mitigate the risk by reconciling outcome forms at the end of each clinic. This ensured that staff identified where forms had not been returned to reception staff before the patient left the department and enabled staff to follow this up with the relevant clinical team. Longer term plans included digitalising the outcome form so that the clinician submitted them through an electronic system at the end of the appointment.
Information management

There were clear and robust service performance measures which were reported and reviewed. The trust used secure electronic systems with appropriate security safeguards. It was widely recognised that paper based information needed to be transferred into electronic formats to ensure a more accurate and timely capture of data to support patient pathways. While the trust patient record system was currently paper based they had invested in new buildings, infrastructure and staff to improve their medical records service and the way that clinical information was managed. This had improved the consistency and quality of medical records so that patient information was more accessible within the outpatient department. Quality audits of patient records was carried out to ensure ongoing accessibility.

Referral processes from GPs were fully electronic and clinical staff had access to pathology results, imaging results and referral letter via electronic systems. Staff told us that the systems worked well generally and that the information was accessible when they needed it. Nursing staff working within the general outpatient department had attended information governance training.

There were arrangements for information used to monitor, manage and report on quality and performance across the outpatient department. We observed data being used through an outpatient dashboard that monitored performance in areas such as waiting times, cancelled clinics and other information relating to service performance measures.

Engagement

The trust had systems and processes in place to engage with patients, staff, the public and local organisations to plan and manage services.

Staff told us there were opportunities to engage with senior leaders and that information was shared in a helpful and collaborative way.

Staff demonstrated an awareness of the role of the freedom to speak up guardian and some were aware of who this was. Those staff who did not have an awareness of who the freedom to speak up guardian was, told us they felt confident to raise concerns with their direct line managers and that these concerns would be addressed.

The trust’s score in the national staff survey in relation to how engaged staff felt in 2017 at 3.96 was similar to their 2016 score of 3.97 and better than the national average for similar organisations. The overall engagement score for the surgical division in which the outpatient department operated was 3.98.

Staff working in the outpatient department told us they regularly attended meetings and that information was shared in a number of forums. This included daily huddles, monthly meetings and through online sources.

A quarterly outpatient news sheet was developed by the outpatient matron. Information contained in the news sheet included general outpatient updates for staff, information on the strategy and updates on objectives and feedback on activities within the department.

Patient information boards were in use in the waiting areas of outpatients and included feedback comments from patients in a ‘you said, we did’ format. Staff demonstrated areas of improvement as a result of patient feedback. For example, there was a focus on handwashing because of some patients providing feedback that they had not seen staff washing their hands.
The outpatient department participated in the Friends and Family Test which gave patients an opportunity to feedback simply whether they would recommend their department to their friends and family. At the time of our inspection the most recent results showed that 92% of patients would recommend the service to their friends and family. Results over time dating back to September 2017 showed the results were between 88% and 92%. This was below the trust target.

Senior staff told us they had worked to engage more openly with patients about areas for improvement within the department. For example, we were told that patients had been consulted about the layout and décor within the breast clinic. In addition, a member of staff who had also been a patient had undertaken a talk to the outpatient team about their long-term condition and ways to improve the outpatient experience for patients.

Patient representatives were invited to participate in rapid improvement workshops as part of the trust’s Kaizen (Kaizen means continuous improvement in business) improvement methodology. At the time of our inspection a rapid improvement workshop was in process for ophthalmology with a patient representative involved. Senior staff from medical records and the booking office had engaged with patients to identify areas for improvements as part of their transformation programme. This had been done by working collaboratively with the local Health watch service.

**Learning, continuous improvement and innovation**

There were standardised improvement tools and methods, and staff had developed the skills to use them.

A trust-wide continuous improvement approach SASH+ programme had been developed and was in operation within the outpatient department. The matron and band seven nurses working within the outpatient department had undertaken the local ‘lean for leaders’ continuous improvement training course. The course taught aspects of improvement methodology and equipped staff to make positive improvements within their own departments. The course included a module where different approaches were taught and taken into the workplace to help leaders support their teams to develop solutions to problems or find innovative ways to take forward solutions.

The lean for leaders course taught a range of improvement tools which were then utilised within normal service delivery. These tools include; service mapping, timed observations, ideas to PDSA (Plan, Do, Study, Act), Rapid Improvement Workshops, and the use of production boards to track delivery and share learning.

Specific improvement projects had been undertaken as a result. For example, by improving the patient journey by offering phlebotomy within the department to reduce burden on phlebotomy dept. Staff had also developed the use of procedure packs so as not to spend time looking for individual items when undertaking a procedure. For example, in the breast clinic staff monitored the number of steps it took for them to access items for a specific procedure, then later monitored the number of steps taken with the use of procedure kits. This had resulted in a reduction in steps from 77 to 17. Staff reported that this meant they didn’t have to leave the patient for as long and had more time with them which was particularly important if patients were distressed or anxious.

At the time of our inspection a five-day rapid process improvement workshop was being held for the ophthalmology department. Staff involved ranged from those at a band two grade up to consultant level and included patient representation and the workshop was led by staff within the Kaizen office. The focus of the improvement work was from the patient perspective and included a deep dive analysis of the service and the development of value streams (a lean-management method for analysing the current state and designing a future state for the service). The initial part
of the workshop involved teaching staff the tools, generating improvement ideas and increasing awareness for all staff. The workshop team then tested out ideas and reviewed them using a PDSA (Plan, Do, Study, Act) approach. By the end of the workshop week a report would be compiled and information shared on the intranet by video and other formats. The ophthalmology team we observed in the workshop at the time of our inspection included the full range of ophthalmology staff. Their focus was on testing out improvements to the outcome form and looking at new ways of working to improve patient access, capacity of the service and the patient experience.

We viewed the plans of the Kaizen office and saw there were future schedules that included plans to continue the improvement work within general outpatients. Staff involved in the ophthalmology rapid improvement workshop were positive about the experience and hopeful that improvements would be made.

There were new ways of working evident across outpatients which included the co-design of services involving patients and families for those with long term conditions. A project for patients with chronic obstructive pulmonary disease and asthma had been developed. The project included group sessions for up to 10 patients and a shared medical appointment where both the patient and those close to them could be involved in the consultation.

In ophthalmology staff had worked with guidance from the Royal National Institute for the Blind to improve patient’s knowledge and engagement with their treatment plans. The project included the development of patient held records.
Acute services

Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services:

Surrey and Sussex Healthcare NHS Trust provides emergency and non-emergency services to the residents of East Surrey, North-East West Sussex, and South Croydon, including the major towns of Crawley, Horsham, Reigate and Redhill. East Surrey hospital in Redhill provides acute and complex care services to these areas.

Urgent and emergency care services at East Surrey hospital, includes a separate children’s department and resuscitation area, a majors area, minors area, resuscitation area, clinical decision unit and primary care streaming. There is also an ambulatory care unit, however this is reported within the core service of medicine.

As the nearest accident and emergency to London’s Gatwick airport, it is placed on standby when a serious aircraft incident is expected, and regularly receives travellers with diseases not commonly encountered in the UK.

Urgent and emergency care services are within the Medicine Division.

The adult emergency department has a five-bedded resuscitation suite; a majors areas consisting of 16 majors cubicles, two side rooms, a minor injury area with four trolley spaces and three side rooms the clinical decisions unit has eight beds and two side rooms. The children’s department has one resuscitation bay, two high dependency bays, three trolley spaces and three side rooms. There is emergency nurse practitioner and GP service for minor injuries and illnesses. The GP service is run by a different healthcare provider seven days a week between 10am and 10pm. The emergency department works closely with the ambulatory department, patients who do not require urgent care are referred to the ambulatory care department.

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

Activity and patient throughput
From August 2017 to July 2018 there were 99,493 attendances at the trust’s urgent and emergency care services as indicated in the chart above.

(Source: NHS England)

Additional data showed that between September 2017 and September 2018 there was 135,098 attendances. Of these attendances 44,077 patients were aged between 0 and 16 years old, 70,302 aged between 17 and 24 years old and 20,719 were aged between 75 and over.

Urgent and emergency care attendances resulting in an admission

The percentage of emergency department attendances at this trust that resulted in an admission remained similar in 2017/18 compared to the previous year. In both years, the proportions were higher than the England averages. Additional data supplied to us showed between September 


2017 and September 2018 the percentage of emergency department attendances was above the England average (33%).

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from June 2017 to May 2018

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>32,924</td>
</tr>
<tr>
<td>Discharged*</td>
<td>43,127</td>
</tr>
<tr>
<td>Referred^</td>
<td>7,925</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>1,219</td>
</tr>
<tr>
<td>Died in department</td>
<td>23</td>
</tr>
<tr>
<td>Left department#</td>
<td>491</td>
</tr>
<tr>
<td>Other</td>
<td>172</td>
</tr>
<tr>
<td>Not known</td>
<td>13,612</td>
</tr>
</tbody>
</table>

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

(Source: Hospital Episode Statistics)

Data provided to us showed between September 2017 and September 2018 there was 36508 patients who arrived at the emergency department by ambulance. This meant there was an average of 100 ambulance arrivals a day.

Patients presented to the department either by walking into the reception area or arriving by ambulance via a dedicated ambulance-only entrance. Patients transporting themselves to the department are seen initially at the reception desk and assessed by a senior nurse and sent to either the GP/minors waiting area or the majors waiting area.

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

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

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

Clinical staff received mandatory training on how to recognise and provide a first response to patients with mental health needs, learning disabilities, autism or dementia.

The mental health liaison team undertook weekly mental health awareness training with the emergency department staff. The trust’s dementia team and learning disability teams provided training for staff. This ensured staff had the necessary skills and knowledge to care for patients with additional needs.

Administration staff booked staff on to mandatory and statutory training and were responsible for communicating this with staff. This was going to change within the next couple of months when the band 7 of each team was going to take ownership of this.

Staff were separated into three groups for training and undertook one training day a quarter. The service planned to change the mandatory and statutory training programme and split it into clinical and non-clinical which would run over a three-year cycle which ensured training was updated regularly.

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

Training was a mixture of online and face to face. Staff reported that it was easy to access mandatory and statutory training and had dedicated time to complete it.

The trust set a target of 80% for completion of mandatory training.

Trust level:

A breakdown of compliance for mandatory training courses as of May 2018 at trust level for qualified nursing staff in urgent and emergency care is shown below:

Please note the training modules have been merged to give overall figures for each module as the raw data included multiple entries of the same modules with training renewal dates.
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control - Level 2 - 1 Year</td>
<td>49</td>
<td>87</td>
<td>56%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Local Data Security Awareness - 1 Year</td>
<td>52</td>
<td>87</td>
<td>60%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety - 2 Years</td>
<td>62</td>
<td>88</td>
<td>70%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling - Level 2 - 2 Years</td>
<td>68</td>
<td>87</td>
<td>78%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>NHS Conflict Resolution (England) - 3 Years</td>
<td>68</td>
<td>87</td>
<td>78%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>73</td>
<td>87</td>
<td>84%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, Safety and Welfare - 3 Years</td>
<td>78</td>
<td>87</td>
<td>90%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic Life Support (Adults &amp; Paeds) Level 2</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>In Hospital Basic Life Support (Adults &amp; Paeds)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - Clinical Update</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - MaST Clinical Update</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - New Staff</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - Update</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management Core Update</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - Basic Life Support</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - Basic Life Support (Adults &amp; Paeds) Level 2</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital BLS (Adults &amp; Paeds) - BLS/ILS</td>
<td>29</td>
<td>29</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital BLS (Adults &amp; Paeds) - BLS/PILS</td>
<td>13</td>
<td>13</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital BLS (Adults &amp; Paeds) BLS/e-ALS</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
In urgent and emergency care the 80% target was not met for five of the mandatory training modules for which qualified nursing staff were eligible. Infection prevention and control - Level 2 was the module with the lowest compliance of 56%.

A breakdown of compliance for mandatory training courses as of May 2018 at trust level for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Numb of staff trained (YTD)</th>
<th>Numb of eligibile staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling - Level 1 - 3 Years</td>
<td>2</td>
<td>30</td>
<td>7%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>NHS Conflict Resolution (England) - 3 Years</td>
<td>4</td>
<td>31</td>
<td>13%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control - Level 2 - 1 Year</td>
<td>8</td>
<td>30</td>
<td>27%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>10</td>
<td>30</td>
<td>33%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety - 2 Years</td>
<td>11</td>
<td>30</td>
<td>37%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Local Data Security Awareness - 1 Year</td>
<td>11</td>
<td>30</td>
<td>37%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Health, Safety and Welfare - 3 Years</td>
<td>13</td>
<td>30</td>
<td>43%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management Core Update</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - Drs Update</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - Basic Life Support - Dr's Update</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - Basic Life Support (BLS Adults &amp; Paeds) Dr's Update</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital BLS (Adults &amp; Paeds) BLS/e-ALS</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital BLS (Adults &amp; Paeds) Dr's Update</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
In urgent and emergency care the 80% target was not met for seven of the mandatory training modules for which medical staff were eligible. Moving and handling level 1 was the module with the lowest compliance of 7%.

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

Additional information provided to us by the trust showed overall compliance was 70% which was below the trust target of 80%.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Staff gave us examples of when and how they had raised safeguarding concerns and could identify the lead safeguarding nurses and how to contact them.

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

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

There were arrangements to keep both adults and children safe from abuse which were in accordance with relevant legislation. Staff were able to identify children and adults who might be at risk of potential harm. There was a children’s safeguarding lead nurse and an adult safeguarding lead nurse within the emergency department.

Staff received effective training around safeguarding adults and children. Training was provided by the trust during staff induction and refreshed regularly.

There were arrangements to safeguard adults and children at risk of radicalisation, domestic abuse and female genital mutilation (FGM). The trust safeguarding training policy included these issues and there were screening tools and referral pathways specifically for these concerns. Staff provided us with examples of when safeguarding concerns had been raised to external agencies.

There was a Child Protection Information Sharing system which authorised staff could access. Staff demonstrated how this was accessed during our inspection.

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

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

Staff knew how to make a multi-agency safeguarding hub referral and demonstrated this during our inspection. The multi-agency safeguarding hub brings together a team of multidisciplinary professionals from partner agencies into the same room to deal with all safeguarding concerns, where someone is concerned about the safety or wellbeing of a child.
Staff knew how to make a multi-agency risk assessment conference referral and demonstrated this during our inspection. A multi-agency risk assessment conference is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, independent domestic violence advisers, probation and other specialists from the statutory and voluntary sectors.

The trust set a target of 80% for completion of safeguarding training.

**Trust level**

A breakdown of compliance for safeguarding training courses as of May 2018 at trust level for qualified nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Numbe of eligible staff (YTD)</th>
<th>Completio n rate</th>
<th>Trust Targe t</th>
<th>Met (Yes/No )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults - Level 2 - 3 Years</td>
<td>79</td>
<td>87</td>
<td>91%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children - Level 3 - 3 Years</td>
<td>11</td>
<td>13</td>
<td>85%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children - Level 2 - 3 Years</td>
<td>5</td>
<td>6</td>
<td>83%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Qualified nursing staff in urgent and emergency care met the 80% target for all safeguarding training modules.

A breakdown of compliance for safeguarding training courses as of May 2018 at trust level for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Numbe of staff trained (YTD)</th>
<th>Numbe of eligible staff (YTD)</th>
<th>Completio n rate</th>
<th>Trust Targe t</th>
<th>Met (Yes/No )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults - Level 2 - 3 Years</td>
<td>11</td>
<td>30</td>
<td>37%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children - Level 2 - 3 Years</td>
<td>5</td>
<td>7</td>
<td>71%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in urgent and emergency care did not meet the 80% target for either of the two safeguarding training modules.

(Source: Routine Provider Information Request (RPIR) – Training tab)
More up to date data supplied to us showed 91% of nursing staff and doctors had completed either level two or three adult safeguarding training. The training included mental capacity Act training, safeguarding and deprivation of liberty training.

**Cleanliness, infection control and hygiene**

The service-controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

We found premises and equipment were clean and cleaners were in the emergency department throughout our visit. The department was equipped with adequate hand washing facilities and staff wore personal protective equipment, such as gloves and aprons.

Hand washing guides were visible in the department with the appropriate World Health Organisation’s “My five moments for hand hygiene” procedures visible above all sinks. The posters clearly defined the key moments of hand hygiene. We observed staff cleaned their hands in line with these guidelines.

Regular hand hygiene audits were carried out and data supplied to us showed 100% compliance between July 2018 and September 2018.

The department undertook audits to ensure intravenous medicines were prepared and administered using Aseptic Non-Touch Technique. Data supplied to us showed 100% compliance in all aspects of preparation and administration between July 2018 and September 2018. Aseptic technique means using practices and procedures to prevent contamination from pathogens (germs). It involves applying the strictest rules to minimise the risk of infection.

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

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

There were systems which ensured that clinical waste, including sharps, was appropriately segregated and disposed of. During our inspection we observed six sharps bins were correctly assembled and labelled in line with national guidelines.

Cleaning services were provided by staff employed by the trust. The same housekeepers worked in the department to provide cleaning services. Dedicated housekeeper cover was available from 7am until 11pm seven days a week. This provided continuity of cleaning and ensured a good relationship between the housekeepers’ staff and emergency department staff. Staff we spoke to knew the names of the domestic staff responsible for the cleaning of the department and were embedded as part of the acute floor team. One housekeeper told us that “she loved her job and staff were very friendly.”

Cleaning was undertaken in line with the national specifications for cleanliness in the NHS framework for setting and measuring performance outcomes. We reviewed cleaning schedules during our inspection and found them fully completed. The department undertook monthly infection control audits. For example, in August 2018 90% compliance was achieved.

Equipment in cubicles and bays such as suction tubing and oxygen masks were checked daily to ensure they were clean. We saw records which confirmed this.

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

**Environment and equipment**

The service had suitable premises and equipment and looked after them well.

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

During our inspection we observed a housekeeper’s portable trolley was unattended throughout the morning, the trolley contained products subject to Control of Substances Hazardous to Health Regulations 2002. These were not securely stored within the trolley meaning they were accessible to all. We raised this issue with the trust’s executive team who took prompt action. The executive team met with more than 50 domestic staff the following morning and explained the need to temporarily remove these products from the trolleys whilst the systems and processes were reviewed. We observed that these products had been removed from the trolleys and were stored securely within a locked cleaning cupboard.

Staff were able to show us where information relating to substances subject to Control of Substances Hazardous to Health was located. Staff confirmed they had received training in the management of substances subject to Control of Substances Hazardous to Health.

Staff regularly serviced all equipment in accordance with manufacturers’ guidance and electrical equipment was tested. Records we viewed demonstrated routine electrical testing, calibration and maintenance of medical equipment was completed as per hospital policy. During our inspection we checked 15 items of electrical equipment which had stickers on which confirmed they had undergone electrical safety testing in the last 12 months.

Resuscitation equipment was readily available, and staff sealed all crash trolleys with a red tag. Resuscitation equipment was checked daily and weekly and we saw two months of records which confirmed this. Equipment on top of the trolley such as suction and oxygen was checked daily, and the drawers opened, and a full check undertaken weekly. We checked five items on the trolley in the resuscitation area which were in date and fit for use.

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

The children’s department was co-located but physically separate, providing a secure area, which was not overlooked by adult patients and visitors.

There was a fully equipped child resuscitation bay and resuscitation trolley with all sizes of equipment. This was checked on a daily basis to ensure they were ready for use and we saw records which confirmed this.

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

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

It was not always possible to confirm in patient records if risk assessments had been completed. The service was in the process of changing from paper-based patient records to electronic patient records. Different patient information was recorded in different places so a mixture of paper and electronic records were used.

Every patient was meant to have a safety checklist completed whilst in the department. The safety checklist was broken down into three sections; checks undertaken within one hour, two hours and three hours of arrival in the department. The checklist included a variety of checks, which included but were not limited to; vital signs measured, identification wristband on patient, suspected sepsis (infection), blood tests and pain score.

We reviewed 15 paper records and saw that not all elements of the checklist or risk assessments had been completed but when we reviewed the electronic records we saw they had been completed. However, this was not consistent, we saw some records did not have a completed venous thromboembolism (blood clot) or risk of falls assessment completed. Staff told us that they did not always have time to complete all the risk assessments. However, if a patient was admitted to the hospital these risk assessments were done within an hour of arriving at the ward.

There were policies and procedures in place for extra observation, supervision, restraint and, if needed, rapid tranquilisation. During our inspection we saw two patients were on constant eyesight observation as identified in their risk assessments. However, we reviewed the notes of a patient who had received rapid tranquilisation which showed that staff had not recorded any physical observations such as whether the patient was breathing. The trusts emergency departments guidelines for rapid control of acutely disturbed patients states: blood pressure, pulse, respiratory rate and level of consciousness should be monitored every 15 minutes after intra muscular injections. We raised this with the matron who told us that they would have expected this to be recorded in the patient’s record, we checked the electronic patient record and they were not recorded there either. The service did not have specific paperwork for documenting physical observations after rapid tranquilisation.

After we highlighted the issue to the trust leadership team the service undertook a retrospective audit on patients receiving rapid tranquilisation who met the criteria outlined in the policy. The audit data showed between 06 August 2018 and 23 October 29 patients were identified as receiving rapid tranquilisation. Of these, four patients were identified as having rapid tranquilisation which met criteria outlined in the policy and all of these had documented physical observations.

Processes for streaming and assessing patients on arrival in the emergency department were in line with guidance issued by the Royal College of Emergency Medicine. We observed that they were operating efficiently. Royal College of Emergency Medicine recommends that systems identify the most time-critical patients for treatment and prioritise the rest.

There were streaming and triage systems for both ambulance and self-presenting patients. Streaming is a recognised system to allocate patients to the most appropriate location and the correct person to manage their needs.

Patients who self-presented to the emergency department were seen by a senior nurse on arrival. Their role was to quickly assess patients (before they were booked in by receptionists) in order to direct them to the most appropriate area of the emergency department. This may be the minor or major treatment areas or the GP-led urgent care area.

Patients arriving by ambulance were handed over to a senior nurse, who directed the patient to the appropriate part of the department. Patients identified as requiring assessment and treatment
in the major treatment area were taken to another area, located just inside the ambulance entrance. This area had six trolleys. The area was staffed by a team of nurses and healthcare support workers 24 hours a day. The team was responsible for undertaking an initial assessment and ordering appropriate investigations and moving patients to the appropriate part of the emergency department, clinical decision unit or ambulatory clinic. The aim was for a rapid assessment and throughput of patients, in order to maintain flow in the emergency department. This system, sometimes known as rapid assessment and treatment, is also recognised by Royal College of Emergency Medicine as one which improves efficiency by ensuring that patients do not wait unnecessarily for investigations or diagnostic decision making.

Children were booked in at reception and then a request for triage was put out over the loud speaker and a senior nurse then triaged them. Triage is a process of initial assessment which is described by Royal College of Emergency Medicine as a system which sorts patients according to a combination of their presenting complaint and measured physiological parameters at the time of arrival in the emergency department.

We spoke with staff who felt that the trust did not sufficiently protect patients and staff from harm. Staff told us that security staff who were not employed by the trust were not very responsive or supportive. Staff gave us numerous examples of when they have requested urgent assistance from security and they had taken a long time to get to the department or not turned up at all. Staff told us that security staff were “hands off and here to protect the building not the staff.” Several members of staff told us that they didn’t always feel safe whilst at work. The trust had taken a number of actions to improve safety for staff. These included ensuring security were now based in the emergency department at night and a more simplified means of reporting incidents. There was also an ongoing a review of hospital wide provision for security.

The service constantly looked at new ways of working to improve efficiency and to ensure patients were cared for in the correct environment with the correct staff. The service had recently introduced a two-tiered approach to trauma calls; a hospital trauma call and an emergency department trauma call. There was set criteria which was followed by nursing staff who determined whether a patient required a hospital trauma call or an emergency department trauma call. A hospital trauma call meant all different specialities such as surgeons attended to the department for the patient. However, the whole team might not be needed and were sent away again which resulted in a waste of time for these staff and may have called them away from other patients within the hospital that needed them. A hospital trauma call tended to be for patients who had multiple injuries or was based on the mechanism of injury. An emergency department trauma call focused on frailer patients who had experienced a fall from standing and may of suffered a significant injury. An emergency department call only prompted assistance from specialist staff already in the department. During the month of August 2018 there were 340 emergency department trauma calls and 13 hospital trauma calls. Before the new system was introduced the hospital, trauma team might have been called 340 times but were not needed.

The average time between patients who brought themselves to the department waited for assessment was 20 minutes between September 2017 and September 2018. This was worse than the best practice time of 15 minutes. However, performance had improved between April 2018 and September 2018 with the exception of September the average time was less than 20 minutes.

During our inspection we did not observe patients waiting significant lengths of time for initial assessment. Staff had oversight of patients waiting in the waiting area and therefore could monitor any deterioration in a patients condition. The computer system tracked the length of time a patient was in the department, so staff knew had been waiting the longest.
The trust scored “about the same” as other trusts for the five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

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

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

The median time from arrival to initial assessment was consistently worse than the overall England median in all months over the 12-month period from August 2017 to July 2018.

In the latest month, July 2018, the trust’s median time from arrival to initial assessment was 18 minutes compared to the England average of eight minutes.

Additional data showed between September 2017 and September 2018 the average median time for initial assessment for ambulances attendees was 20 minutes. This was still not in line with Standards set by the Royal College of Emergency Medicine. However, performance was improving between April 2018 and September performance varied between an average mean of 15 minutes (May 2018) and 20 minutes.
Ambulance – Time to initial assessment from August 2017 to July 2018 at Surrey and Sussex Healthcare NHS Trust

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

East Surrey hospital

From August 2017 to July 2018 the monthly percentage of ambulance journeys with turnaround times over 30 minutes at East Surrey hospital has remained fairly stable. The winter period (December 2017 to March 2018) did see an increase and the highest percentage of turnaround times over 30 minutes.

From April 2018 onwards there has been a reduction in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at East Surrey hospital.

Ambulance: Number of journeys with turnaround times over 30 minutes - East Surrey

Ambulance: Percentage of journeys with turnaround times over 30 minutes - East Surrey

(Source: National Ambulance Information Group)

Additional data supplied to us showed a noticeable reduction in the amount of ambulance turnaround times of over 60 minutes. Between September 2017 and September 2018, the highest amount was 89 in February 2018. During the last five months (May 2018 -September 2018) there
was only nine ambulance turnarounds of over 60 minutes. This was due to a change in the process and location of where and how ambulance attendances were managed.

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

From 5 June 2017 to 18 June 2018 the trust reported 789 “black breaches”.

The number of breaches reported increased throughout the winter months with February 2018 having the highest number of black breaches reported with 193.

There were systems for the ongoing monitoring of risks to patients in the emergency department so that staff could identify seriously ill and deteriorating patients. We saw staff consistently adhered to these systems.

The emergency department used a nationally recognised ‘track and trigger’ system to identify critical illness or deteriorating patients. For patients arriving by ambulance, the receiving nurse was required to record patients' observations, as recorded by the ambulance crew, undertake a first set of emergency department observations and calculate an early warning score. This information was recorded within the patient’s electronic records. We checked a number of these records and found that early warning scores were consistently recorded. However, once this had been completed we saw there was confusion regarding the early warning score System that was used. The service was changing over to National Early Warning Score 2 (NEWS2) when the changeover to electronic records was completed.
NHS England and NHS Improvement recommends NEWS2. It is the early warning system for identifying acutely ill patients - including those with sepsis - in hospitals in England.

The NEWS2 is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, such as blood pressure and heart rate which are already recorded in routine practice, when patients present to, or are being monitored in hospital. Six simple physiological parameters form the basis of the scoring system:

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

We reviewed 10 sets of paper records and saw that eight had a national early warning score documented and two had NEWS2 documented. The matron confirmed that at the time of our inspection staff should be using the early warning score system.

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

We observed national early warning score being performed and concerns escalated through appropriate channels.

An audit undertaken in September 2018 showed 100% compliance with observations being completed. The same audit showed a 76% compliance with the national early warning score being documented with the observations. We reviewed the department’s action plan to address non-compliance with documenting a national early warning score. The plan stated that with the implementation of electronic patient record a national early warning score will automatically be generated when the patients observations were entered. Therefore, a re-audit will be undertaken in January 2019 to ensure that observations are charted for all patients requiring that level of care.

The service used a screening tool to identify suspected sepsis (severe blood infection). There was a prompt on the paper record and electronic record completed by the nurse in the assessment and treatment area in the emergency department. Similarly, the senior nurse was prompted to consider the possibility of sepsis in self-presenting patients and where sepsis was indicated, patients would be transferred to the majors treatment area.

Up to date and evidence-based guidelines for the management of sepsis were visible in all areas in the department. Sepsis screening was a mandatory process within the department on the computer system. Any patient with a National Early Warning Score of five or more on arrival to the department, the system triggered a ‘red flag sepsis alert’ and prompted users to get an immediate senior review and early diagnosis.

The sepsis screening tool was based on “Sepsis Six.” The sepsis six is the name given to a bundle of medical therapies designed to reduce deaths and serious illness associated with sepsis. The sepsis six consists of three diagnostic and three therapeutic steps – all to be delivered within one hour of the initial diagnosis of sepsis. However, we reviewed audit data in relation to screening for sepsis which showed variable compliance. Between January 2018 and July 2018
compliance varied between 62% (June) and 94% (February). The trust did not supply anymore up to date audit data in relation to sepsis.

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

Data supplied to us showed between January 2018 and July 2018 in four of the six months patients received antibiotics within one hour in line with national guidelines, the remaining two months 80% compliance was achieved.

There was nominated medical and nursing sepsis clinical leads. They led on sepsis education, promotion of early diagnosis with the screening tool and rapid treatment.

There were laminated flow charts displayed for a variety of different emergency conditions such as major haemorrhage (bleeding) for staff to refer to.

The service had an escalation process which set out the steps to be taken to address crowding and flow issues in the emergency department. We saw it was laminated and stuck to the walls making it easy for staff to locate and use for reference. The escalation process set out clear triggers and actions to be taken with simple flow charts for staff to follow. On the reverse of the plan was useful contact details for ease of reference for staff. We did not see the escalation plan in use at the time of our inspection. Staff we spoke to were positive about it and said it was easy to follow.

The mental health liaison team created joint care plans for patients at high risk to note risks to self and others. The care plan included information for emergency department staff if they attended the emergency department. The care plans included recommendations regarding medicines, environment changes required to reduce patient stress, observation levels and family and professional contact numbers.

There were clear pathways in the emergency department for patients who presented with mental health needs, to ensure that they were located in the most appropriate part of the department and, importantly ensuring they were supervised if assessed as at risk of harming themselves or absconding. Following initial assessment some patients would wait in the minor treatment area. This area was not secure but allowed some level of observation. The clinical decision unit and emergency department were commonly used to accommodate patients with mental health needs.

The mental health liaison service provided around the clock access to mental health liaison and/or other specialist mental health support if staff were concerned about risks associated with a patient’s mental health. The mental health liaison team had a one-hour response time to respond to requests for assessment and support. Staff described a positive relationship with the mental health liaison team and found advice and support easily accessible.

Five hospitals in Sussex provided a place of safety, which the service could access. The Mental Health Act gives police powers to take people who appear to be suffering from a mental health disorder to a place of safety for assessment for up to 72 hours - in the interests of the health or safety of the person, or the protection of the public. All 136 suites have additional staff in the ward numbers to nurse admissions as required. The suites are frequently in use, so patients were nursed in the department or clinical decision unit until a place suitable for their needs became available for their onward admission. During our inspection we saw a patient was waiting in the emergency department for 48 hours whilst awaiting a bed at one of these locations. We saw the patient had a registered mental health nurse supervising them at all times.
The electronic patient records system had an alert function which highlighted if a patient had a pre-existing mental health condition or care plan.

**Nurse staffing**

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. However, there were a significant number of registered nurse vacancies and there was heavy reliance on temporary staff to ensure that assessed and planned staff to patient ratios were consistently met.

The children’s department had two registered children’s nurses on each shift. This was in line with Facing the Future: Standards for Children in Emergency Care Settings 2018.

The emergency department had recently reviewed nurse staffing numbers and skill mix to meet increasing demand. Additional funding had been secured to ensure a nurse to patient ratio of 1:4 instead of 1:5 was maintained. At the time of our inspection these additional posts were in the process of being advertised.

Staffing was reviewed twice a day at handovers in the department and three times a day at the site management meetings. If the department was short staffed, the staffing across the whole hospital was reviewed and additional staff sought from other areas in order to support the department.

The trust reported the following qualified nursing staff numbers as of December 2017 and May 2018 for urgent and emergency care:

<table>
<thead>
<tr>
<th>Location</th>
<th>December 2017</th>
<th>May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Trust level</td>
<td>74.3</td>
<td>102.2</td>
</tr>
</tbody>
</table>

The staff fill rate in May 2018 has improved since December 2017 with 4.5 more WTE staff in post. *(Source: Routine Provider Information Request (RPIR) – Total staffing tab)*

Staff told us that there were often unfilled shift which meant they were short staffed. Data supplied to us showed that between 01 July 2018 and 30 September within the majors area there was an average of 1.4 shifts unfilled daily.

From June 2017 to May 2018, the trust reported a vacancy rate of 25% for qualified nursing staff in urgent and emergency care. This was higher the trust target of 12%.

There was a rolling band 5 nurse and band 6 nurse recruitment campaign and regular recruitment days in an effort to employ more nurses.

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

From June 2017 to May 2018, the trust reported a turnover rate of 19% for qualified nursing staff in urgent and emergency care. This was higher than the trust target of 12%.

*(Source: Routine Provider Information Request (RPIR) – Turnover tab)*
From June 2017 to May 2018, the trust reported a sickness rate of 4% for qualified nursing staff in urgent and emergency care. This was slightly higher than the trust target of 3%.

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

Staff told us that bank and agency staff employed were often regularly utilised and so were familiar with the department. There was a local induction checklist which was completed by temporary staff and records were held in the department.

Staff told us that they would like to work bank in the department however, the rate of pay stopped them doing so as they considered it was not enough, and they could work agency in neighbouring trusts at a higher rate.

Medical staffing

The service had enough doctors with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. However, the service did not provide consultant presence 16 hours a day every day, in line with the Royal College of Emergency Medicine’s recommendations. Although the service provided 17 hours consultant presence Monday to Friday, which exceeded the RCoEM guidance, it only provided 14 hours per day consultant presence on a Saturday and Sunday which was not in line with the guidance.

There was a consultant in the emergency department between 7am and midnight Monday to Friday and between 8am and 10pm at weekends. This was not in line with Royal College of Emergency Medicine’s recommendations and meant senior expertise was not always available. A consultant was on call outside the hours of midnight and 7am and were able to give advice over the phone or come in if required.

There were 10 whole time equivalent (WTE) consultants who were adult trained and one of these was dual-trained (adults and children).

One consultant provided medical leadership, support and guidance for doctors in training specialist doctors and extended roles. We observed the consultant was based within an office in the department and staff were able to discuss management plans of patients with the consultant.

There was an additional consultant who in the summer worked a shift between 8am and 4pm and in the winter between 2pm and 8pm. The service had identified fluctuations in demand and reflected these in the additional consultant to meet the needs of the department.

During our inspection doctors we spoke with did not express concerns about staffing levels and told us they felt adequately supported by senior staff.

Urgent and emergency care did not use locum doctors to cover shifts. Any limited shortfalls in staffing were covered by their own staff.

The trust reported the following medical staffing numbers as of December 2017 and May 2018 for urgent and emergency care:

<table>
<thead>
<tr>
<th>Location</th>
<th>December 2017</th>
<th>May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>East Surrey hospital</td>
<td>48.6</td>
<td>51</td>
</tr>
</tbody>
</table>
The staff fill rate in May 2018 has declined slightly since December 2017 with one less WTE staff in post.
(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From June 2017 to May 2018, the trust reported a vacancy rate of 4% for medical staff in urgent and emergency care. This was lower than the trust target of 12%.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From June 2017 to May 2018, the trust reported a turnover rate of 39% for medical staff in urgent and emergency care. This was higher than the trust target of 12%. This figure included all staff including trainees who turnover every three months. When considering only permanent staff turnover is 19.35%.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From June 2017 to May 2018, the trust reported a sickness rate of 1% for medical staff in urgent and emergency care. This was lower than the trust target of 3%.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

In May 2018 the proportion of consultant staff reported to be working at the trust in urgent and emergency care was lower than the England average and the proportion of junior (foundation year 1-2) staff was the same as the England average. The trust has a much larger than average proportion of middle-career staff working in urgent and emergency care.

**Staffing skill mix for the 43-whole time equivalent staff working in urgent and emergency care at Surrey and Sussex Healthcare NHS Trust.**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>21%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>33%</td>
<td></td>
</tr>
<tr>
<td>Junior*</td>
<td>23%</td>
<td>23%</td>
</tr>
</tbody>
</table>

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

(Source: NHS Digital Workforce Statistics)
Records

It was not always possible to tell if appropriate records of patients care and treatment were kept. At the time of the inspection a mixture of paper records and electronic patient records were in use. The service had a plan to go ‘paper light’ in November 2018. Different aspects of patients’ care were documented in different places. For example, doctors documented the care and treatment given on the electronic patient record, but nursing documentation was in the paper record. Staff had to use both systems to ensure they had up-to-date information.

The department used an electronic system for tracking lengths of stay, x-rays and tests. The electronic system was used to document the initial early warning score, when a certain score was met triggered a reminder for staff to consider sepsis. A paper-based checklist and nursing documentation was used. Patient records were kept securely and confidentially.

We checked 15 paper records and saw some were incomplete. For example, safety checklists, which staff were required to complete for all patients receiving care and treatment in the major treatment areas, were not consistently completed. However, it was not always possible to tell if the paper records were incomplete as staff had documented on the electronic record. Staff demonstrated the new electronic patient record to us during the inspection which we saw would improve the consistency and readability of patient records.

Assessment tools within patient records reflected best practice. Patients conditions were reviewed, and treatment plans were followed. Documentation showed observations were regularly undertaken, monitored and all early warning scores calculated and recorded.

Staff could access the patient’s full medical notes if required. Administration staff had authorisation to request a patient’s full medical notes and out of hours this could be done via the site manager. Staff told us they arrived quickly.

Discharge summaries were generated and sent to the patients GP by post or emailed over if urgent.

Patients with pre-existing physical or mental health illnesses were easily identifiable on the electronic patient system. The electronic patient system allowed alerts to be added to patients, there was a symbol next to the patient name.

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

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

Medicines

The service prescribed, gave, recorded and stored medicines in line with best practice and guidance. Patients received the right medication at the right dose at the right time. However, hospital prescriptions were not stored securely.

A pharmacy within the hospital provided take home prescriptions for patients, however, the prescriptions were not stored securely and were therefore liable to misuse. We saw prescriptions were in the majors area in a container on the wall. We alerted the consultant to these who removed them and told us they were meant to be stored securely within the office. We escalated this to the trust’s executive team who took immediate action. When we returned to the department
the next day we were told that the prescriptions were now stored securely within the controlled drug cupboard.

Medicines, including controlled drugs were appropriately stored in secure areas. This ensured they were stored and dispensed in line with The Misuse of Drugs Regulations 2001. We checked the controlled drug records, which were fully completed, with no omissions. Controlled drugs are medicines liable for misuse that require special management.

Suitable emergency medicines were available, stored appropriately and regularly checked. Medicines stored in fridges were stored at the correct temperature at the time of our visit and records confirmed that temperature checks had taken place for the previous month. When temperatures were found not to be in the correct range, appropriate action had been taken.

We saw medical gas cylinders were correctly stored and the correct signage was in place in line with legislation.

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

Appropriate patient group directions were available for use. Patient group directions are agreements which allow some registered and appropriately trained nurses to supply and administer certain medicines to a pre-defined group of patients without them having to see a doctor. There was a process for reviewing patient group directions to ensure they remained up to date and a member of staff had the responsibility of monitoring the need for additional patient group directions and liaising with clinical teams. For example, staff had identified the need for a patient group direction for antibiotics to ensure they were given quickly and in line with best practice.

Nurses checked the discharge medicines and discussed them with patients. Patients were given a copy of their discharge summary. The department had a restricted list of pre-packed medicines available to support a quick and easy discharge process.

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

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Between April 2018 and September 2018 199 incidents were reported. Of these 144 (72%) resulted in no harm, 50 (25%) in low harm and 5 (3%) resulted in moderate harm. The top three themes of incidents were relating to medicines (16%), abuse to staff (14%) and care implementation (12%).

In the 2017 staff survey 100% of nursing staff within the majors area said if they were concerned about unsafe clinical practice they knew how to report it.

The service managed patient safety incidents well. Staff recognised incidents and reported them in line with trust policy. Staff had the necessary skills and knowledge to investigate incidents effectively. All band 6 and 7 nurses had undertaken root cause analysis training. Lessons learned with the whole team and the wider service were shared. Learning was shared via a range of
methods including directly through email, morning handovers, a social media application and at daily huddles.

Information was also shared on an electronic screen in the staff rest room. The screen displayed a variety of information including incidents which staff could read. The incident was summarised and identified good practice, areas for improvement and learning points for sharing.

Staff were able to give examples on when they have reported incidents and action had been taken as a result of it. For example, a nurse had reported some chairs in a waiting area that were damaged and sharp, these were then replaced after it was reported.

There were bi-monthly ‘hot topic’ meetings, where the care of patients who had complications or unexpected outcomes, was reviewed so that learning could be identified and shared. The last meeting had taken place in September 2018 and included topics; recording pain scores and reassessment of pain scores in children and follow up actions from a national sedation audit. We saw from the meeting minutes that they were well attended and included a variety of subjects.

The division of medicine held fortnightly emergency department rounds. Emergency rounds included but not only limited to the risk register, incidents, complaints, performance and individual case studies. They were multidisciplinary, and the purpose was to increase awareness, seek consensus on system changes and disseminate learning to a multitude of professionals, including senior management.

Deaths were reviewed independently, and any learning identified and shared. All patient deaths were reviewed by an independent consultant and graded one to four. One meaning no concerns in the care given and four meant identified areas of concern or requiring further investigation. The clinical lead produced a quarterly report of all deaths which was reported to the executive team.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From July 2017 to August 2018, the trust reported no incidents classified as never events for urgent and emergency care.

*(Source: NHS Improvement – STEIS)*

**Duty of Candour**

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

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from July 2017 to August 2018.

A breakdown of these incidents by type is shown below:
Three slips/trips/falls meeting Serious Incident Framework criteria
Two diagnostic incidents including delay meeting Serious Incident Framework criteria (including failure to act on test results)
One medication incident meeting Serious Incident Framework criteria.

(Source: NHS Improvement - STEIS)

Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.

The NHS Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

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

(Source: Safety thermometer - Safety Thermometer)
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

The service provided care and treatment in accordance with evidence-based guidance, including Royal College of Emergency Medicine (RCEM) and National Institute for Health and Care Excellence (NICE) guidelines. There was a variety of clinical guidelines, which were well organised and easily accessible on the intranet; staff demonstrated this to us during the inspection. There was a nominated consultant who was responsible for ensuring these were up to date.

We saw there were comprehensive action plans to address any areas that required improvement in national and local audits. During our inspection we saw evidence of this. For example, a procedural sedation checklist had been introduced. This provided a standardised safety checklist for administering sedation for procedures.

We observed staff worked in accordance with national best practice guidance. For example, they followed National Institute for Health and Care Excellence Acutely ill adults in hospital: recognising and responding to deterioration (CG50).

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

We saw national guidance specifically for children was displayed within the children’s department. For example, we saw the clinical guidelines for managing a baby with bacterial meningitis displayed in the child resuscitation area.

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

Local audit information was displayed for staff on noticeboards and the electronic screen in the staff restroom. It was used to highlight areas of good practice and areas where improvement was needed.

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

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

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences.

The service recognised the high proportion of elderly patients within the local area and had identified their needs. Hot food was available for patients whilst in the department, so they could have a hot meal. Staff could obtain take home and settle packs for patients which included basic provisions such as milk and bread.
Snack boxes were available for patients which included a choice of sandwich, a drink and fruit. Staff telephoned the canteen to request these and they were then delivered to the department.

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

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

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

The children’s department had a variety of fruit and cordial juices available for children attending the department.

In the CQC Emergency Department Survey, the trust scored 7.1 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

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

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief. However, an initial pain score and subsequent re-assessment of pain was not always documented. This may in part be due to the cross-over between paper and electronic records and pain scores were not consistently recorded in the same place.

Records we reviewed showed that pain relief was given to patients in a timely way. There was not an effective method of determining if the pain relief had been effective as the initial pain score and re-assessment was not always documented.

There were a variety of recognised pain assessment tools used for children for example, smiley faces which children could point to. For non-verbal children an assessment was based on behaviours such as the Faces, Legs, Activity, Cry, and Consolability which incorporates a parent's description of individual behaviours.

The adult pain tool score used was a score between zero and 10, zero being no pain and 10 being the worst pain a patient had ever experienced. The specialised pain score was used for the assessment of pain in patients who could not verbalise, for example patients living with dementia or patients with communication difficulties.

Patients told us they were regularly asked if they were in pain or required pain relief and it was administered quickly when it was required.

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

In the CQC Emergency Department Survey, the trust scored 5.6 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was about the same as other trusts.

The trust scored 7.3 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was also about the same as other trusts.
Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

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

The department provided thrombolysis onsite 24 hours a day, seven days a week as part of the stroke pathway. Thrombolysis is a treatment to dissolve dangerous clots in blood vessels, improve blood flow, and prevent damage to tissues and organs. The service could refer patients to another hospital for the surgical removal of a clot.

The table below summarises East Surrey hospital’s performance in the 2016/17 moderate and acute severe asthma audit.

When compared to other trusts, performance was better in none of the audit measures, worse in one of the audit measures, and similar in six of the audit measures. In this context, ‘similar’ means that the trust’s performance fell within the expected range of results.

The Royal College of Emergency Medicine standard was met in none of seven of the relevant audit measures.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets RCEM standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of records submitted to the audit</td>
<td>80</td>
<td>N/A</td>
<td>No standard</td>
</tr>
<tr>
<td>Standard 1a: O2 should be given on arrival to maintain sats 94-98%</td>
<td>20%</td>
<td>Similar</td>
<td>☒</td>
</tr>
<tr>
<td>Standard 2a: Vital signs should be measured and recorded on arrival at the ED</td>
<td>37%</td>
<td>Similar</td>
<td>☒</td>
</tr>
<tr>
<td>Standard 3: High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED</td>
<td>30%</td>
<td>Similar</td>
<td>☒</td>
</tr>
<tr>
<td>Standard 4: Add nebulised Ipratropium to nebulised β2 agonist bronchodilator therapy</td>
<td>72%</td>
<td>Similar</td>
<td>☒</td>
</tr>
<tr>
<td>Standard 5: If not already given 5a: Within one hour of arrival (acute severe)</td>
<td>19%</td>
<td>Similar</td>
<td>☒</td>
</tr>
</tbody>
</table>
before arrival to the ED, steroids should be given as soon as

| 5b: Within four hours (moderate) | 28% | Similar | ✗ |

Standard 9: Discharged patients should have oral prednisolone prescribed according to guidelines

| 22% | Bottom 25% | ✗ |

(Source: Royal College of Emergency Medicine)

The table below summarises East Surrey hospital’s performance in the 2016/17 consultant sign-off audit.

When compared to other trusts, performance was better in one of the audit measures, worse in two of the audit measures, and similar in one of the audit measures. In this context, ‘similar’ means that the trust’s performance fell within the expected range of results.

The Royal College of Emergency Medicine standard was met in none of the four relevant audit measures.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets RCEM standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atraumatic chest pain in patients aged 30 years and over: Seen by a consultant</td>
<td>5%</td>
<td>Bottom 25%</td>
<td>✗</td>
</tr>
<tr>
<td>Fever in children under 1 year of age: Seen by a consultant</td>
<td>25%</td>
<td>Top 25%</td>
<td>✗</td>
</tr>
<tr>
<td>Patients making an unscheduled return to the ED with the same condition within 72 hours of discharge: Seen by a consultant</td>
<td>0.0%</td>
<td>Bottom 25%</td>
<td>✗</td>
</tr>
<tr>
<td>Abdominal pain in patients aged 70 years and over: Seen by a consultant</td>
<td>6%</td>
<td>Similar</td>
<td>✗</td>
</tr>
</tbody>
</table>

(Source: Royal College of Emergency Medicine)

The table below summarises East Surrey hospital’s performance in the 2016/17 severe sepsis and septic shock audit.

When compared to other trusts, performance was similar to expected in all of the audit measures. In this context, ‘similar’ means that the trust's performance fell within the expected range of results.

The Royal College of Emergency Medicine standard was met in none of eight of the relevant audit measures.
<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets RCEM standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of records submitted to the audit</td>
<td>89</td>
<td>N/A</td>
<td>No standard</td>
</tr>
<tr>
<td>Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival.</td>
<td>63%</td>
<td>Similar</td>
<td>✗</td>
</tr>
<tr>
<td>Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED</td>
<td>70%</td>
<td>Similar</td>
<td>✗</td>
</tr>
<tr>
<td>Standard 3: O2 was initiated to maintain SaO2&gt;94% (unless there is a documented reason not to): Within one hour of arrival</td>
<td>27%</td>
<td>Similar</td>
<td>✗</td>
</tr>
<tr>
<td>Standard 4: Serum lactate measured: Within one hour of arrival</td>
<td>64%</td>
<td>Similar</td>
<td>✗</td>
</tr>
<tr>
<td>Standard 5: Blood cultures obtained: Within one hour of arrival</td>
<td>55%</td>
<td>Similar</td>
<td>✗</td>
</tr>
<tr>
<td>Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given: Within one hour of arrival</td>
<td>47%</td>
<td>Similar</td>
<td>✗</td>
</tr>
<tr>
<td>Standard 7: Antibiotics administered: Within one hour of arrival</td>
<td>51%</td>
<td>Similar</td>
<td>✗</td>
</tr>
<tr>
<td>Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival</td>
<td>9%</td>
<td>Similar</td>
<td>✗</td>
</tr>
</tbody>
</table>

(Source: Royal College of Emergency Medicine)

The audit summary and action plan was shared with us in response to the Royal College of Emergency Medicine Audit: Procedural sedation in adults 2015/16.

Actions taken included the development of a procedural sedation profoma and a checklist that is completed within the patients notes.

From August 2017 to July 2018, the trust’s unplanned re-attendance rate to the emergency department within seven days was worse than the national standard of 5%, however it was consistently better than the England average.
In the latest month, July 2018, the trust’s unplanned re-attendance rate to the emergency department within seven days was 7.0% compared to an England average of 8.2%.

**Unplanned re-attendance rate within seven days - Surrey and Sussex Healthcare NHS Trust**

![Graph showing unplanned re-attendance rate from August 2017 to July 2018](image)

(Source: NHS Digital - A&E quality)

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

There was a practice development nurse. They described to us a comprehensive in-house training programme for staff and a structured approach to developing staff, using a competency framework. There was a variety of in-house study days, which included all essential role-specific competencies, including training in the use of equipment. We saw completed competency documents in staff files and competencies were reviewed as part of the appraisal process.

The practice development nurse had developed a system which ensured managers easily knew what training, qualifications and skills all staff had. They maintained a board which had every staff members name and magnets next to them to signify their training, skills and qualifications. For example, nurses who could care for children had a ‘p’ magnet next to their name. This was used when doing the staff rota and staff allocations to ensure the right skill-mix of staff.

The department had joined with similar departments in the area to provide in-house training days. The hospitals took it in turns to provide in-house training for staff, for example advanced life support training. This enabled staff to received recognised training which was affordable.

Data given to us by the trust showed that 100% of band 6 and 7 nurses had an advanced life support and advanced trauma support training. One hundred percent of doctors had advanced trauma life support training, 78% had advanced paediatric life support training and 73% had advanced life support training.

International nurses and doctors were given an understanding of UK systems and processes...
before they worked clinically. They underwent a four-week classroom-based induction to ensure they had the skills and knowledge required to perform their role.

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

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

There were a range of extended roles within the department which included advanced care practitioners, associate practitioners, nurse associates, physician’s assistant and nurse practitioners. The service was committed to extending the use of these roles in the department.

The trust had processes in place to recruit registered mental health nurses from a local agency to ensure staff with the correct skills and knowledge looked after vulnerable patients with a mental health illness.

From April 2017 to March 2018, 83% of all staff in urgent and emergency care at the trust received an appraisal compared to a trust target of 90%.

The trust has provided the data for the following staff groups, but it did not include details of any medical staff for any core service.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals completed</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>17</td>
<td>17</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>29</td>
<td>26</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>59</td>
<td>44</td>
<td>75%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing and midwifery registered were the only staff group who did not meet the 90% appraisal completion target.

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

More up to date appraisal data showed 100% of doctors had received an appraisal and 95% of other staff including nurses had received an appraisal both were equal to or better than the trust target.

**Multidisciplinary working**

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

Staff, teams and services worked well to deliver effective care and treatment. Medical staff told us they felt well supported by the rest of the hospital. Most referrals from the emergency department were to the acute medical or surgical specialty teams.
Staff worked across health care disciplines and with other agencies when required to care for patients. These included but were not limited to: district nurses, community services, physiotherapists, occupational therapists, social workers, mental health services, learning disability services, police and GPs.

There was an ambulatory emergency unit, where emergency department clinicians could refer appropriate patients, who were unlikely to require admission. The ambulatory care consultant had access to the emergency department computer system and could identify suitable patients. They routinely attended the emergency department for the morning handover meeting where they identified suitable patients.

There was a frailty team within the hospital which the service could access. The frailty team consisted of geriatricians, doctors, community nurses, older persons nurse specialists, physiotherapists, occupational therapists and health care support workers. Staff told us that they had a positive relationship with the frailty team and said they were very proactive in identifying patients that might be suitable for their input.

There were monthly meetings with Clinical Commissioning Groups, the local ambulance trust, local safeguarding team, domestic abuse agency, improving access to psychological therapies teams, mental health liaison team and emergency department staff. These meetings enabled staff to develop care plans and co-ordinate care and interventions for frequent attending patients, to divert those who do not need the emergency department from attending unnecessarily. Improving access to psychological therapies can be accessed by patients with low to moderate depression or anxiety which is cognitive behavioural therapy based and can be therapist or computer led.

There was a positive working relationship with the local ambulance service. Comments from ambulance crew that we spoke to said, “it’s my favourite place to bring patients to” and “only got good things to say about the place.”

Patients received a multidisciplinary assessment of their needs prior to being discharged to ensure they were safe to be discharged home. A multidisciplinary Rapid Discharge Team were based within the department. The team included social workers, occupational therapists and physiotherapists who coordinated care with the emergency department clinical team. The team and staff were very positive about the service they delivered and had established links to resources in the community to provide assistance and rehabilitation.

There were strong working relationships with community drug teams, homeless charities, alcohol teams, Age UK and community mental health teams. We saw there were posters within the department with contact numbers of these organisations and staff reported a positive relationship with these organisations.

Staff reported positive relationships with other specialties. There was a daily morning meeting which brought all the specialties in a room to discuss treatment plans.

The stroke service was highlighted by staff as a good example of multidisciplinary working. When patients were admitted or on the way to the emergency department with a suspected stroke, the stroke team were alerted immediately which meant they were able to start treatment without delay. Time is critical in the management of stroke and effective multidisciplinary working was the key to a good outcome for patients.

**Seven-day services**

Staff always had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. All staff had access to an electronic records system that they could all update.
The department had around the clock access to mental health liaison and/or other specialist mental health support if staff were concerned about risks associated with a patient’s mental health.

The service was compliant with the NHS Seven Day Services Clinical Standards. For example, support services, both in the hospital and in primary, community and mental health settings were available seven days a week.

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

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

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

Hours of pharmacy provision

Pharmacy services were available between 9am-5pm Monday to Friday. There was an on-call pharmacist available after 5pm outside of these hours who was available to give advice by phone or come into the hospital.

Health promotion

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

Staff on the unit would advise patients about stopping smoking, obesity and alcohol use where necessary. There was a wide variety of health promotion information available for patients and visitors, for example, advice on healthy eating and preventive vaccinations.

Information was displayed educating patients on choosing the NHS service that can best treat their symptoms. Posters and information asked patients to use the service carefully, so it could best support those who needed it most. There was information for patients on other services in the area which might be able to meet their needs for example, pharmacists, GP’s, walk in clinics and self-care at home. The matron told us that one of the departments biggest challenges was educating patients on the most appropriate service to access based on their needs.

In the children’s department we saw there was information on different phone applications that could be downloaded to provide support for children and adolescents suffering from depression or an eating disorder. There were contact details of organisations that could provide support and advice for children and adolescents suffering from a mental health illness, drug or alcohol misuse or eating disorder. In addition, there was information on ‘five ways to ensure wellbeing’ for children and adolescents.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.
Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

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

Two patients were detained under the Mental Health Act Section 5 (2) during our inspection. This is a temporary hold of an informal or voluntary service user on a mental health or physical health ward in order for an assessment to be arranged under the Mental Health Act 1983. This ensured their immediate safety whilst the assessment was arranged. We saw that staff had sought advice and support from the mental health liaison team in the care and management of these patients and this was reflected within their care records.

Staff referred patients for a mental health assessment if they were suspected to be experiencing depression.

Staff told us that the mental capacity of a patient was usually assessed by medical staff using the formal mental capacity assessment tool. We observed a doctor undertaking a mental capacity assessment during our inspection. We reviewed the patient’s records which confirmed this had been undertaken and documented appropriately.

The trust includes training for the Mental Capacity Act and Deprivation of Liberty within the mandatory level 1 and level 2 safeguarding training modules.

Please see the “Safeguarding” section for details of training compliance.

(Source: Routine Provider Information Request (RPIR) – Quality statement)
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. We saw many staff in different roles interact with patients in a kind, respectful and considerate way.

Feedback from patients included “the whole process has been good” and “have been well looked after.”

We observed a doctor talking to a patient who desperately wanted to go home in a gentle, kind and considerate manner. The doctor said to the patient “I know it has been a long day and you want to go home but I just want to keep an eye on you for a bit longer and it doesn’t mean you can’t go home later.”

Staff had the skills to sensitively manage difficult behaviours that patients displayed. We observed staff sensitively and calmly managed a patient who became agitated. Senior staff quickly agreed the patient required sedation and this was done in a private area of the ward to protect their dignity.

Receptionists and nursing staff who greeted patients who self-presented to the emergency department were polite and attentive. We observed staff welcoming these patients to the department and offering advice on where to sit and wait.

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

We observed staff maintaining patient’s privacy and dignity at all times by keeping them covered and drawing curtains during examinations and procedures. We observed staff asking for permission to enter patient bed areas when the curtains were closed. During our inspection we observed two patients who were being cared for in private areas on the ward to maintain their privacy and dignity as they were becoming distressed and staff wanted to ensure the patient had a private area to be cared for and to manage patient safety.

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

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

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

We saw staff spoke to children in a way they could understand and took time to explain what was going to happen and ensured it was understood before delivering the treatment.

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was consistently better than the England average from August 2017 to July 2018.

In the latest month, July 2018, trust performance was 95% recommended compared to the England average of 87% recommended.
Emotional support

Staff provided emotional support to patients to minimise their distress.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Within the children’s waiting area we saw evidence of positive feedback from parents received, one comment was "We wanted to thank you all, for your professionalism and compassion you showed to our son." There were further comments that staff were supportive to parents while their child was being treated. There were a variety of items available to distract children whilst undergoing treatment, these included mobile TVs and DVD players, building blocks and interactive games.

Staff provided emotional support to patients to minimise their distress. We saw a member of staff sensitively trying to calm a patient down and return to their room. During our inspection the security guard was called to assist with a patient who had left the department. We observed the doctor explaining to the security guard the best way to deal with the patient.

There was a multi-faith chaplaincy service available in the hospital which provided a multi-faith service for patients and their families.

Staff we spoke with demonstrated understanding of how to provide emotional support to patients with mental health needs and those in crisis. They also understood how mental health challenges could manifest themselves and how they could tailor care and treatment to the patient’s needs. During our inspection we saw that two patients who had a mental health illness were cared for in side rooms away from the main department but were constantly supervised.
Staff demonstrated understanding of the importance of providing emotional support to patients living with dementia in an environment that could be hectic and confusing.

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

**Understanding and involvement of patients and those close to them**

Staff involved patients and those close to them in decisions about their care and treatment.

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

The names of staff allocated to different areas was displayed on notice boards within the department.

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

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

We observed clear communication between the nurse in the streaming role and self-presenting patients. The nurse welcomed patients and visitors and provided explanations and what to expect during their time in the department.

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren’t there?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing, and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>6.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>6.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>6.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)
Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people. However, external agencies were not always able to support patients using the service.

Patients with a mental health illness often experienced long delays. Staff told us that mental health beds were hard to obtain for patients requiring admission. During our inspection two patients suffered delays in admission to a mental health facility; one was delayed for more than 24 hours and the other more than 48 hours.

There was a suitably furnished mental health assessment room located in the clinical decision unit, which met the recommended safety standards (see premises and equipment), it was a private and comfortable space.

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

The children's area was a securely accessed area, audio-visually separate from the main adults' area. It was sensitively decorated, furnished and equipped with toys, wall puzzles and interactive TV screens.

The department had regular meetings to discuss any patients who were classed as frequent attenders. Initially a cohort of 30 patients were identified by the service and were discussed at the multidisciplinary meeting with the department staff, mental health team, police, ambulance and substance abuse staff. We saw meeting minutes which confirmed this. This enabled them to put a care management plan in place. When a frequent attender visited the emergency department, staff could access a care plan on the patient’s record and ensure they were treated appropriately.

The service had appropriate discharge arrangements for people with complex health and social care needs. Staff and the care systems they followed helped to provide good care to patients in need of additional support.

The service worked in collaboration with the charities Age UK and the Red Cross. On request the charities would provide patients transport home and stay with them for a while whilst they settle back into their home environment.

There was a large range of information within the department which gave patients and visitors information about services provided in the local community. For example, drug and alcohol misuse services and domestic violence support groups.

The department saw a significant number of patients with needs relating to frailty, approximately 10 a day. To ensure they received appropriate care, a frailty lead and team of frailty practitioners were in post to support discharge packages and reduce the risk of readmission.

In the reception area, we saw that there were easy clean chairs for patients to use whilst waiting for treatment and there appeared to be sufficient seating in the waiting areas. Staff were able to identify if community care was available. Daily multi-agency telephone calls identified what community support was available.
Meeting people’s individual needs

The service took account of patients’ individual needs.

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

Young infants attending the department were assessed and treated by specialist teams. Infants who were under 4 weeks old were immediately fast-tracked to the paediatric inpatient ward were specialist doctors and nurses were able to provide care and treatment most suitable to their needs.

Staff in the children’s department had collaborated with the local coroner regarding care given to children who died within the department. Staff had worked closely with the local coroner to ensure that the child’s body was preserved for post mortem whilst still allowing parents to create memories and keepsakes of their child. For example, removing medical equipment and taking photographs of the equipment for the coroner and making hand and foot prints of the child.

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

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

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

When a patient was taken to the emergency department under Section 136 of the Mental Health Act, an approved mental health professional and/or external agency visited to manage risk and attempt to prevent admission to inpatient setting.

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

If patients with a mental health condition attempted to discharge themselves, staff reported they would talk to the individuals and encourage them to stay on the unit. If there were significant concerns, staff would call security who would offer one to one supervision. However, staff told us that security staff were not responsive and had not received training in caring for people living with dementia or de-escalation techniques. Data supplied to us by the trust showed 69% of all staff including security staff had received de-escalation techniques training.

We observed two registered mental health nurses who were supplied by an external agency to observe two patients with mental health support needs to ensure they had their needs met whilst waiting for a mental health assessment.

There was an effective pathway for assessing patients who were alcohol dependant. Medicines to reduce anxiety were commenced in the department and patients were promptly referred to the alcohol abuse service.
The needs of patients attending with complex needs such as living with dementia were taken into account at triage and noted in assessments. Carers, families and escorting mental health professionals were involved in information gathering to ensure patient needs were documented. Patients with additional needs had a care plan to help staff quickly understand support required.

The Forget Me Not scheme for managing and supporting the needs of patients living with dementia was embedded into the department. Staff placed laminated symbols beside patient names on their bed and the electronic recording system symbolising whether suspected or assessed dementia support needs had been identified for that patient.

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

There was access to frailty mental health specialists who could offer guidance and support to nursing staff and patients’ carers and family members.

The department did not have a separate viewing room for family to see their relative’s body if they had died. The Royal College of Emergency Medicine: End of life care for adults in the emergency department 2015 recommends this as good practice. The department had one relatives room, which met the criteria set out in the same guideline. The room had comfortable seating and access to a toilet and tea and coffee making facilities.

The department had access to interpreting and translation services for those who did not speak English. This included face-to-face interpreters, British Sign Language, telephone interpreting and translation services. Written patient information available which could be printed out in different languages on request.

The service had appropriate arrangements for people with complex and social care needs. Staff and the consultants constantly reviewed admissions to ensure that those in greatest need were seen as a matter of urgency. The mental health liaison team could also see the departments electronic board listing incoming and triaged patients, so they could plan for new admissions.

If patients were admitted from a residential care setting, the staff encouraged a carer/escort to attend with the patient to offer additional support to the patient.

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

The Learning Disabilities team had developed health passports for patients with support needs. This ensured their needs, for example, what and how the patient ate and drank, was shared with staff to better meet patient need. We did not see any in use during our inspection.

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

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your</td>
<td>7.8</td>
<td>About the same as</td>
</tr>
<tr>
<td>condition with the receptionist?</td>
<td></td>
<td>other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency</td>
<td>6.9</td>
<td>About the same as</td>
</tr>
<tr>
<td>department last?</td>
<td></td>
<td>other trusts</td>
</tr>
</tbody>
</table>
Q20. Were you given enough privacy when being examined or treated? 9.2 About the same as other trusts

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

Access and flow

People could access the service when they needed it. Waiting times from treatment and arrangements to admit, treat and discharge patients were in line with or better than the national average.

The department had a campaign in place regarding patients that were ‘fit to sit’ on a chair rather than stay on a trolley. This helped staff make decisions to aid patient flow when patients arrived in the department on an ambulance trolley. In addition, the service had recently implemented a ‘sub wait’ area. Patients who were going to require an intervention within an hour were placed in this area, for example, a repeat blood test. The area was directly next to the staff base to enable patients in this area to be supervised.

Staff working in the emergency department told us that the mental health liaison team were very responsive and quickly came to assess patients. The service had a service level agreement with the mental health trust which set out that patients attending the department with a mental health illness would be assessed within one hour of arrival. The four patient records we reviewed of mental health patients confirmed this had happened. Patients self-referred to the mental health liaison team via the emergency department, however they had to undergo a triage assessment beforehand meeting the team.

Staff and managers told us that the ownership of the targets were shared across the whole multidisciplinary and executive leadership team and was not just the responsibility of the emergency department. Staff told us that this had a positive impact and had improved staff morale and encouraged better communication and teamwork.

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

Patients were informed of how long they could expect to wait. There were information screens in the waiting areas which informed patients of how long they could expect to wait to be seen and how many other patients were in the department.

There was a process which ensured that patients were referred to the most appropriate speciality. The service had agreed an admissions policy with the rest of the specialities within the hospital. The policy set out which type of patient conditions would be referred to each different speciality.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust met the standard for all 12 months in the period from August 2017 to July 2018 and were consistently better than the England average.

In the latest month, July 2018, the trust’s median time to treatment was 24 minutes compared to the England average of 64 minutes.
Median time from arrival to treatment from August 2017 to July 2018 at Surrey and Sussex Healthcare NHS Trust

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

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. The trust met the standard for four of the 12 months in the period (April, May, June and July 2018) from August 2017 to July 2018 and were better than the England average for all months in the period.

Additional data supplied to us showed that during April, May and June 2018 95% of patients admitted, transferred or discharged within four hours of arrival in the emergency department. This was in line with the Department’s standard.

Four hour target performance - Surrey and Sussex Healthcare NHS Trust

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

From August 2017 to February 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was similar to the England average.

From March 2018 to July 2018 the percentage of patients has reduced to a much lower level with fewer patients waiting over four hours from decision to admit until admission. 

Percentage of patients waiting more than four hours from the decision to admit until being admitted - Surrey and Sussex Healthcare NHS Trust
Over the 12 months from August 2017 to July 2018, no patients waited more than 12 hours from the decision to admit until being admitted.

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

From August 2017 to July 2018 the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was lower than the England average. From October 2017 to July 2018 the trust reported that no patients left urgent and emergency care services before being seen for treatment.

Percentage of patients that left the trust's urgent and emergency care services without being seen - Surrey and Sussex Healthcare NHS Trust

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

From August 2017 to July 2018 the trust’s monthly median total time in the emergency department for all patients was consistently higher than the England average.
In the latest month, July 2018, the trust’s median total time in the emergency department for all patients was 182 minutes compared to the England average of 150 minutes.

More recent data supplied to us by the trust showed that between September 2017 and September 2018 the median total time in the emergency department was 188 minutes. This was higher than the England average (150 minutes).

**Median total time in the emergency department per patient - Surrey and Sussex Healthcare NHS Trust**

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

**Learning from complaints and concerns**

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

Patients were encouraged to report concerns about their care and treatment. We found leaflets in the reception area, which directed patients and visitors to the trust’s Patient Advice and Liaison Service. Staff told us if a patient or visitor told them they wished to complain, they would ask a senior member of staff to speak with them to see if their concerns could be resolved. Otherwise, they would be directed to the Patient Advice and Liaison Service office. There were Patient Advice and Liaison Service leaflets available, which contained contact details, including a telephone number, and email address.

The service managed patients ‘expectations whilst in the department. There was information on the waiting room walls which described the different pathways into and through the emergency department and information explaining the different areas within the department and the different staff roles within it. There was also information for patients which set out the reasons why delays may occur in the emergency department. It also invited patients to make a comment or suggestion.
Complaints were investigated by appropriate senior staff who had received training and complainants received a full written response. We reviewed a sample of complaint responses and saw that concerns had been taken seriously, investigated thoroughly and sympathetically. A complaints database was maintained for the emergency department and clinical decisions unit and this was also overseen by the trust’s complaints department. Any delays were notified to complainants.

Staff were able to give us examples of learning from complaints. For example, a patient’s next of kin had changed and this had not been updated on the electronic patient record which led to a delay in notifying a patient’s next of kin of their admission. Because of this, every time a patient attended the department, next of kin details were checked to ensure they were up to date. Staff explained to us how they had met with the family to talk through the complaint and worked together on solutions.

From June 2017 to May 2018 there were 70 complaints about urgent and emergency care. The trust took an average of 51 days to investigate and close complaints. This is not in line with the trust’s complaints policy. Their complaints policy states that under current legislation trusts have six months to resolve complaints, but that a response time is agreed for each complaint and is usually 25 working days, (about 35 calendar days).

Patient care was the subject with the most complaints, accounting for 41% of all complaints about urgent and emergency care.

A breakdown of complaints by subject is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>29</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>22</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>8</td>
</tr>
<tr>
<td>Prescribing</td>
<td>3</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>3</td>
</tr>
<tr>
<td>Communications</td>
<td>2</td>
</tr>
<tr>
<td>Other (specify in comments)</td>
<td>2</td>
</tr>
<tr>
<td>Privacy, dignity &amp; well being</td>
<td>1</td>
</tr>
</tbody>
</table>

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

From June 2017 to May 2018 there were 3,928 compliments in urgent and emergency care.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. However, staff were not able to tell us who the lead for mental health was.

The Divisional Chief Nurse led the nursing team within the medicine division who was supported by six matrons one of which provided nursing leadership for the emergency department and four lead nurses. The matron who had been in post five months at the time of our inspection, managed a team of band 7 nurses. They were responsible for the day-to-day running and co-ordination of the different departments. The band 7’s managed band 6 nurses, band 5 nurses, health care assistants and other associated roles. The urgent care centre was managed by a Nurse Consultant who was supported by Emergency Nurse Practitioners and GP’s.

Medical leadership within the medicine division was provided by a Chief of Medicine who was supported by a personal assistant and an Associate Director. They were supported by five clinical leads, three service managers and 14 other members of staff for example, chief pharmacist and head of therapies.

Staff told us that all of the local and executive management teams were visible and accessible, and the chief executive was in the department almost daily. The team were highly respected, and staff told us they felt supported and listened to.

The nursing team was established with experienced staff that provided clinical and professional leadership by supporting and appraising junior staff. A new, experienced matron had been in post for five months. Staff were positive about the new matron and gave examples of improvements that had been made since their appointment. For example, the process and the location of ambulance handovers had changed which had decreased ambulance turnaround times.

The leadership team appeared well informed and had a cohesive view of what needed to be done. All staff told us clearly about their lines of reporting to the leadership team and told us they felt valued, supported and respected in their roles.

Consultant leadership in the department was committed and consultants demonstrated clinical ownership of the patients in the department.

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

The mental health liaison team had the expertise to lead the mental health service within the department. However, staff were not able to tell us who the lead was on mental health.

Staff told us the executive management team was also very present. This included the chief executive and the chief nurse who were seen almost daily within the department.

There was a universally held view that the executive management team understood and owned the challenges faced by the emergency department and were focused on implementing system-wide change by holding all partners to account. The agreement of the admissions policy, led by an emergency department consultant and the medical director was seen as a key milestone in terms of whole-hospital ownership of emergency department targets. Local leaders told us that “there is good support from the executive team who recognise the importance of the ownership of targets.”
The leadership team had a good knowledge of how services were provided and were quick to address any shortcomings that we identified during the inspection. They accepted full responsibility and ownership of the quality of care and treatment within their department and encouraged their staff to have a similar sense of pride.

In the 2017 staff survey 60% of administration staff agreed strongly to the statement my immediate line manager gives me clear feedback on my work and 32% agreed. This was a slight decrease from the 2016 survey.

**Vision and strategy**

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

We saw the service had a common vision and strategy which was written within a triangle these were displayed throughout the different departments.

The department strategy was demonstrated within a triangle with the patient at the top and right patient, right place, right speciality first time at the bottom of the triangle. This focussed on patients getting the right place for their care with the right specialist first time. Above this in the triangle was the team objectives which fed into the annual priorities then strategic objectives, then trust values which were safety and quality, one team, dignity and respect and compassion and then the trust vision. At the forefront of the objectives, priorities and values was the patient.

The service had a mental health strategy for adults and child and adolescent mental health services which was due to be approved at the clinical governance meeting the week of our inspection. The trust board included a clinical lead responsible for the mental health strategy and developing clear, measurable health outcomes.

**Culture**

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

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

We were told about SASH+, an initiative to develop a culture of continuous improvement. The trust was just one of just five NHS trusts in England to work with healthcare experts at Virginia Mason in Seattle, USA for a period of five years. During the five-years, which began three years before this inspection, the trusts staff were supported to develop a culture of continuous improvement based on lean principles. The SASH+ culture of continuous improvement always put the patient first.

Staff told us they were encouraged to suggest improvement ideas and given the time to take these forward.

Staff in different roles told us they enjoyed working in the emergency department and clinical decision unit. They felt well supported, valued and respected by peers and managers. Teamwork, peer support and camaraderie were cited by many staff as the reasons they enjoyed coming to work.

Staff told us there was respect for seniority and the chain of command, but they saw each other and treated each other as equals and there was a flat hierarchy. Staff told us, and we observed that only first names were used when communicating with each other.
We observed interactions between staff that were cooperative, supportive and appreciative. They worked collaboratively and shared responsibility where necessary.

Patients attending the department with a mental health illness were treated exactly the same as patients attending with physical health needs. The clinicians and leadership team promoted a culture of parity of care between patients who attended with either mental health or physical health needs.

The patient records we reviewed showed that consideration was given to their mental health and emotional wellbeing in day to day activity.

Staff felt supported in their work and there were opportunities to develop their skills and competencies, which were encouraged by leaders and practice educators. Staff also felt that they could raise ideas that could be potential solutions to the departments issues and they would be taken seriously, and their ideas considered by the leadership team. For example, the introduction of the cuppa soups for patients in the winter.

Staff we spoke to were not aware of who the Freedom to Speak Up Guardian was but had an understanding of their role and how to contact them if required.

**Governance**

The department used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

Governance and performance management arrangements were proactively reviewed and reflected best practice. They were discussed at bi-monthly governance and ‘hot topic’ meetings and was used to demonstrate effectiveness and progress. Issues discussed included new clinical guidelines, the results of incident investigations, complaints and updates to the risk register. ‘Hot topic’ meetings reviewed mortality and morbidity and were well-established.

The wider division of medicine reviewed complaints, incidents, the risk register, performance and identified learning fortnightly within the department led by the Chief of medicine. This ensured clinical leaders had an understanding of the risks and challenges the emergency department faced. The information reviewed was on one sheet of paper which was displayed in the department so that staff could read the information.

**Management of risk, issues and performance**

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

The service undertook de-briefing sessions with staff if they had been involved in a traumatic or difficult case. A hot de-brief was undertaken at the time, another in a week’s time and a further one in three months’ time. The de-briefs were multi-agency and multidisciplinary. Anyone who was involved were invited to the de-brief including ambulance and administrative staff. Staff we spoke to were positive about the de-briefs.

A live major incident event had taken place with the emergency department on 19 September 2018 which involved more than 30 patients. The trust’s major incident policy was due to be reviewed so the service thought it was a good opportunity to do an exercise before, so any changes could be incorporated. In addition, senior nursing roles had recently changed to a nurse in charge and a co-ordinator, so it was a good opportunity to test the new roles. Staff were very positive about the exercise and identified learning. For example, the declaration of the major incident was not communicated to the nurse in charge and there were not any portable radios to
allow staff to communicate quickly with each other. The major incident plan provided clinical guidance and support to staff on treating patients of all age groups and included information on the triaging and management of patients suffering a range of injuries. These included injuries caused by burns, blasts or chemical contamination.

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

Newsletters were produced each month, sent to all staff by email and displayed in the emergency department which included information on learning from incidents and complaints.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. There was real time information available to show departmental activity and operational performance and there was a daily review of metrics and breach analysis by the senior management team in order to drive improvements.

The service had access to and used telemedicine to determine if specialist input at a different hospital was required. For example, photographs of burn injuries were securely sent to the regional burns unit for review to determine if their input was required.

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

Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

The leadership team had engaged with its staff on a “our winter your department” campaign. This gave staff the opportunity to suggest ideas which would provide additional support in the winter months for their patients. For example, the department were introducing cuppa soups for patients whilst in the department to help keep them warm and hydrated.

In the 2017 staff survey 21% of nursing staff in the majors area responded that they strongly agreed that they would recommend their organisation as a place to work and 58% agreed. This was similar to the 2016 survey.

In the 2017 staff survey 50% of medical staff responded that they strongly agreed that they would recommend their organisation as a place to work and 41% agreed. This was a slight decrease from the 2016 staff survey.

There was a focus on education and developing the staff. There were clear development and career progression pathways for all grades of staff. Staff told us that they felt invested in and appreciated.

The trust held yearly SASH Star Awards which publicly acknowledged and celebrated an individual or team’s exceptional contribution to the trust’s on-going success. The awards were aligned to reflect the trust’s core values: Dignity and Respect; Compassion; Safety and Quality
and One Team. Awards were offered in 11 categories and shortlisted individuals and teams were invited to the ceremony with their nominees to celebrate their achievement.

Staff counselling was available and the number to contact for support was visible in the department.

@SASHCharity Surrey and Surrey Hospitals Charity was a local hospital charity supporting East Surrey Hospital and the care and services provided by @sashnhs. Staff and members of the local community supported SASH Charity by donating, fundraising or volunteering, which benefits from the care at the hospital and the local community. For example, @SASHCharity and other local charities had raised funds to build a dementia friendly garden at the hospital for patients living with dementia.

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

The trust was using the internet-based Care Opinion company to listen to what patients, service users and carers were saying. Care Opinion work with health and care providers, commissioners, health boards, regulators, professional bodies, educators, researchers and patient groups. Comments on the website about the hospital included “From coming through A&E and then being transferred to the ward, I can honestly say this hospital stood out from others. It is very clean, efficient and professional. Staffed by wonderful, caring people, to whom nothing was too much trouble.”

We reviewed comments on the National Health Service choices website regarding the hospital, the hospital was rated as four and a half stars out of five by service users. Comments from the website included “The A&E department was spotless as was the Surgery Centre where he went after his operation. The staff were absolutely amazing. Every single one of them.”

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

Learning, continuous improvement and innovation

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

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

There were a number of quality improvement projects which were underway in the emergency department. Staff identified there was a high haemolysis rate of blood samples. This resulted in a delay as the blood sample had to be taken from the patient again. Haemolysis of blood samples occurs when the red blood cells get damaged and therefore the results of the blood tests are inaccurate and need to be repeated. The service researched the best way to prevent haemolysis. For example, by mixing the blood tubes with anticoagulant additives gently first or taking an extra sample first and discarding it. Prior to making the changes in the process there was a haemolysis rate of just under 21% which had now reduced to just under 2% (the national average is 8%).
The department was currently working on additional sepsis training for nurses. This would allow nurses to assess patients who were identified as having sepsis and to administer antibiotics under a patient group direction.
Acute services

Medical care (including older people’s care)

East Surrey Hospital is part of Surrey and Sussex Healthcare NHS Trust (SASH). The trust is a provider of acute hospital services in West Sussex and East Surrey, offering care to a local population of 535,000 and people from further afield due to the proximity of Gatwick airport, the M25 and M23 motorways.

SASH was formed in 1998, when East Surrey Hospital and Crawley Hospital merged to become Surrey and Sussex Healthcare NHS Trust. The trust delivers outpatient, diagnostic and planned care from Caterham Dene Hospital, the Earlswood Centre, and Oxted Health Centre in Surrey and at Crawley and Horsham Hospitals in West Sussex.

Since our last inspection in 2014, the trust had increased capacity at East Surrey from 650 to 697 beds, with another ward under construction at the time of our visit. It has ten operating theatres, along with four more theatres at Crawley Hospital and a day surgery unit. The hospital’s trauma unit works in partnership with major trauma centres in south London and Brighton. The trust is a major local employer, with a workforce of over 4,200 staff. The trust is also an associated university hospital of a Sussex university and supervises final year medical students.

At our last inspection, medical care services and the hospital overall was rated as ‘good.’

Facts and data about this service

The medical division at SASH is one of four clinical divisions at East Surrey Hospital and manages 382 medical inpatient beds in 18 wards. The division offers acute assessment and inpatient services including elderly medicine, respiratory medicine, stroke care, cardiology, general medicine, endocrinology, and diabetes. The division also delivers specialty medicine services in dermatology, rheumatology, and neurology. The hospital has a cardiac investigations department, chemotherapy day unit and haematology team. Other facilities include the Tandridge ward, where care and support is available to patients medically ready for discharge and a discharge unit where patients who have been discharged from hospital can collect take-home medications and await transport or family.

The medical division is also responsible for urgent and emergency care services. Please see this section for our inspection report about these services.

(Source: Routine Provider Information Request (RPIR) – Sites and acute context tab)

The trust had 34,092 medical admissions from June 2017 to May 2018. Emergency admissions accounted for 19,657 (58%). A further 734 (2%) were elective, and the remaining 13,701 (40%) were day case.

Admissions for the top three medical specialties were:
General Medicine, 16,598 admissions
Gastroenterology, 9,008 admissions
Respiratory medicine, 2,059 admissions

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse and avoidable harm. Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory harm.

Overall, we found clearly defined and embedded systems, reliable processes, and standard operating procedures to keep people safe and safeguarded from abuse, using local safeguarding procedures whenever necessary. These were reviewed regularly and improved when needed. Safeguarding was well understood by all staff and implemented consistently across the division.

Policies reflected national, professional guidance and legislation and were proper for the care setting and addressed people’s diverse needs.

Mandatory training

Divisional staff received up-to-date training in all safety systems, processes, and practices. Training was delivered through a mix of face to face sessions and e-learning, which could be accessed on any computer connected to the internet. This meant training could be completed at convenient times during or after work and at home. Staff liked the flexibility of this system and said it made it easier to keep up to date with training.

Overall, staff told us they received enough training to ensure they had the right skills to do their jobs. Staff said they had ‘protected time’ to allow them to complete training and attend courses. Staff received training to help make them aware of the potential needs of people with mental health conditions, learning disability and dementia.

The trust employed practice educators on wards to help improve compliance with clinical and mandatory training. All the staff we spoke with said they had completed their annual updates. We saw examples of colour-coded charts showing individual training status. These were on display in staff rooms or ward offices, and where individuals were showing as ‘red,’ managers gave clear accounts of the reason, such as long-term sickness or parental leave. In other cases, we saw that the dates were shown of the next booking.

Mandatory training completion rates

The trust set a target of 80% for completion of mandatory training. Based on figures provided by the trust, training compliance rates for certain topics were lower than target (see below).
## Trust level

A breakdown of compliance for mandatory training courses as of May 2018 at trust level for qualified nursing staff in medicine is shown below:

Please note the training modules have been merged to give overall figures for each module as the raw data included multiple entries of the same modules with training renewal dates.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control - Level 2 - 1 Year</td>
<td>137</td>
<td>239</td>
<td>57%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Local Data Security Awareness - 1 Year</td>
<td>158</td>
<td>239</td>
<td>66%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>NHS Conflict Resolution (England) - 3 Years</td>
<td>160</td>
<td>240</td>
<td>67%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety - 2 Years</td>
<td>169</td>
<td>239</td>
<td>71%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling - Level 2 - 2 Years</td>
<td>190</td>
<td>241</td>
<td>79%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Health, Safety and Welfare - 3 Years</td>
<td>190</td>
<td>239</td>
<td>79%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and</td>
<td>195</td>
<td>239</td>
<td>82%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Human Rights - 3 Years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>8</td>
<td>8</td>
<td>100%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Basic Life Support - MaST</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Basic Life Support (Adults &amp; Paeds) Level 2</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>In Hospital Basic Life Support (Adults &amp; Paeds)</td>
<td>24</td>
<td>24</td>
<td>100%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>In Hospital Resuscitation (including BLS)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td><strong>rationalise and training</strong></td>
<td>rationalise the training</td>
<td>rationalise the training</td>
<td>rationalise the training</td>
<td>rationalise the training</td>
<td></td>
</tr>
<tr>
<td>Medicine Management - Clinical New Staff</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Medicine Management - Clinical Update</td>
<td>41</td>
<td>41</td>
<td>100%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Medicine Management - MaST</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Clinical Update</td>
<td>8</td>
<td>8</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>-----</td>
<td>-----</td>
<td>------</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Medicine Management - New Staff</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine Management - Update</td>
<td>28</td>
<td>28</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine Management Core Update</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - Basic Life Support</td>
<td>13</td>
<td>13</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - Basic Life Support (Adults &amp; Paeds) Level 2</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital BLS (Adults &amp; Paeds) - BLS/ILS</td>
<td>37</td>
<td>37</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital BLS (Adults &amp; Paeds)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
In medicine the 80% target was not met for six of the mandatory training modules for which qualified nursing staff were eligible. Infection prevention and control – level 2 was the module with the lowest compliance of 57%.

A breakdown of compliance for mandatory training courses as of May 2018 at trust level for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling - Level 1 - 3 Years</td>
<td>2</td>
<td>23</td>
<td>9%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>NHS Conflict Resolution (England) - 3 Years</td>
<td>5</td>
<td>24</td>
<td>21%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control - Level 2 - 1 Year</td>
<td>11</td>
<td>23</td>
<td>48%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Health, Safety and Welfare - 3 Years</td>
<td>12</td>
<td>23</td>
<td>52%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Training Module</td>
<td>Participants</td>
<td>Compliance %</td>
<td>Target</td>
<td>Meeting Target</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>--------------</td>
<td>--------------</td>
<td>--------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>13</td>
<td>23</td>
<td>57%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Fire Safety - 2 Years</td>
<td>13</td>
<td>22</td>
<td>59%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Local Data Security Awareness - 1 Year</td>
<td>14</td>
<td>23</td>
<td>61%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Medicines Management - MaST Update Dr's</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Medicines Management - Drs Update</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Resus - Basic Life Support - Dr's Update</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Resus - Basic Life Support (BLS Adults &amp; Paeds) Dr's Update</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Resus - In Hospital BLS (Adults &amp; Paeds) BLS/e-ALS</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

In medicine the 80% target was not met for seven of the mandatory training modules for which medical staff were eligible. Moving and handling level 1 was the module with the lowest compliance of 9%.

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

Ward managers acknowledged that rates in some topics were lower than target, but showed us up-dated records. They described how action undertaken to improve compliance included monthly performance measurement, transparency about achievements and staff recognition awards.

Managers stated that a ‘three-year cycle’ of statutory and mandatory training was being introduced to help rationalise and improve training compliance.

We saw that mandatory training completion rates had improved since these figures were supplied and the clinical areas we visited had achieved trust targets.

**Safeguarding**

Safeguarding adults, children and young people at risk was always given priority. Staff took a proactive approach to safeguarding and focused on early identification. They took steps to prevent abuse or discrimination that might cause avoidable harm, responded appropriately to any signs or allegations of abuse and worked effectively with others, including people using the service, to agree and implement protection plans.

Female genital mutilation and sex exploitation awareness was incorporated into safeguarding training which was delivered as part of the statutory and mandatory training programme as well as induction courses for new staff. There were also arrangements to safeguard children at risk of radicalisation. The trust safeguarding training policy included these issues and there were screening tools and referral pathways specifically for these concerns.
We spoke with patients and relatives who said they felt safe on the ward and were always treated respectfully by staff. Staff described how they identified a safeguarding concern and the processes used to report a concern or incident. We saw examples of safeguarding referrals and we noted the investigation reports included learning points following investigation.

Staff knew who the safeguarding lead was to obtain support and advice. This indicated that staff identified the risks of abuse and were actively reporting it through correct channels. Managers explained that there was a Child Protection Information Sharing system which authorised staff could access.

**Safeguarding training completion rates**

The trust set a target of 80% for completion of safeguarding training.

**Trust level**

A breakdown of compliance for safeguarding training courses as of May 2018 at trust level for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Numbe of staff trained (YTD)</th>
<th>Numbe of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children - Level 3 - 3 Years</td>
<td>12</td>
<td>12</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults - Level 2 - 3 Years</td>
<td>195</td>
<td>239</td>
<td>82%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children - Level 2 - 3 Years</td>
<td>53</td>
<td>74</td>
<td>72%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

Qualified nursing staff in medicine met the 80% target for two of the three safeguarding training modules for which they were eligible.

A breakdown of compliance for safeguarding training courses as of May 2018 at trust level for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults - Level 2 - 3 Years</td>
<td>13</td>
<td>23</td>
<td>57%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children - Level 2 - 3 Years</td>
<td>14</td>
<td>22</td>
<td>64%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>
Medical staff in medicine did not meet the 80% target for either of the two safeguarding training modules.

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

On the wards we visited, we saw that training compliance rates had improved since these figures were provided and now met or exceeded the trust target.

**Cleanliness, infection control and hygiene**

The division controlled infection risks very well. Staff kept themselves; equipment and their premises clean, tidy, and free from clutter. Divisional staff followed the national specifications for cleanliness in the NHS, which is a framework for setting and measuring performance outcomes.

Without exception, the clinical and public areas we viewed were maintained to an excellent standard. Storage, beverage, and utility spaces, including cleaner’s cupboards, were also of a commendable standard. We saw examples of ‘visual standards’ displayed in these areas and staff adhered to these standards, which resulted in consistently high levels of presentation and organisation.

We visited eleven wards or department across the site and saw that beds, trolleys and medical equipment were clean and stored correctly. In therapy rooms, sluices and clinical equipment stores, use was made of green-coloured ‘I am clean’ stickers. These showed the date and time the article was cleaned along with the name of the person who cleaned it. We saw these details had been completed in all cases, which meant staff could quickly find items that were ready for use.

The 2017 patient-led assessment of the care environment survey supported our observations. This showed the trust scored 99.9%, for cleanliness, which was better than the England average of 98%.

Daily housekeeping support was provided to each area by an in-house team. Staff told us they were permanently allocated to a ward and we saw housekeepers working in their respective areas throughout the day. Ward staff knew the names of the housekeepers responsible for cleaning their unit and were embedded as part of the trust’s ‘one team’ values. Housekeepers had routine cleaning schedules to follow and kept account of their progress by completing regular cleaning audits and quality monitoring. We saw records of these on cleaning trolleys and we noted staff changing the colour-coded mops and cloths to suit the cleaning task.

The hospital had up to date infection prevention and control policies readily available for staff to access on the trust intranet. Staff we spoke to were aware of these policies and knew how to find them.

Inpatients were screened for MRSA and MSSA in compliance with infection control policy. MRSA is a type of bacterial infection which is resistant to many antibiotics and is capable of causing harm to patients. A care plan was implemented if a positive result was obtained and we saw examples documented in the patient plans we reviewed.
There were adequate numbers of side rooms to allow any patient who presented an infection risk to others to be isolated. We saw that these rooms were identified using a system of signs that helped inform visitors and staff about any special precautions needed.

All staff we observed during the inspection were ‘bare below the elbows’ and dressed in line with trust policy. We saw ample supplies of personal protective equipment such as aprons and gloves in dispensers on walls and we saw these items being used. Gloves were readily available in wall mounted storage bins. We saw the full range of glove sizes stocked. This meant staff had convenient access to correctly fitting gloves, which help reduce the chance of accidental tearing.

Fluid spillage kits were also readily available and staff knew how to use them. Sharps boxes were managed in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 (the Sharps Regulations). Marked and secure containers were placed close to the areas where medical sharps were used. Instructions for staff on the safe disposal of sharps were displayed in clinical areas and sluice rooms. We also saw clear guidance for staff on the action to take in case of a needle stick injury. These posters were displayed in treatment rooms.

We saw disposable privacy curtains in use throughout the division which were marked with dates last changed. All had been changed within the last three months, in accordance with trust policy. This complied with Hospital Building Note 00-09: ‘infection control in the built environment’ and indicated that staff routinely changed curtains to help reduce the chances of germs passing from one person or object to another.

The trust’s hand decontamination policy was up to date and described when staff should wash their hands. We saw staff following the policy and adhering to the NHS national patient safety agency’s “clean your hands campaign,” which is based on the World Health Organisation’s “Five moments for hand hygiene.” Antimicrobial hand-rub dispensers were mounted on the walls at strategic points throughout the hospital as well as outside each room or bay. These all had gel and we saw all levels of staff using the product as they moved around the hospital.

In addition to posters and reminder cards distributed among the wards, we saw electronic audio-visual displays reminding visitors about good hand hygiene sited at main entrances. We also saw posters designed to remind relatives not to visit loved ones if they had coughs or colds themselves.

Patients, visitors and staff had current infection control information available. Each of the wards or units we inspected displayed their infection prevention and control audit results.

The trust had systems to support the management of infection prevention and control. These included the use of ward ‘champions’ and infection prevention team with qualified infection control nurses. The team worked across all hospital departments coordinating with other health-care professionals, patients, and visitors to prevent and control infections. The infection control teams’ responsibilities included giving advice, giving education, and training, monitoring infection rates and auditing infection prevention and control practice.

We saw one refuse room in the acute medical unit (AMU) that had litter on the floor between wheelie bins. This was at once rectified when we spoke to staff. In three other areas we noticed latex gloves in the domestic waste. Some of these bins did not have caution labels and in one
case, a newer member of the ward catering team was unclear about use of gloves. To the credit of the staff involved, we saw an open acknowledgement, rapid correction, and a willingness to ‘own the problem and solution’ at all levels of the division in response. We saw that our observation was consistent with a waste segregation audit conducted after our visit, which noted that staff required refresher training. The same audit showed that waste bins were now labelled.

**Environment and equipment**

The hospital had suitable premises and equipment and looked after them well. The trust had invested in new facilities since our last inspection and patients were now benefitting from a high standard of decor, fixtures, and fittings. All areas we saw supported the safe delivery of care. Rooms were well-equipped, airconditioned when appropriate and had enough furnishings for their intended purpose. Corridors, treatment rooms and toilets were spacious with doors wide enough to fit wheelchairs.

Car parking was readily available for staff and visitors. Entryways to the hospital were clearly marked. Main entrances had covered ‘drop off’ bays and dropped kerbs to aid wheelchair users or those with limited mobility reach the building while still being sheltered from the elements. All main doors were automated, again aiding people living with less mobility.

The wards and public areas we visited were kept in excellent decorative order. Dementia-friendly contrast colour schemes were used throughout and the overall standard of signage and information points were among the best we have seen in the region.

There was access to emergency equipment in clinical areas, including portable oxygen, suction and automated defibrillators stored on purpose-built trolleys. These were stocked and checked daily in accordance with guide sheets attached to each trolley, which were collected by resuscitation training staff and audited. All bays and rooms we visited had piped oxygen and suction which functioned correctly.

Storage areas we checked appeared visibly clean and well-organised, with plentiful shelving. Beds, furniture and electrical equipment were labelled with asset numbers and labels showing service dates. Staff told us that the medical equipment was well maintained centrally by the in-house engineering service and sufficient items were available for use.

Non-public areas of the wards (including clearing and clinical storerooms) were secured with keypad locks to control access, as were medicine cupboards, emergency and medication trolleys, notes trolleys and cleaners’ trolleys.

Staff could show us where information relating to substances subject to Control of Substances Hazardous to Health (CoSSH) regulations was kept. Staff confirmed they had received CoSSH training.

Fire safety equipment was available throughout the hospital and we saw fire equipment safety checks had been completed by an external specialist contractor.
Our observations were consistent with the results of the 2017 patient-led assessment of the care environment survey showed the trust scored 95%, for condition, appearance, and maintenance, which was better than the England average of 94%.

Assessing and responding to patient risk

Overall, we found that staffing levels were sufficient to keep people safe. Staff shortages were responded to quickly and adequately. There were effective handovers and shift changes to help ensure that staff managed risks to people who used the service. Staff recognised and responded appropriately to changes in the risks to people who used the service. Risks to safety from changes or developments to services were assessed, planned for and managed effectively.

We noted excellent examples of management and screening tools in use. Two revised nursing care documents had been introduced in August: the ‘Patient admission/discharge assessment and daily evaluation’ booklet and the ‘Patient bedside safety booklet risk assessments and care plans.’

Both booklets were printed using colour to emphasise safety points and were wire bound for daily use and easy inclusion into the patient record. The latter document contained a series of risk assessments using nationally recognised tools.

We checked eight sets of bed charts and notes and found these had been completed legibly and accurately. We saw that nursing and therapy staff escalated any concerns about deteriorating health and those decisions about changes to care or treatment plans were made by staff that were competent to do so.

We noted in the clinical files that in all cases a consultant assessed patients within 12 hours of admission. This service had on-site access to level two and three critical care (high dependency and intensive care) units for patients if required.

Senior clinical staff told us that there were two daily nursing handovers and six multidisciplinary meetings a week where each patient was risk assessed. We saw two multidisciplinary meetings and saw effective risk-based discussions and decisions that supported what we had been told.

The trust used a national early warning system track and trigger flowchart. It is based on a simple scoring system in which a score is given to physiological measurements (for example blood pressure and pulse). The scoring system enabled staff to show patients who were becoming increasingly unwell and provide them with increased support. In the notes we reviewed we found that the national early warning system scores had been calculated consistently and accurately. Nursing and therapy staff escalated any concerns about deteriorating health and those decisions about changes to care or treatment plans were made by competent staff.

We saw systems to help with the early identification and management of sepsis. The sepsis screening tool was based on Sepsis Six. The Sepsis Six is the name given to a bundle of medical therapies designed to reduce deaths and serious illness associated with sepsis. There was nominated medical and nursing Sepsis Clinical Leads. They led on sepsis education, promotion of early diagnosis with the screening tool and rapid treatment. Nursing staff told us they
had good support from the doctors and the outreach support team whenever a patient’s deterioration was observed.

The division had developed a ‘Patient well-being standards’ check form to prompt and record the results of nursing ‘rounds,’ which were completed by a designated nurse (usually the team lead) two-hourly. We saw these documents in use and managers explained they helped provide ‘one glance’ assurance that patients were individually assessed for pain, nutrition and risk of deterioration.

**Nurse staffing**

While the trust acknowledged significant challenges in this area, the medical division had enough staff with the right qualifications, skills, training, and experience to keep people safe from avoidable harm and abuse and to give the right care and treatment.

The division used an e-rostering system to manage nursing staffing in clinical areas. Managers explained that a new module had been purchased that provided a ‘live’ snapshot of staffing showing patient numbers combined with the complexity of their illness and care needs. Staffing needs were reviewed three times a day as part of ‘site meetings’ and the system checked whenever the unit matron visited their wards or departments.

At ward level, staffing was reviewed at ‘safety huddles’ and the ward lead or manager could call on assistance from the temporary staffing bureau as well as the critical care outreach team when faced with a deteriorating patient. The service was making use of a range of extended roles for qualified staff, which included advanced care practitioners, associate practitioners, nurse associates, physician’s assistant and nurse practitioners.

The overall vacancy factor for nursing in the division was 20.3%, with the care of the elderly wards reporting the highest vacancy rates. Risk assessments and escalation protocols meant that staff were clear when one to one care was required as well as registered mental Nurse (RMN) agency support. Planned versus actual safer staffing data and care hours per patient day (CHPPD) was reported to the board monthly and staffing requirements were formally reviewed twice a year. Staff gave us examples of when establishments were increased as a result of this level of governance.

During our inspection, we saw that the number of people on duty closely matched the staffing templates used and this information was displayed on performance boards at ward entrances and staff notice boards.

The lack of registered nurses was a concern raised by staff and managers and was included on the divisional and corporate risk registers. The trust had acted to address the shortfall by encouraging and supporting those wishing to undertake nursing studies and recruiting overseas nurses. Overseas nurses were supported while they undertook English language tests and objective structured clinical examinations to enable them to register with the UK Nursing and Midwifery Council. These nurses were actively supported through employment as healthcare assistants and the provision of subsidised accommodation.
We saw arrangements for nursing staff to hand over the care of patients between shifts and noted the widespread use of printed handover sheets. These had relevant information on the specific needs and risks of patients that supported the delivery of safe care.

**Planned vs. Actual**

The trust reported the following qualified nursing staff numbers as of December 2017 and May 2018 for medicine:

<table>
<thead>
<tr>
<th>Location</th>
<th>December 2017</th>
<th>May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned WTE staff</td>
<td>Actual WTE staff</td>
</tr>
<tr>
<td>Trust level</td>
<td>340.0</td>
<td>211.6</td>
</tr>
</tbody>
</table>

The staff fill rate in May 2018 stayed the same as the fill rate in December 2017. We saw data showing planned versus actual (safer staffing report, October 2018) that showed nursing staffing in the medical division ranged from 94% (Chaldon ward) to 99% (Discharge lounge). This indicated that the trust delivered staff levels close to planned.

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

**Vacancy rates**

From June 2017 to May 2018, the trust reported a vacancy rate of 36.9% for qualified nursing staff in medicine. This was higher than the trust target of 12%.

- East Surrey hospital: 37.5%
- Crawley hospital: 2.0%

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

**Turnover rates**

From June 2017 to May 2018, the trust reported a turnover rate of 19.8% for qualified nursing staff in medicine. This was higher than the trust target of 12%.

- East Surrey hospital: 20.5%
- Crawley hospital: 0.0%

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

From June 2017 to May 2018, the trust reported a sickness rate of 3.0% for qualified nursing staff in medicine. This was in line with the trust target of 3%.

- East Surrey hospital: 3.1%
- Crawley hospital: 1.8%

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

Bank and agency staff usage

The trust operated a ‘bank’ service and also called in nursing and therapy staff from trust-approved agencies. According to data provided by the trust, 3221 shifts were covered by bank or agency staff in the last year.

We requested a further breakdown of figures but the trust was unable to provide these. Managers explained that they had a system where managers locally cover temporary gaps with substantive staff moving to a system where all shifts are reported to the temporary staffing bank as soon as they become available, even if internal cover can be sourced.

We saw that the staff bank was preferred over external agency use, as permanent staff taking on extra shifts were familiar with work processes and environments. Where agency staff were used, we were told that shifts were block-booked whenever possible. This meant the agency nurse worked a pattern of shifts on the same ward or unit, which helped ensure they were familiar with the work.

Agency nursing and therapy staff had orientation checks completed by a senior staff colleague on their first shift and we saw completed examples, with the exception of a locum therapist.

Medical staffing

Managers and senior clinicians were satisfied with medical staffing levels and successes in recruiting medical staff. We found that numbers of doctors at the right grades were suitable to meet the needs of patients.

Newly admitted patients received consultant review within NHS guidelines (NHSE Seven Day Services Clinical Standards, September 2017) and we saw ward rounds taking place. Consultants worked ‘blocks’ of multiple shifts which helped maximise the continuity of care for patients.

A consultant on-call system was operated by the hospital switchboard. This involved the use of pagers and mobile phones supplied by the trust. We saw evidence of ‘on call’ rotas for medical specialties and medical staff we spoke to told us they could access advice from a consultant at any time (including weekends) and felt well-supported.

The trust provided data showing that 100% of doctors were ATLS qualified and over 70% trained in APL or ALS skills.
Planned vs. Actual

The trust reported the following medical staffing numbers as of December 2017 and May 2018 for medicine:

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<tr>
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<th>May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned WTE staff</td>
<td>Actual WTE staff</td>
</tr>
<tr>
<td>Trust level</td>
<td>121.0</td>
<td>122.0</td>
</tr>
</tbody>
</table>

Staff fill rates for medical staff in medicine have been over 100% in both December 2017 and May 2018 due to more WTE staff in post than planned for.

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

Vacancy rates

From June 2017 to May 2018, the trust reported a vacancy rate of -3.0% for medical staff in medicine. This was lower than the trust target of 12% and the negative vacancy rate is due to an over establishment of medical staff.

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

Turnover rates

From June 2017 to May 2018, the trust reported a turnover rate of 31.8% for medical staff in medicine. This was higher than the trust target of 12%.

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

Sickness rates

From June 2017 to May 2018, the trust reported a sickness rate of 0.7% for medical staff in medicine. This was lower than the trust target of 3%.

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

Staffing skill mix

In May 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was slightly lower than average, with a greater proportion of staff coming from the registrar group.
Staffing skill mix for the 167 whole-time equivalent staff working in medicine at Surrey and Sussex Healthcare NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>37%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>8%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>38%</td>
<td>28%</td>
</tr>
<tr>
<td>Junior*</td>
<td>18%</td>
<td>22%</td>
</tr>
</tbody>
</table>

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

(Source: NHS Digital - Workforce statistics)

Records

Overall, staff maintained records of patients’ care and treatment in a way that kept people safe. The trust was in transition to a ‘paper light’ scheme so the records we inspected were a mixture of paper and electronic records. Managers we spoke to were aware of the risks and had acted to minimise these through team briefings and ‘safety huddles.’ Staff we spoke with were positive about the changes being implemented.

We found that the records were clear, up-to-date, and available to each speciality of staff providing care. In the notes we reviewed we saw a good standard of record keeping. The records held all required information such as admission details, signature list and consent to treatment. The care records included multidisciplinary input where needed for example, entries made by physiotherapist, occupational and mental health practitioner. Progress notes were complete, clear, legible, dated and signed.

Patients’ records were readily accessible to those who needed them and we found they were stored securely in locked notes trolleys.

The assessment tools within patient records reflected best practice. Patients conditions were reviewed, and treatment plans were followed.

Records were archived on site, which meant records could be retrieved promptly. The trust used an in-house patient records service and hospital transport team to facilitate this service. Staff told us the records arrived quickly.
Medicines

We checked two wards in detail and overall, found that staff prescribed, gave, recorded, and stored medicines well. Patients received the right medication at the right dose at the right time. The trust had current medicines management policies, together with protocols for high-risk procedures involving medicines such as the intravenous administration of antibiotics. These were readily available for staff to access.

Prescribers also had access to relevant resources on medicines management, including electronic copies of the trust formulary and standard references such as the British National Formulary (BNF). We also saw printed copies of the current edition at ward stations.

Medicines were stored securely behind locked doors with access restricted to appropriate staff. Controlled drugs (medicines that need extra checks and special storage arrangements because of their potential for misuse) were stored securely and managed appropriately, with stock balances in all areas checked daily.

Clinical rooms used to store were airconditioned and had automated temperature control systems monitored centrally. Fridge temperatures were monitored daily to ensure medicines were stored within a specified temperature range. We saw records showing these checks were made.

Suitable emergency medicines were available on the resuscitation trolleys which were secure, sealed and checked regularly.

There was good clinical pharmacy support with a regular ward based pharmacist and technician available who were well embedded into the team.

Arrangements for the supply of medicines were good. There were effective arrangements for medicines supplies and advice out of hours. The ward had pre-packs of frequently used medicines available to reduce the delays in discharge. A pharmacy technician topped up stores of medicines and intravenous fluids in the department daily. Staff did not report any problems with the supply of medicines.

Staff told us that the pharmacy team were a valuable resource in identifying issues with medicines and encouraging improvement. There was good clinical input by the pharmacy team, providing advice to staff and patients, and making clinical interventions with medicines to improve patient safety. A clinical pharmacy service was available seven days a week which meant medicines reconciliation was completed within 24 hours of a patient being admitted.

The provider carried out a range of medicines related audits to assess how they were performing, and to identify areas for improvement. These included audits of controlled drugs, missed doses, medicines reconciliation, and safe and secure handling of medicines.

Arrangements were in place to ensure that medicines incidents were reported, recorded and investigated and staff we spoke with knew how to report incidents involving medicines.
Incidents

The service managed patient safety incidents well. Staff recognised what constitute an incident and reported them. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff reported incidents using a commercial software package linked to the trust intranet. People we spoke to confirmed they had received training and felt confident about using the system.

We reviewed two recent investigation reports and saw evidence of learning from that was shared across the trust through email alerts, announcements on the trust intranet and at local level during team and divisional meetings.

Duty of Candour

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Staff had a good knowledge about duty of candour and managers were clear about their responsibilities. We saw examples of when the regulation had been applied and we noted that the software would not allow a serious incident to be closed until the duty of candour section of the file was completed.

This facility gave the trust extra assurance that duty of candour was being followed by managers dealing with the incident report.

Never Events

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

From July 2017 to August 2018, the trust reported no incidents classified as never events for medicine.

(Source: NHS Improvement - STEIS)

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 16 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from July 2017 to August 2018.

A breakdown of these incidents by type is shown below:

- 12 slips/trips/falls meeting SI criteria
• Two treatment delays meeting SI criteria
• One sub-optimal care of the deteriorating patient meeting SI criteria
• One diagnostic incident including delay meeting SI criteria (including failure to act on test results)

(Source: NHS Improvement - STEIS)

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection took place one day each month and was then submitted within 10 days. Data from the Patient Safety Thermometer showed that the trust reported 38 new pressure ulcers, four falls with harm and seven new catheter urinary tract infections from November 2016 to November 2017 for medical services.

We observed safety performance charts displayed in staff meeting rooms and ward entrances. These showed current ‘safety thermometer’ information about key indicators such as falls and staffing levels. The charts helped staff and visitors understand what the trust was monitoring and how each ward or department was performing against the targets set by the trust.

Data from the Patient Safety Thermometer showed that the trust reported 16 new pressure ulcers, nine falls with harm and 21 new urinary tract infections in patients with a catheter from July 2017 to July 2018 for medical services.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Surrey and Sussex Healthcare NHS Trust

1. Total Pressure ulcers (16)

2. Total Falls

3. Total CUTIs (21)

1. Pressure ulcers levels 2, 3 and 4
2. Falls with harm levels 3 to 6
3. Catheter acquired urinary tract infection level 3 only

(Source: Safety thermometer - Safety Thermometer)
Is the service effective?

Evidence-based care and treatment

The division provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. New and updated guidance was evaluated and shared with staff.

We saw that staff were able to access national and local guidelines through the trust’s intranet. There were enough computer terminals provided on the wards we visited and we saw staff using the resources. We saw examples of guidance they had access to, such as the National Institute for Health Care Excellence (NICE), Royal Colleges guidelines, UK Resuscitation Council and British Dietetic Association.

The standardised care pathways were based on current best practice and National Institute for Health and Care Excellence guidance. For example, the acute stroke pathway incorporated NICE guidance and the service itself was working toward the international dysphagia diet standardisation initiative (IDDSI).

The trust routinely reviewed the effectiveness of care and treatment by using performance dashboards, local and national audits. We saw minutes from various departmental and directorate-wide meetings that showed that where audit results had been documented, these were discussed and plans developed to address any issues.

Nutrition and hydration

The trust used nationally recognised tools to assess patients’ nutrition and hydration. We reviewed patient bedside safety booklets and saw that nutritional assessments were up to date.

Staff told us that additional support from the dietitian service was available when needed. Some of the fluid balance charts we reviewed were incomplete. This meant it was not always possible to assess if the patient had received adequate fluid intake or output.

Staff explained that dieticians monitored patients who received nutrition through a nasogastric or parenteral feeding tube. Parenteral feeding is the process by which a patient receives nutrients intravenously bypassing the usual process of eating and digestion.

Staff and patients had access to dietitians who were accessible during office hours. After this, there was a telephone service for advice. Dietitians contributed to patient care plans and recorded instructions for other members of the multi-disciplinary team. Staff told us that dietitians and speech and language therapists (SALT) supported them to look after patient’s nutritional needs.

Staff offered patients three main meals and high calorie snack boxes were available if needed. There was a choice of food and the hospital was able to cater for cultural, religious, and therapeutic diets. The trust used a clear system of alert signs to represent food or fluid restrictions as well as special dietary needs. These were displayed on the wall above each bed or on the door.
of separate rooms. These provided visiting staff and therapists with a visual reminder that the patient had a special requirement or need.

We saw staff using coloured place mats and water jugs to show people who needed aid to eat their meals. In addition, a ‘blue plate’ system had been introduced to improve the colour contrast between food and crockery, which aided people with dementia. The wards we visited also had protected meal times. This meant the greatest number of staff were available to help and allowed patients to eat without distraction. Managers stated that ‘butterfly volunteers’ had been recruited to help provide additional support.

Our findings were consistent with the 2017 patient-led assessment of the care environment survey, which showed the trust scored 90% for food and hydration. This was better than the England average (89%).

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain. The trust had a pain management policy that staff could read on the intranet, and the policy included information on how to contact the specialist pain team. Staff we spoke to know how to contact them.

We saw a daily pain management care plan incorporated into the bedside booklet, which included a pictogram designed to help patients who could not speak show their level of pain or discomfort. The adult pain tool score used was a score between 0 and 10, zero being no pain and 10 being the worst pain a patient had ever experienced. The Abbey Pain score was used for the assessment of pain in patients who could not verbalise for example patients living with dementia or patients with communication difficulties.

Nurses assessed pain at set intervals to check patients and this was also recorded on the ‘patient well-being’ sheets.

Patients told us they were regularly asked if they were in pain or required pain relief and it administered quickly when it was required.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local and regional audit results with those of other services and used these to benchmark and compare with other trusts nationally. There was a clinical audit lead for the department who lead on audit completion and compliance, and reported to the governance and quality committee via the divisional management.
Relative risk of readmission

Trust level

From May 2017 to April 2018, patients at the trust had a higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Elective Admissions – Trust Level

![Bar chart showing risk of readmission for elective admissions by specialty.]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions
- Patients in clinical haematology had a higher than expected risk of readmission for elective admissions
- Patients in cardiology had a similar to expected risk of readmission for elective admissions

Non-Elective Admissions – Trust Level

![Bar chart showing risk of readmission for non-elective admissions by specialty.]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

- Patients in general medicine, respiratory medicine and geriatric medicine all had a lower than expected risk of readmission for non-elective admissions

(Source: Hospital Episode Statistics - HES - Readmissions (01/05/2017 - 30/04/2018))

East Surrey hospital

From May 2017 to April 2018, patients at East Surrey hospital had a higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.
Elective Admissions - East Surrey hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions
- Patients in cardiology had a similar to expected risk of readmission for elective admissions
- Patients in clinical haematology had a higher than expected risk of readmission for elective admissions

Non-Elective Admissions - East Surrey hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

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Sentinel Stroke National Audit Programme (SSNAP)

East Surrey hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade C in latest audit, August to November 2017.

East Surrey hospital

<table>
<thead>
<tr>
<th>Team-centred KI levels</th>
<th>Aug-Nov 16</th>
<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
<th>Aug 17 - Nov 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>A</td>
<td>B↓</td>
<td>A↑</td>
<td>A</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>D↑</td>
<td>D</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>C↑</td>
<td>D↓</td>
<td>B↑↑</td>
<td>C↓</td>
</tr>
</tbody>
</table>
### Team-centred KI levels

<table>
<thead>
<tr>
<th></th>
<th>Aug-Nov 16</th>
<th>Dec 16 - Mar 17</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>C↓</td>
<td>C</td>
<td>B↑</td>
<td>B</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>C↓</td>
<td>A↑↑</td>
<td>B↓</td>
<td>A↑</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>C↓</td>
<td>B↑</td>
<td>C↓</td>
<td>B↑</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>B</td>
<td>B</td>
<td>C↓</td>
<td>C</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>B↓</td>
<td>B</td>
<td>B</td>
<td>A↑</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>D</td>
<td>D</td>
<td>D</td>
<td>C↑</td>
</tr>
<tr>
<td>Team-centred Total Key Indicator Level</td>
<td>C↓</td>
<td>C</td>
<td>B↑</td>
<td>B</td>
</tr>
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</table>

### Patient-centred performance

<table>
<thead>
<tr>
<th></th>
<th>Aug-Nov 16</th>
<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
<th>Aug 17 - Nov 17</th>
</tr>
</thead>
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<tr>
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<td>D</td>
</tr>
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<td>D↓</td>
<td>B↑↑</td>
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<td>B</td>
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<td>D</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>Patient-centred total key indicator level</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
<td>B</td>
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</tbody>
</table>

### Overall scores

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<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
<th>Aug 17 - Nov 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
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<td>C↑</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>C</td>
<td>A↑↑</td>
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<td>A</td>
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<tr>
<td>Audit compliance band</td>
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<td>C</td>
<td>C</td>
<td>C</td>
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<tr>
<td>Combined Total Key Indicator level</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
<td>B</td>
</tr>
</tbody>
</table>
Lung Cancer Audit

The trust took part in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 80.1%, which did not meet the audit minimum standard of 90%. The 2016 figure was 74.2%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 10.8%. This is worse than expected. The 2016 figure was significantly worse than the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 62.9%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 64.1%. This is within the expected range. The 2016 figure was significantly worse than the national level.

The one-year relative survival rate for the trust in 2016 is 31.8%. This is within the expected range. The 2016 figure was not significantly different to the national level.

National Audit of Inpatient Falls 2017

The crude proportion of patients who had a vision assessment (if applicable) was 16%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 55%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 100%. This met the national aspirational standard of 100% and was included in the audit report as a case study in quality improvement: “To ensure that all patients who are admitted to the hospital are screened for cognitive decline and delirium, an online ‘dementia assessment’ (developed for the department CQUIN) must be completed by the admitting doctor. Access to the electronic patient records and results is restricted without completion of the assessment.”

The crude proportion of patients with a call bell in reach (if applicable) was 88%. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians London, SSNAP audit)

(Source: National Lung Cancer Audit)

(Source: Royal College of Physicians)
Competent staff

The division made sure staff were competent for their roles. The trust offered comprehensive learning and development to its staff and we heard numerous examples of staff achieving significant career advancement through these opportunities. This included the use of practice-based educators for clinical staff to help monitor and support staff through training.

Managers appraised work performance and held monthly supervision meetings with staff to give support and check the effectiveness of the service. Managers used the appraisal process to identify staff learning and development needs. Staff told us they had regular team meetings and were supported with their continuous professional development.

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

The trust had recruitment policies and procedures together with job descriptions for all grades of staff. Managers described how the trust completed recruitment checks to ensure new staff were experienced, qualified, competent, and suitable for their role. All new employees undertook trust and local induction with added support and training when needed.

We observed established processes for induction of permanent and temporary (bank and agency) staff. We saw examples of these staff had applied in all the wards and units we visited. Staff showed us completed induction records and told us the induction processes supported them in their roles.

Medical staff told us they had been provided with good education opportunities and were almost always able to attend in-house training sessions. The trust hosted medical students from a nearby university and we observed ward-based teaching sessions using multimedia resources.

We saw electronic systems that helped managers check the status of staff needing validation and continuing registration with professional bodies. Registered nurses we spoke with told us the trust supported them in preparing for revalidation, which is a process all nurses and midwives must complete to renew their registration. Nursing staff also described having monthly one-to-one clinical supervision meetings.

A wide range of specialist nurses supported the nurses on the ward. For example, the dementia care team, palliative care team, safeguarding leads, diabetes care team and discharge coordinators.

Appraisal rates

From April 2017 to March 2018, 95% of all staff within medicine at the trust received an appraisal compared to a trust target of 90%.

The trust has given the data for the following staff groups, but it did not include details of any medical staff for any core service.

All six of the staff groups met the 90% appraisal completion target.
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<tr>
<th>Staff group</th>
<th>Individuals required</th>
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<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met</th>
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</table>

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

### Multidisciplinary working

Staff of various kinds worked together as a team to benefit patients. Doctors, nurses, and other healthcare professionals supported each other to give skilled care. There were clear lines of accountability that contributed to the effective planning and delivery of patient care. At ward ‘huddles’ and meetings, we saw proactive engagement between all members of the multidisciplinary team.

Ward rounds were well organised and well attended by representatives from the ward clinical team, therapists and operational managers.

We saw examples of strong and positive effective multidisciplinary working. We saw effective working relations between speciality doctors, nurses, therapists and specialist nurses.

The wards used integrated patient records, which were shared by clinical staff and therapists. This improved communication and meant that care was better co-ordinated between healthcare professionals.

Medical, nursing and therapy staff of all grades described good working relationships with staff in other directorates. Staff worked across health care disciplines and with other agencies when needed to care for patients. For example, the ambulatory medical unit and the consultant worked closely with the emergency department to identify suitable patients who could be transferred immediately. Similar arrangements existed between the ED and the acute stroke service.

### Seven-day services

The division had achieved seven-day services in line with NHSE Seven Day Services Clinical Standards. The seven-day service programme is designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter the hospital.

Consultant and multidisciplinary team cover was available every day including weekends, with on-call arrangements for bank holidays.
Diagnostic services were available throughout the week and staff did not report any issues with obtaining diagnostic results out of normal hours. Staff always had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. All staff had access to an electronic records system that they could all update.

There was an on-call pharmacy service outside of normal working hours and therapy services such as physiotherapy for inpatients was available every day including weekends.

The wards had access to radiology support every day and there was on call radiologist cover available. A similar level of service was provided by microbiology and pathology departments.

The rapid discharge team were available seven days a week to ensure that it was safe to discharge patients who were frail or had mobility problems. The discharge service and lounge operated throughout the week.

**Health promotion**

We saw a wide range of information and support available for patients, their families and carers.

Extensive use was made of literature stands throughout public areas of the hospital and there were leaflets on managing different health conditions as well as local resources that could aid.

Staff told us the trust frequently placed information campaigns and displays in the main foyer. We did not see one during our visit.

We saw a selection of leaflets printed in different languages.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

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

The trust had a current policy based on the guidance issued by the Department of Health that staff followed for consent to examination and treatment. The trust also had a pictorial guide supporting people with learning disabilities about what giving consent meant.

Staff demonstrated a sound understanding of the legislation and best practice about consent, the Mental Capacity Act, and Deprivation of Liberty Safeguards. Staff we spoke with were clear about their responsibilities in relation to gaining consent from people, including patients who lacked capacity to consent to their care and treatment.

We saw examples in the records where the consultant responsible for the patient’s care undertook mental capacity assessments for those unable to consent.

The trust had an assessment of capacity checklist for patients aged 16 and above for the consultant to complete.
Mental Capacity Act and Deprivation of Liberty training completion

The trust includes training for the Mental Capacity Act and Deprivation of Liberty within the mandatory level 1 and level 2 safeguarding training modules.

Please see the “Safeguarding” section for details of training compliance.

(Source: Routine Provider Information Request (RPIR) – Quality statement)
Is the service caring?

**Compassionate care**

The feedback we received from people who used the service, those who are close to them and stakeholders was continually positive about the way staff treated people. People we spoke with, including volunteers and support staff were unwavering in their praise about the ward-based staff of all grades for ‘going the extra mile.’

We found there was a strong, visible person-centred culture. Staff are highly motivated and inspired to offer care that was kind and promotes people’s dignity. Staff interacted with people who used the service and those close to them in a respectful and considerate way. During our inspection, we saw kind interactions from all trust staff across all wards. Staff were encouraging, sensitive and supportive towards patients and those close to them.

Patient feedback we received included comments such as “I am at a loss to find the words that truly reflect the family’s thanks for the care and attention you and your nurses, and indeed all members of staff, provided J during her protracted stay in your care”, “you have an incredibly dedicated staff that does you great credit” and “…demonstrated a level of care that we shall be forever in your debt”.

Throughout the division, we saw many examples of thank you notes and cards written to staff expressing their gratitude and some of these had been placed on display in ward offices and staff rooms.

People’s privacy and dignity needs were consistently understood and respected. We observed physical and intimate care interactions between staff and patients where procedures were explained and consent asked. We saw in all wards and units that staff drew curtains before examinations and spoke quietly enough so patients in adjacent beds could not hear conversations. These aspects indicated staff actively used the ‘6C’s’ of ‘Compassion in Practice - Nursing, Midwifery and Care Staff - Our Vision and Strategy 2012: compassion, care, commitment, courage, competence, communication’.

In the ambulatory care units, we saw innovation in the way the service helped people to manage their own health and care when they can and to maintain their independence as much as possible. The division provided ‘one stop’ services and step-down day care as part of a flexible offering.

Staff introduced themselves to patients and their carers in line with National Institute for Health and Care Excellence, QS15 Statement 3: Patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.

We observed all staff consistently wearing name badges and we saw the widespread use of displays showing key staff on each ward and we were also shown a leaflet describing how to recognise clinical staff grades and specialities by their uniforms. Patients told us that all clinical and therapy staff introduced themselves and we noted that the nurse in charge wore a red badge to help make them easily identifiable.
Our observations were consistent with the 2017 patient-led assessment of the care environment survey, which showed the trust scored 84% for ‘privacy, dignity and wellbeing’. This was better than the England average of 83%.

**Friends and Family test performance**

**East Surrey hospital**

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Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard. Only wards with at least 100 responses over the year have been included in these tables.

**Friends and family Test – Response rate between 01/08/2017 to 31/07/2018 by site.**

![Graph showing response rates](image)

The Friends and Family Test response rate for medicine at the trust was 22% which was slightly lower than the England average of 25% from August 2017 to July 2018.

(Source: NHS England Friends and Family Test)
Emotional support

Staff provided emotional support to patients to minimise their distress. Staff supported and encouraged links to external resources to help patients, families and carers cope with their emotional needs.

The wards and units we visited had side rooms available that could be used for private or difficult conversations with patients and families. Staff were knowledgeable and sensitive to space, time and people’s needs when providing diagnosis and potential emotionally charged information. They clearly understood the impact that a person’s care, treatment or condition would have on their wellbeing and on those close to them.

Staff encouraged patients to establish links with support services and condition specific special interest groups. Staff provided appropriate and timely support and information to cope emotionally with their care, treatment and condition. This is in line with National Institute for Health and Care Excellence, QS15 Statement 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety.

Patients also had access to physiotherapists and occupational therapists that provided practical support and encouragement for patients with both acute and long-term conditions. Patients spoke highly of the therapy staff and told us of the help and support they received from them.

There was a non-denominational hospital chaplaincy service, which provided pastoral support for patients and their relatives, carers and staff. Staff we spoke to knew how to contact the service and we also saw patient leaflets on display in ward areas.

Understanding and involvement of patients and those close to them

We found a service that was fully committed to working in partnership with patients and always involved patients and those close to them during decision making and discussing next steps in care. Staff involved patients and those close to them in decisions about their care and treatment. Staff took peoples’ opinions and beliefs into consideration.

Patients and their relatives told us that staff communicated with them at an appropriate level and they were able to understand their care and treatment plans. This made patients and their relatives feel valued and engaged in episodes of care. This is in line with National Institute for Health and Care Excellence, QS15 Statement 2: Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills.

Staff established effective ways to communicate with people when their protected equality and other characteristics made this necessary. We heard examples of speech and language therapists engaging with patient-centred multidisciplinary teams to conduct assessments and education sessions regarding communication charts and assistive technology aimed at facilitating rehabilitation as well as supporting future communication needs in a community and social setting.

Family members felt positive about the involvement they had in their relatives’ treatment and discharge processes. Patients were given time to ask questions when being told about new treatment options in line with National Institute for Health and Care Excellence, QS15 Statement 4: Patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care.
Service delivery to meet the needs of local people

Patients were admitted to the medical wards via direct referral from their general practitioner, a ‘step down’ transfer from a critical care unit at the hospital or through the accident and emergency department.

Overall, people’s individual needs and preferences were central to the delivery of tailored services. The trust had invested in facilities that led to innovative approaches to providing integrated person-centred pathways of care that also involved other service providers, particularly for people with multiple and complex needs.

Staff at all levels clearly and passionately described how they met patients’ needs and demonstrated a good awareness of protected characteristics including race, sexuality and disability. We saw a variety of resources made available to staff to help them support these population groups. For example, the Public Health England and Royal College of Nursing toolkit to support gay, lesbian and bisexual young people, a resource guide designed to help staff respond to the needs of patients and clients who identify as ‘transgender’ and a communication guide for patients who had a learning disability.

The trust dementia service acted effectively to meet the needs of the local people. The trust had adopted a range of initiatives such as the ‘butterfly’ scheme to help staff recognise and care for those patients living with cognitive impairment.

Staff we spoke with knew how to access these guides and where to get assistance when required. Systems for contacting the safeguarding team and social services were well established and understood by all staff.

On the wards and units we visited, we saw clear advice and guidance on how to make a complaint about the service. This was mirrored on the trust website.

We did not observe any mixed sex breaches and staff told us these were “negligible”.

The service had appropriate discharge arrangements for people with complex health and social care needs. Staff and the care systems they followed helped to provide good care to patients in need of additional support. The trust had an integrated discharge team and we saw that discharge information was monitored through daily operational meetings such as board rounds and multi-disciplinary case conferences.

Average length of stay

Trust level

From June 2017 to May 2018 the average length of stay for medical elective patients at Surrey and Sussex Healthcare NHS Trust was 3.0 days, which is lower than the England average of 6.0 days.

For medical non-elective patients, the average length of stay was 7.1 days, which is higher than the England average of 6.4 days.

Elective Average Length of Stay – Trust Level
• The average length of stay for elective patients in cardiology, gastroenterology and clinical haematology is lower than the England average.

**Non-Elective Average Length of Stay – Trust Level**

Note: Top three specialties for specific trust based on count of activity.

- The average length of stay for elective patients in general medicine and respiratory medicine is higher than the England average.
- The average length of stay for elective patients in geriatric medicine is lower than the England average.

**East Surrey hospital**

From June 2017 to May 2018 the average length of stay for medical elective patients at East Surrey hospital was 3.0 days, which is lower than England average of 6.0 days.

For medical non-elective patients, the average length of stay was 7.1 days, which is higher than England average of 6.4 days.

**Elective Average Length of Stay - East Surrey hospital**

Note: Top three specialties for specific site based on count of activity.

- The average length of stay for elective patients in cardiology and clinical haematology is lower
than the England average.

- The average length of stay for elective patients in gastroenterology is similar to the England average.

### Non-Elective Average Length of Stay - East Surrey hospital

![Bar chart showing average length of stay for non-elective patients in various specialties.](chart)

*Note: Top three specialties for specific site based on count of activity.*

- The average length of stay for non-elective patients in general medicine and respiratory medicine is higher than the England average.
- The average length of stay for non-elective patients in geriatric medicine is lower than the England average.

### Meeting people’s individual needs

The services took account of patients’ individual needs. The trust employed specialist nurses to support the ward staff. This included dementia and palliative care nurses who provided support, training and had developed resource files for staff to reference. Wards also had ‘champions’ who acted as additional resources to promote best practice.

The 2017 patient-led assessment of the care environment survey showed the trust scored 88% for dementia care, which was better than the England average of 76% and 92% for care of people with disabilities against an average of 82%.

We saw several innovations in the way divisions met older peoples’ individual needs. For example, the wards had staff allocated to each bay to help reduce unwitnessed falls in frail elderly patients. Bays were fitted with desks and computer terminals used by the member of the nursing staff, which meant staff did not have to leave the bay to complete documentation or other administrative tasks. Other initiatives we saw in the care for the elderly wards included ‘dressed for success’ and ‘end pyjama paralysis’ (aimed at encouraging patients to wear familiar clothes and sit out for meals), activity boxes and reminiscence displays.

The general environment had been designed to help with those with limited mobility. This included assisted bathrooms and lavatories, mobility aids and provision of manual handling equipment. The trust had also responded to patient feedback about noise at night. A sound measuring and alert device had been installed along with signage and special lighting to remind users to reduce noise. In addition, reviews had been conducted into staff footwear and patients issued with earplugs and eyeshades.
Staff told us that specialist equipment such as bariatric equipment or specialist pressure relieving mattresses were available on request.

We saw dementia friendly environments in all areas of the hospital. The dementia-friendly facilities in the newly established Pendleton unit were particularly impressive. Signage and decor used bold and clear colours to aid orientation.

Wards used ‘forget me not’ flower pictograms to help visiting staff identify patients living with dementia, or those with short term memory loss or confusion. The flower symbols were placed next to the patient’s name on their bed and used on the patient status board in the ward office.

Red trays were used on the wards to identify those patients who needed help with feeding along with high-contrast crockery. We saw that eating and drinking requirements were displayed near each bed or room.

Nurses used ‘intentional rounding’ to help ensure that patients’ needs were met. Nursing staff usually carried out the rounds at set times through the days and we saw completed records confirming this.

We saw pictorial aides available for use with people with communication difficulties.

Each bed had a call bell in place and within reach of the patient. We saw these being answered promptly by staff.

Throughout the hospital we saw leaflets and useful information on display to help patients and their relatives understand their conditions and the treatment options available. The printed information available in English and a selection of other languages, along with a telephone based interpreter service for those patients or relatives who needed help.

**Access and flow**

People could access the service when they needed it. Overall, arrangements to admit, treat and discharge patients were in line with good practice.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From July 2017 to June 2018 the trust's referral to treatment time (RTT) for admitted pathways for medicine was similar to or slightly better than the England average.

In the latest month, June 2018, 94.2% of this group of patients were treated within 18 weeks compared to the England average of 88.7%.
Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for medicine broken down by specialty is below.

Three specialties were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>100.0%</td>
<td>97.0%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>100.0%</td>
<td>93.0%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>95.7%</td>
<td>93.7%</td>
</tr>
</tbody>
</table>

Three specialties below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>91.4%</td>
<td>96.4%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>81.5%</td>
<td>82.1%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>73.7%</td>
<td>82.2%</td>
</tr>
</tbody>
</table>

Patient moving wards per admission

From June 2017 to May 2018, no ward movements for non-clinical reasons have been reported for medical inpatients except on the medical escalation ward (where all patients experienced at least one bed move).

(Source: Trust Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night

From June 2017 to May 2018, there were 2,672 patients moving wards at night within medicine. The greatest number of moves at night was for Godstone Ward, which is for general medicine and clinical haematology, and had 354 moves at night over the year.
Learning from complaints and concerns

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

We saw advice leaflets readily available on the wards and departments we inspected. Patients had access to the Patient Liaison and Advice service, who supported patients with concerns and complaints and gave information about NHS services. Staff could access the complaints policy on the trust’s intranet and knew how to direct patients to make a complaint. Patients we spoke with said they would raise any issues or concerns with the ward staff in the first instance and were aware that a complaints process existed.

Medical and nursing staff told us that they received feedback from any complaint they had been involved in. We saw examples of incident and complaint investigations that had been communicated to staff through ward and divisional meetings. Staff confirmed that complaints were discussed at clinical governance meetings and information disseminated to staff through team meetings and briefings. We reviewed a sample of team meeting minutes and saw that complaints were discussed and monitored.

We reviewed five complaints and their responses and found they had been investigated and closed in compliance with the trust complaints policy. In all cases, we saw the service had completed thorough investigations, supported people and explained outcomes to the person.

Summary of complaints

From June 2017 to May 2018 there were 167 complaints about medicine. The trust took an average of 54 days to investigate and close complaints. This is not in line with the trust’s complaints policy. Their complaints policy states that under current legislation trusts have six months to resolve complaints, but that a response time is agreed for each complaint and is usually 25 working days, (35 calendar days).

Patient care was the subject with the most complaints, accounting for 39% of all complaints about medicine.

East Surrey hospital received the most medicine complaints with 159, whilst Crawley hospital received five and Horsham hospital three.

A breakdown of complaints by subject and site is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Crawley hospital</th>
<th>East Surrey hospital</th>
<th>Horsham hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>3</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>Appointments</td>
<td></td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>1</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>----</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communications</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify in comments)</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>End of life care</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilities</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting times</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated care (inc delayed discharge due to absence of care package)</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consent</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Privacy, dignity &amp; well being</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

From June 2017 to May 2018 there were 2,865 compliments within medicine. The Pendleton unit received the most compliments, accounting for 12% of all compliments made.

A breakdown of the number of compliments by ward is shown below:

<table>
<thead>
<tr>
<th>Ward/team</th>
<th>Number of compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pendleton Unit</td>
<td>352</td>
</tr>
<tr>
<td>Acute Medical Unit (Ward)</td>
<td>336</td>
</tr>
<tr>
<td>Tilgate Ward</td>
<td>327</td>
</tr>
<tr>
<td>Godstone Ward (Medical)</td>
<td>251</td>
</tr>
<tr>
<td>Bletchingley Ward</td>
<td>216</td>
</tr>
<tr>
<td>Coronary Care Unit</td>
<td>173</td>
</tr>
<tr>
<td>Godstone Ward (Haematology)</td>
<td>166</td>
</tr>
<tr>
<td>Holmwood Ward</td>
<td>166</td>
</tr>
<tr>
<td>Meadvale Ward</td>
<td>160</td>
</tr>
<tr>
<td>Angio Suite</td>
<td>138</td>
</tr>
<tr>
<td>Tilgate Annex Ward</td>
<td>135</td>
</tr>
<tr>
<td>Chaldon Ward</td>
<td>128</td>
</tr>
<tr>
<td>Nutfield Ward</td>
<td>98</td>
</tr>
<tr>
<td>Kingsfold Unit (Ambulatory emergency care)</td>
<td>95</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Hazelwood Ward</td>
<td>64</td>
</tr>
<tr>
<td>Capel Ward</td>
<td>60</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,865</strong></td>
</tr>
</tbody>
</table>

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

Is the service well-led?

**Leadership**

We found a service that had compassionate, inclusive, and effective leadership at all levels. The management team demonstrated high levels of experience, capacity and capability needed to deliver excellent and sustainable care. There was a firmly embedded system of leadership development and succession planning.

We saw comprehensive and successful leadership strategies were in place, such as the SASH+ programme, to help ensure and sustain delivery and to develop the desired culture. We found a stable and highly visible senior management team that possessed a deep understanding of issues, challenges and priorities in their service, and beyond.

The medical division is one of four clinical divisions at East Surrey Hospital. Each division was led by a ‘triumvirate.’ This consisted of an operational manager, a clinical director and a lead nurse who worked closely together to support and manage all aspects of their directorate.

The division was further divided into five clinical specialities (each with a designated clinical lead) and six functional groups of wards, each under a matron and working with nominated service managers and managers with finance, HR and risk roles. The structure helped ensure that clinical, care, therapy and operational managers were involved in the management and planning of hospital activities at every level.

During our inspection we saw excellent examples of very strong ward and department leadership. Staff told us they felt well supported, valued and that that their opinions counted. Ward managers we spoke with knew what their wards were doing well and could name the challenges and risks their team faced in delivering skilled care.

Staff spoke in very positive terms about the visibility of the executive management team in addition to their divisional leadership. There was also overwhelmingly positive praise for the chief executive and other members of the senior management team, who were regarded as highly visible and approachable. One member of staff said of the CEO, “he knows just about every person here by name.” This is a creditable reputation to have among employees and emphasises the friendly and positive culture that has been created and fostered.
Vision and strategy

We saw that the trust’s strategy and supporting goals and plans were stretching, challenging and innovative, while staying achievable. The strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership.

We found a systematic and integrated approach to monitoring, reviewing, and giving evidence of progress against the strategy and plans. Plans were consistently and thoughtfully implemented, and had a positive impact on quality and sustainability of services.

There was wide use of wall art and poster displays along with other publications about the vision and values of the trust as we visited the wards. These were readily available for staff, patients, and the public to view. The trust published information about its mission, values, and vision on its public website.

Staff at all levels spoke positively and passionately about the organisation, and clearly understood what the vision, values and strategy for the division was and how their own ward and work contributed to achieving this.

Culture

During our inspection, the phrase “#one team” was used often and appeared to have real meaning among the people we spoke with. For example, a member of the housekeeping team told us “one team really does work – we all help each other out”. It also became clear that the trust leadership had helped achieve and inspired a shared purpose, and strove to deliver and motivate staff to succeed. We met managers who had progressed from administrators; housekeepers who had progressed to healthcare assistants and qualified nurses who had progressed from healthcare assistants, all with help and support of the trust and colleagues. One senior manager proudly told us they had started with the trust as an HCA.

We found high levels of satisfaction across all staff, including those with protected characteristics under the Equality Act. There was a strong organisational commitment and effective action towards ensuring that there was equality and inclusion across the workforce. Staff were proud of the organisation as a place to work and spoke highly of the culture. Members of the BAME group told us that they had opened up membership to people from all minority groups and the CEO had joined the forum.

Within the medical division, we saw that staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this process. There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people’s experiences.

Staff said they understood the trust whistleblowing policy and would feel comfortable using it if necessary. We also saw information displayed on the wards advising staff of the whistleblowing procedure. This indicated that the trust had an ‘open culture’ in which staff could raise concerns without fear.
Governance

The trust used a divisional governance model and triumvirate working, which was popular with managers we spoke with.

Each of the triumvirate leadership had clear lines of responsibility for designated wards and departments. We reviewed the minutes of meetings, which showed that regular team and management meetings took place. The minutes documented how information on incidents and complaints were investigated and any learning shared and good practice promoted.

Wards and units of the division completed monthly quality reports which detailed performance against safety metrics. This report was shared at divisional governance meetings and at higher levels.

Management of risk, issues and performance

There was a demonstrated commitment to best practice performance and risk management systems and processes. The organisation reviewed how they function and ensured that staff at all levels had the skills and knowledge to use those systems and processes effectively. Problems were identified and addressed quickly and openly.

We found there were updated divisional risk registers at ward and divisional level. Managers we spoke with were aware of the registers and knew the main risks and the actions needed to reduce the risks that had been found. We saw examples of risk registers that had been recently reviewed and showed actions completed. This indicated the divisions had actively identified risks, reviewed them, and implemented control measures.

Performance management was well embedded into the wards and units we visited. We saw a routine triumvirate meeting, attended by the management team, ward managers and representatives from clinicians, therapists, and finance.

This approach was mirrored at an operational level by senior management and board level staff who met three times a day at the hospital ‘command centre’ to review and manage issues relating to staffing levels, patient flow and bed vacancies.

Information management

The trust collected, analysed, managed, and used information well to support all its activities, using secure electronic systems with security safeguards. The trust’s website provided safety and quality performance reports and links to other web sites such as NHS Choices. This gave patients and members of the public a range of information about the safety and governance of the hospital.

Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage services, and collaborated with partner organisations effectively.
The trust involved patients and the public in developing services by involving them in the planning, designing, delivering and improvement of services. The various means of engagement included a range of patient participation groups including the hospital volunteers, Healthwatch, feedback from the Friends and Family Test and inpatient surveys.

The management team told us that any innovative ideas put forward by staff were discussed at weekly ward meetings and monthly team meetings. Useful suggestions and innovative ideas were then passed on to the clinical and quality boards. All the staff we spoke with felt informed and involved with the day-to-day running of the service and its strategic direction.

We saw positive examples of public engagement during our visit. We spoke with hospital volunteers who were helping sell books to raise funds for the trust.

**Learning, continuous improvement and innovation**

We found a commitment at all levels to sharing data and information proactively to drive and support internal decision making as well as system-wide working and improvement.

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

The way the trust supported and encouraged innovation was a real strength. We saw good examples across the divisions and our observations were consistent with positive feedback we received from staff individually and at the focus groups.
The surgical division at Surrey and Sussex Healthcare National Health Service Trust provides a wide range of surgical services including; breast, colorectal, endoscopy, ear nose and throat, gastroenterology, ophthalmology, oral and maxilla-facial, orthopaedics, paediatric, upper Gastrointestinal, urology and vascular surgery.

The trust provides 24-hour emergency and trauma services and East Surrey hospital is the designated receiving unit in the event of a major incident, providing cover for Gatwick airport.

Outpatient services are provided from a number of locations, including Crawley and Horsham hospitals.

**East Surrey Hospital:**

Offers elective and emergency surgery through ten operating theatres. It has an admission lounge, day-case unit, endoscopy unit and a dental and maxillofacial team.

There are 161 inpatient beds for surgical patients, split across eight wards:

<table>
<thead>
<tr>
<th>Team/ward</th>
<th>Description (provided by the trust)</th>
<th>Number of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brook Ward</td>
<td>Brook ward provides short stay general surgery and ENT within 10 single en-suite rooms. This is the designated ward for surgical amenity patients which are accessed for scheduled surgery via the booking teams.</td>
<td>10</td>
</tr>
<tr>
<td>Buckland Ward</td>
<td>Provides care for both simple and complex urology patients. The ward has a urology suite area co-located with a number of clinics delivered through a dedicated nurse specialist team. The ward facilitates out of hours direct admissions and telephone advice for patients and carers.</td>
<td>21</td>
</tr>
<tr>
<td>Charlwood Ward</td>
<td>Provides care for Gastrointestinal medical patients located near to the endoscopy unit and the Gastrointestinal surgical ward.</td>
<td>20</td>
</tr>
<tr>
<td>Copthorne Ward</td>
<td>Provides acute upper and lower Gastrointestinal surgery for planned and emergency pathways. The ward manages a number of patients stepping down from the critical care environments.</td>
<td>20</td>
</tr>
<tr>
<td>Leigh Ward</td>
<td>Provides care for both planned and emergency trauma patients.</td>
<td>27</td>
</tr>
<tr>
<td>Ward</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Newdigate Ward</td>
<td>Dedicated hip fracture unit. Multi professional care is delivered through trauma consultants, orthogeriatricians and a wide range of therapy support staff.</td>
<td></td>
</tr>
<tr>
<td>Surgical Assessment Unit</td>
<td>Surgical Assessment Unit assesses patients from the following four specialities:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>General Surgery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urology</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Orthopaedics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ENT (Ears, Nose and Throat)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SAU also offers a Rapid Access Clinic for both General Surgical and ENT patients requiring urgent hospital follow up but not needing an admission into the Main Hospital. Patients needing to stay longer than 72 hrs are transferred to the speciality specific ward.</td>
<td></td>
</tr>
<tr>
<td>Woodland Ward</td>
<td>Provides care for the planned orthopaedic pathway which requires all patients to be screened Meticillin Resistant Staphylococcus Aureus negative. Any other patients cared for on Woodland are admitted following agreed criteria for admission.</td>
<td></td>
</tr>
</tbody>
</table>

**Crawley Hospital:**

Offers elective day surgery through four operating theatres, including urgent gynaecology procedures and minor hand trauma. It also has a surgical short stay unit with 12 recliner spaces for patients having procedures under local anaesthetic, 27 recovery trolley spaces and a post-op lounge for up to eight patients awaiting discharge.

(Source: Routine Provider Information Request (RPIR) – Sites and acute context tab)

The trust had 33,497 surgical admissions from June 2017 to May 2018. Emergency admissions accounted for 8,858 (26%), 21,665 (65%) were day case, and the remaining 2,974 (9%) were elective.

(Source: Hospital Episode Statistics)
Is the service safe?
By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training
The trust set a target of 80% for completion of mandatory training. Although compliance had been achieved in all but five courses, it was considered that a trust target of 80% was quite low. This meant that the trust would tolerate one in five staff not having completed their mandatory training.

Trust level
A breakdown of compliance for mandatory training courses as of May 2018 at trust level for qualified nursing staff in surgery is shown below:

Please note the training modules have been merged to give overall figures for each module as the raw data included multiple entries of the same modules with training renewal dates.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control - Level 2 - 1 Year</td>
<td>185</td>
<td>284</td>
<td>65%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>NHS Conflict Resolution (England) - 3 Years</td>
<td>199</td>
<td>286</td>
<td>70%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling - Level 2 - 2 Years</td>
<td>210</td>
<td>291</td>
<td>72%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety - 2 Years</td>
<td>215</td>
<td>284</td>
<td>76%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Local Data Security Awareness - 1 Year</td>
<td>218</td>
<td>284</td>
<td>77%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>249</td>
<td>284</td>
<td>88%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, Safety and Welfare - 3 Years</td>
<td>252</td>
<td>284</td>
<td>89%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital BLS (Adults &amp; Paeds) - BLS/ILS (R-AM)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital Resuscitation</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital BLS (Adults &amp; Paeds) BLS/ILS (R-AM)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic Life Support - MaST</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>In Hospital Resuscitation (including BLS)</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Course</td>
<td>Staffed</td>
<td>Attended</td>
<td>Compliant</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>---------</td>
<td>----------</td>
<td>-----------</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td>Medicines Management - MaST Clinical New Staff</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation Half Day Recertification ILS (AM Session)</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - Clinical New Staff</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - New Staff</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - Basic Life Support (Adults &amp; Paeds) Level 2</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital BLS (Adults &amp; Paeds) - BLS/PILS</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>In Hospital Basic Life Support (Adults &amp; Paeds)</td>
<td>16</td>
<td>16</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - MaST Clinical Update</td>
<td>17</td>
<td>17</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic Life Support (Adults &amp; Paeds) Level 2</td>
<td>18</td>
<td>18</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - Update</td>
<td>19</td>
<td>19</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>20</td>
<td>20</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - Basic Life Support</td>
<td>23</td>
<td>23</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management Core Update</td>
<td>26</td>
<td>26</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - Clinical Update</td>
<td>59</td>
<td>59</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital BLS (Adults &amp; Paeds) - BLS/ILS</td>
<td>75</td>
<td>75</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation ILS</td>
<td>78</td>
<td>78</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In surgery at trust level the 80% target was not met for five of the mandatory training modules for which qualified nursing staff were eligible. Infection prevention and control – level 2 was the module with the lowest compliance of 65%.
A breakdown of compliance for mandatory training courses as of May 2018 at trust level for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling - Level 1 - 3 Years</td>
<td>2</td>
<td>12</td>
<td>17%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>NHS Conflict Resolution (England) - 3 Years</td>
<td>4</td>
<td>12</td>
<td>33%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Health, Safety and Welfare - 3 Years</td>
<td>6</td>
<td>12</td>
<td>50%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>7</td>
<td>12</td>
<td>58%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control - Level 2 - 1 Year</td>
<td>7</td>
<td>12</td>
<td>58%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety - 2 Years</td>
<td>8</td>
<td>12</td>
<td>67%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Local Data Security Awareness - 1 Year</td>
<td>10</td>
<td>13</td>
<td>77%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>In Hospital Basic Life Support (Adults &amp; Paeds)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management Core Update</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - Dr's Update</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - Basic Life Support - Dr's Update</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - Basic Life Support (BLS Adults &amp; Paeds) Dr's Update</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital Basic Life Support Dr's BLS training</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus In Hospital MaST BLS &amp; AED Awareness Training (Dental)</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In surgery at trust level the 80% target was not met for seven of the mandatory training modules for which medical staff were eligible. Moving and handling level 1 was the module with the lowest compliance of 17%.

Nb. No medical staff training figures were listed for Crawley hospital, so the above figures relate to East Surrey hospital only and no site level breakdown is available for medical staff.
### East Surrey hospital

A breakdown of compliance for mandatory training courses as of May 2018 for qualified nursing staff in the surgery department at East Surrey hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control - Level 2 - 1 Year</td>
<td>145</td>
<td>219</td>
<td>66%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>NHS Conflict Resolution (England) - 3 Years</td>
<td>154</td>
<td>220</td>
<td>70%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling - Level 2 - 2 Years</td>
<td>163</td>
<td>225</td>
<td>72%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety - 2 Years</td>
<td>160</td>
<td>219</td>
<td>73%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Local Data Security Awareness - 1 Year</td>
<td>173</td>
<td>219</td>
<td>79%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>191</td>
<td>219</td>
<td>87%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, Safety and Welfare - 3 Years</td>
<td>194</td>
<td>219</td>
<td>89%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic Life Support - MaST</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic Life Support (Adults &amp; Paeds) Level 2</td>
<td>17</td>
<td>17</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>In Hospital Basic Life Support (Adults &amp; Paeds)</td>
<td>14</td>
<td>14</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>In Hospital Resuscitation (including BLS)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - Clinical New Staff</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - Clinical Update</td>
<td>45</td>
<td>45</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - MaST Clinical New Staff</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - MaST Clinical Update</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - New Staff</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - Update</td>
<td>14</td>
<td>14</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Name of course</td>
<td>Number of staff trained (YTD)</td>
<td>Number of eligible staff (YTD)</td>
<td>Completion rate</td>
<td>Trust Target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>------------------------------</td>
<td>--------------------------------</td>
<td>-----------------</td>
<td>--------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Medicines Management Core Update</td>
<td>23</td>
<td>23</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - Basic Life Support</td>
<td>21</td>
<td>21</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - Basic Life Support (Adults &amp; Paeds) Level 2</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital BLS (Adults &amp; Paeds) - BLS/ILS</td>
<td>41</td>
<td>41</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital BLS (Adults &amp; Paeds) - BLS/ILS (R-AM)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital BLS (Adults &amp; Paeds) - BLS/PILS</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital BLS (Adults &amp; Paeds) BLS/ILS (R-AM)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital Resuscitation</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation Half Day Recertification ILS (AM Session)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation ILS</td>
<td>43</td>
<td>43</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At East Surrey hospital the 80% target was not met for five of the mandatory training modules for which qualified nursing staff were eligible. Infection prevention and control – level 2 was the module with the lowest compliance of 66%.

**Crawley hospital**

A breakdown of compliance for mandatory training courses as of May 2018 for qualified nursing staff in the surgery department at Crawley hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling - Level 2 - 2 Years</td>
<td>16</td>
<td>28</td>
<td>57%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control - Level 2 - 1 Year</td>
<td>18</td>
<td>28</td>
<td>64%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>NHS Conflict Resolution (England) - 3 Years</td>
<td>22</td>
<td>29</td>
<td>76%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Local Data Security Awareness - 1 Year</td>
<td>23</td>
<td>28</td>
<td>82%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety - 2 Years</td>
<td>27</td>
<td>28</td>
<td>96%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, Safety and Welfare - 3 Years</td>
<td>27</td>
<td>28</td>
<td>96%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Course Description</td>
<td>Quantity</td>
<td>Total</td>
<td>Compliance</td>
<td>达标</td>
<td>Notes</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------</td>
<td>-------</td>
<td>------------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>28</td>
<td>28</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>In Hospital Resuscitation (including BLS)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - Clinical Update</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - MaST Clinical Update</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - New Staff</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - Update</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management Core Update</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - Basic Life Support (Adults &amp; Paeds) Level 2</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital BLS (Adults &amp; Paeds) - BLS/ILS</td>
<td>12</td>
<td>12</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital BLS (Adults &amp; Paeds) BLS/ILS (R-AM)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation Half Day Recertification ILS (AM Session)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation ILS</td>
<td>12</td>
<td>12</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At Crawley hospital the 80% target was not met for three of the mandatory training modules for which qualified nursing staff were eligible. Moving and handling level 2 was the module with the lowest compliance of 57%.

Statutory and mandatory training was booked through the human resources department or could be completed online, depending on the course and whether it required face to face attendance. Different wards, and theatres had different systems for monitoring compliance but of these we viewed, all were fit for purpose. Staff were only given two opportunities to attend any sessions before the matter would be escalated to managers.
Safeguarding

The trust set a target of 80% for completion of safeguarding training.

Trust level

A breakdown of compliance for safeguarding training courses as of May 2018 at trust level for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children - Level 3 - 3 Years</td>
<td>17</td>
<td>17</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children - Level 2 - 3 Years</td>
<td>28</td>
<td>32</td>
<td>88%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults - Level 2 - 3 Years</td>
<td>247</td>
<td>284</td>
<td>87%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Qualified nursing staff in surgery at trust level met the 80% target for all three of the safeguarding training modules for which they were eligible.

A breakdown of compliance for safeguarding training courses as of May 2018 at trust level for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children - Level 2 - 3 Years</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults - Level 2 - 3 Years</td>
<td>8</td>
<td>12</td>
<td>67%</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in surgery met the 80% target for one of the two safeguarding training modules for which they were eligible.
East Surrey hospital

A breakdown of compliance for safeguarding training courses as of May 2018 for qualified nursing staff in the surgery department at East Surrey hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children - Level 2 - 3 Years</td>
<td>22</td>
<td>26</td>
<td>85%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults - Level 2 - 3 Years</td>
<td>189</td>
<td>219</td>
<td>86%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children - Level 3 - 3 Years</td>
<td>17</td>
<td>17</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Qualified nursing staff in surgery at East Surrey hospital met the 80% target for all three of the safeguarding training modules for which they were eligible.

Crawley hospital

A breakdown of compliance for safeguarding training courses as of May 2018 for qualified nursing staff in the surgery department at Crawley hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults - Level 2 - 3 Years</td>
<td>26</td>
<td>28</td>
<td>93%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Qualified nursing staff in surgery at Crawley hospital met the 80% target for the one safeguarding module for which they were eligible.

Details of contacts for adult safeguarding teams were prominently displayed in ward areas. Staff we spoke with were aware of their obligations relating to safeguarding, where to seek advice if it was needed and how to make a referral.

Staff we spoke with had a good understanding of the mental health act and were able to get assistance from a psychiatric liaison nurse if a patient was suffering with mental ill health.

Cleanliness, infection control and hygiene

All areas of the surgical division we visited were visibly clean. All equipment we checked was clean. There were sufficient dispensers of hand sanitiser on entry and exit to the ward areas and on all the wards. All the dispensers we saw and used had sufficient hand sanitiser in them. Sinks that were used to wash hands had instructions on how to wash hands correctly in line with national guidelines. Personal protective equipment such as gloves or aprons were available outside all the bays and outside the individual side rooms on the wards. The side rooms could be used by patients that were infectious and required isolation.
We saw nursing and medical staff in theatres use good hand cleaning technique in accordance with Association for Perioperative Practice guidelines. Skin preparation was carried out with solution that cleaned the skin in accordance with national Institute for Health and Care Excellence CG74, prevention and treatment of surgical site infection.

Personal protective equipment was available in theatres including masks, with or without visors, sterile and non-sterile gloves and gowns in various sizes.

There were sufficient cleaning products available throughout theatres that could be used in a wide range of situations. Cleaning schedules were evident and up to date. A daily schedule of cleaning was completed with instructions about areas to clean. These were signed off by the housekeeper and then countersigned by the housekeeping supervisor. Audits of the checklists were completed in line with the national specifications for cleanliness.

Buckets used for cleaning were colour coded according to the Association for Perioperative Practice standards.

There were sharps bins of various sizes available. These were assembled correctly and generally not overfilled. However, we noted that in theatre ten, clinical and domestic waste bins were full to the top. There was a sharps bin in one of the temporary theatres that was filled above the fill line. Sharps were disposed of according to the Health Technical Memorandum 07.01 – Safe Management of Health Care Waste.

There was an infection control lead for the surgical division. The role of the infection control nurse is to prevent the spread of infectious agents, such as viruses and bacteria. The infection control nurse divided their time between clinical (25%) and educational (75%).

The trust participated in Public Health England’s Surgical Site Infection Surveillance Service, of orthopaedic surgery (hip replacement, knee replacement and repair of fractured neck of femur). The latest available data indicated that the trust had 0% SSI for knee replacement; 0.8% for neck of femur (all hospitals 1.3%); 1.1% for hip replacement (all hospital 0.8%).

In theatres we saw that one member of staff that would have had access to the clinical areas was wearing nail varnish and false eye lashes. There was also one member of staff directly working in theatres that was wearing a cotton bracelet and false eyelashes. These presented an infection risk. This was reported to senior staff during the inspection.

It was noted that in theatres nine and ten, there were numerous remnants of patches of sticky tape. This represented an infection risk.

Environment and equipment

During the inspection we visited eight different surgical wards, looked at the environment on each of them and randomly sampled the equipment in use on those wards. We saw that store rooms were tidy, well-ordered and well stocked. Dirty utility rooms were clean and substances hazardous to health were well managed. On one ward there was a patient kitchen area that contained a dishwasher and the tablets used when the dishwasher was in operation. Because this room contained hazardous tablets, there was a code lock on the door.

Where equipment was stored in corridors on the wards, it was done so safely as the corridors were wide. However, the corridor from theatres to recovery had a lot of stored equipment which on occasions made it difficult to manoeuvre a bed. We were told that this area had become congested as theatre ten was being used as a trauma theatre due to the problems with ventilation that had closed theatres one and two. We also saw that a fire door into recovery was propped open with a wooden wedge. This was repeated in theatres nine and ten. Staff were alerted to this...
and closed the doors when it was pointed out however the doors were seen to be wedged open again, later in the inspection.

Checks of resuscitation trolleys on the wards showed that all the contents were stored correctly, all equipment was in date and there were no gaps in the logs, which showed that regular checks were being carried out in accordance with the Resuscitation Council Guidelines 2015.

Checks on the resuscitation trolley in the theatres recovery area showed that the daily check list was completed. We looked inside and found that all drugs stored were in date. We also checked the contents of the sepsis response box and a lipid rescue box. A lipid rescue box contains equipment to deal with local anaesthetic induced cardiac arrest. These were both stocked with the correct equipment.

There was a paediatric resuscitation trolley and paediatric difficult airway trolley in theatres. These were checked daily and all equipment was in date.

Woodland ward was exceptionally warm even though the inspection took place on a cool autumn day. This was caused because there was little air that could come into the ward. Although there were windows on one side, the other side had been blocked by the placement of a pre-fabricated building adjacent to it. Staff told us that it was extremely warm in the summer, particularly July. As a result, they had taken the ambient temperature each day in July. This showed ambient temperatures higher than 25 degrees for most days in July.

The surgical assessment unit was also noted to be warm and patients we spoke with told us they had complained about the heat.

We noted in theatre four that there was a fridge that contained medicines that would be used for surgical procedures to the eye. The fridge was not working and it wasn’t known if it had stopped working or had been turned off. The staff in theatres removed the medicines and returned them to the pharmacy.

Theatres had been refurbished approximately 12 months prior to the inspection. The fabric of the rooms was good and there was no damage visible.

There were call bells in the theatres, recovery area and anaesthetic rooms. There was a system of lights that would direct staff to the site of the emergency and the crash trolley would be moved from recovery.

We asked three staff about the process they would need to follow in the event of an alarm being sounded or if there was a need to evacuate. All three understood and could explain and show the inspection team what they would do. There were clear procedures in place to follow if this happened.

In theatres we checked seven different pieces of equipment. We saw evidence that all had undergone electrical testing which was in date and all items checked had been serviced at the correct intervals.

We checked the difficult airway trolley for adult and paediatric patients. This was complete with laminated guide cards attached. This was sited in a corridor, with a permanent place marked on the wall, in a position that made it easily accessible if it was needed.

However, we did see that a warming cabinet in theatre four did not have a log book for checking the temperature. This meant that staff could not be certain that it was working correctly. This could mean that fluids like blood and intravenous fluids that are warmed in a warming cabinet may affect attempts to restore a patient’s body temperature to a normal range during or following a surgical procedure to avoid hypothermia.
We had a number of staff raise concerns about how long it took to take a patient from some of the wards and the pre-operative / pre-assessment area to theatres and that this could affect patient flow.

**Assessing and responding to patient risk**

In the event that a patient deteriorated significantly, the service had 24-hour, seven-day access to the critical care outreach team. They would be able to visit the wards to assess, in conjunction with the critical care consultant whether the patient should be admitted to critical care.

The service had access to an alcohol withdrawal nurse specialist who could provide guidance if a patient recovering from surgery started to withdraw from alcohol.

Staff in the surgical division could also get advice from a mental health nurse. They could provide immediate advice when needed and act as a link between the ward staff and the psychiatric liaison team.

Charlwood ward had a system during a night shift where patients that were a falls risk and required 1-1 monitoring, would be looked after by a health care assistant. The health care assistant that was monitoring the patient wore a yellow badge so that the rest of the team would know that they had to stay in place. If that health care assistant had any cause to leave the patient, they would have to hand the badge on to a colleague to ensure that the patient received constant monitoring.

We reviewed the major haemorrhage (bleeding) protocol and checked the trolley. Both were in order and fit for purpose. We also spoke with two staff, independently about what they would need to do if they suspected a major haemorrhage. Both could explain the protocol and the process they would follow.

We observed three instances where the World Health Organisation five steps to safer surgery Safety Checklist was completed. This was noted to be a well-rehearsed check. All staff in the theatre team complied with all the elements of the check. In the temporary theatres there were World Health Organisation check list ‘champions’ that oversaw the checklist to ensure it was followed. Instrument checklists were read out and checked at the beginning of each case.

We saw in theatres and on the wards that the service used the National Early Warning Score (NEWS 2). The NEWS is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, already recorded in routine practice, when patients present to, or are being monitored in hospital. Six simple physiological parameters form the basis of the scoring system:

1. respiration rate
2. oxygen saturation
3. systolic blood pressure
4. pulse rate
5. level of consciousness or new confusion*
6. temperature.
When reviewing patient records, we saw that these had been completed correctly.

Staff had trialled taking a patient to theatres to test how long it took. As a result, they had two emergency telephones installed along the way to reduce any risk and had worked through a scenario where the patient went into cardiac arrest during the journey through the corridor.

A surgical list was produced each day which showed who was having surgery and in what order. There were occasions when the list would have to change for a variety of reasons. We saw that the original list was written on rather than amended and re-printed. The standard operating procedure ‘Operating List Build, Order and Sign-off’ stated, ‘where changes to list order do become necessary this should be discussed with all members at the WHO pre-meet before any changes are made. The team leader in charge of the operating room will communicate this to the theatre co-ordinator. The team leader will also be responsible for the withdrawal of existing operating lists from all areas within the Theatre Suite, version control, and the re-publication and distribution of the new lists’.

Nurse staffing

The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. Rotas were planned to ensure they had the right skill mix for the planned surgical lists.

The trust reported the following qualified nursing staff numbers as of December 2017 and May 2018 for surgery:

<table>
<thead>
<tr>
<th>Location</th>
<th>December 2017</th>
<th>May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned WTE staff</td>
<td>Actual WTE staff</td>
</tr>
<tr>
<td>Trust level</td>
<td>320.0</td>
<td>240.9</td>
</tr>
</tbody>
</table>

The staff fill rate in May 2018 has improved since December 2017 with 25.7 more WTE staff in post.

From June 2017 to May 2018, the trust reported a vacancy rate of 22% for qualified nursing staff in surgery. This was higher than the trust target of 12%.

- East Surrey hospital: 19%
- Crawley hospital: 32%

From June 2017 to May 2018, the trust reported a turnover rate of 15% for qualified nursing staff in surgery. This was higher than the trust target of 12%.

- East Surrey hospital: 14%
- Crawley hospital: 27%

From June 2017 to May 2018, the trust reported a sickness rate of 4% for qualified nursing staff in surgery.

- East Surrey hospital: 3%
- Crawley hospital: 8%
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template, but was not provided in a format that would allow us to give bank usage as a percentage of activity. Use of bank and agency staff varied across the surgical division depending on the ward. Staff we spoke with told us that the majority of shifts are filled by staff that are employed by the trust, working bank shifts.

**Medical staffing**

The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

The trust reported the following medical staffing numbers as of December 2017 and May 2018 for surgery:

<table>
<thead>
<tr>
<th>Location</th>
<th>December 2017</th>
<th>May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned WTE staff</td>
<td>Actual WTE staff</td>
</tr>
<tr>
<td>Trust level</td>
<td>64.7</td>
<td>77.5</td>
</tr>
</tbody>
</table>

Staff fill rates for medical staff in surgery have been over 100% in both December 2017 and May 2018 due to more WTE staff in post than planned for.

From June 2017 to May 2018, the trust reported a vacancy rate of -19% for medical staff in surgery. This was lower than the trust target of 12% and the negative vacancy rate is due to an over establishment of medical staff.

- East Surrey hospital: 12% over-establishment
- Other medical staff: 55% over-establishment

Other medical staff refers to medical staff who work across a number of sites at the trust (including the dental services split between East Surrey Hospital and Caterham Dene), all of which are overstaffed according to the information submitted by the trust.

From June 2017 to May 2018, the trust reported a turnover rate of 49% for medical staff in surgery. This was higher than the trust target of 12%.

- East Surrey hospital: 51%
- Dental service split between East Surrey hospital and Caterham Dene: 38%

From June 2017 to May 2018, the trust reported a sickness rate of 1.7% for medical staff in surgery. This was lower than the trust target of 3%.

- East Surrey hospital: 1.0%
- Dental service split between East Surrey hospital and Caterham Dene is 4.0%

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template, but was not provided in a format that would allow us to give bank usage as a percentage of activity. For the period 1 June 2017 and 31 May 2018, a total of 841.5 shift were filled by bank staff. In the same period a total of 1353 shifts were filled by agency staff.
In May 2018, the proportion of consultant staff reported to be working at the trust was similar to the England average and the proportion of junior (foundation year 1-2) staff was lower than average.

**Staffing skill mix for the whole time equivalent staff working at Surrey and Sussex Healthcare NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>48%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>17%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>26%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>9%</td>
<td>11%</td>
</tr>
</tbody>
</table>

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

During our inspection we saw that wards and theatres had largely met their template for medical and nursing staffing. We did not see any areas where there were or had been significant shortfalls in staffing numbers that would have compromised patients safety.

(Source: NHS Digital Workforce Statistics)

**Records**

We reviewed six sets of records for patients on the surgical wards. These were paper based records. They were stored safely in lockable trolleys. Trolleys were not seen to be unlocked and unattended at any time. They were well-ordered and contained sufficient detail of the patient to deliver safe care and treatment.

We saw that antibiotic start dates, their clinical indication and stop dates were recorded. Drug charts and allergy information was correctly documented. Clear reasons for any scans were given and pain relief was also detailed.

We saw one patient that had a ‘do not attempt cardio pulmonary resuscitation’ order in place. There was clear evidence of a discussion having taken place with the patients relative. All documentation was completed and signed correctly. We also saw that a ceiling of care discussion had been had with the relative.

Allergies recorded on chart in line with National Institution for Care Excellence guidance. Regular medicines prescribed including route, frequency, all signed by prescriber and no missed doses. Medicines that were taken when needed (PRN) all included frequency / maximum dose in 24 hours.

We reviewed three sets of records in theatres. They all included a full care plan including venous thromboembolism assessments, anaesthetic / medicine charts a pre-operative assessment and consent.
Three operating registers were checked and all three were complete and there were no missing signatures.

We reviewed discharge plans for two patients that were waiting to go home. We saw that the medical notes were up to date, all test results had been recorded and medication given was correctly recorded.

The trust had a frequent shuttle van that could take records between the East Surrey and Crawley Hospital sites. The records team worked 24 hours, seven days a week.

On the surgical assessment unit, patient notes were kept in an unlocked trolley at the nurses’ station. This had been risk assessed and was not deemed to be a risk as there was always someone at the station and if someone left, they would lock the trolley.

**Medicines**

We looked at medicines storage across the surgical wards and theatres. We checked a small number of rooms where medicines were stored and saw that all medicine cupboards were locked and labelled correctly, fridge temperature logs were completed and up to date. All recordings were within the expected range. We reviewed three controlled drugs books in theatres which were also completed correctly.

The clinic room on Charlwood Ward, where the medicines were stored was exceptionally hot although there was no recording, and no means of recording the room’s ambient temperature. We also saw that there was no means of recording the ambient temperature in any of the other clinic rooms.

Codeine (a pain relieving medicine) prepacks were recently made available on several surgical wards for nursing staff to dispense after being prescribed for discharge. Nursing staff were supposed to log the patient number for all packs supplied. We saw that was not always occurring, on the surgical assessment unit where four packs in the last 10 were not recorded.

The trust had a specialist antibiotic pharmacist and current guidelines were available on the trust intranet and via a smart phone app.

Pharmacists could access patient summary care records. Pharmacists completed full medicine reconciliation (medicine reconciliation is the process of creating the most accurate list possible of all medications a patient is taking — including drug name, dosage, frequency, and route — and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications) for all patients within 24 hours of admission during weekdays and weekends.

All discharge prescriptions were electronically written and then screened by a clinical pharmacist before dispensing. There was a clinical pharmacy service every day. Principles of antimicrobial stewardship had been implemented.

Any antibiotics prescribed had to be reviewed and re-prescribed after 72 hours. New prescription charts implemented had been implemented trust wide six weeks prior to the inspection which prompted antibiotics to be reviewed and re- prescribed after being administered for three days.

In theatres, controlled drugs books were checked and reconciled with the drugs at the start and finish of each shift. Controlled drugs are a group of medicines liable for misuse that require special management. They were locked in a suitable cupboard, which only authorised staff had access to.

We saw that on Copthorne ward, saline and water ampoules were not locked away in a cupboard, nor were medicines to treat heartburn and indigestion. However, the doors to the rooms were locked.
We saw that the medicine cupboard in theatres was well stocked. Medicines that were coming up to their expiry were marked to show this. We checked ten different packs at random and they were all in date.

**Incidents**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From July 2017 to August 2018, the trust reported one incident classified as a never event for surgery.

The incident occurred in July 2018 and related to a wrong sized implant being fitted during a joint replacement procedure.

*(Source: NHS Improvement - STEIS)*

Staff told us that following the never event, immediate action was taken and a new process for checking implants, pre, and post operatively was introduced. An independent ‘after action review’ was carried out by a member of staff from outside theatres. A monthly audit on implant checking was introduced and changes were made to the way they were stored.

We directly asked five staff if they knew how to report incidents. All told us that they had received training in how to use the incident reporting system and how they were encouraged to tick the feedback box. Those that had done that had received feedback on what action had been taken. Staff also confirmed that they would be happy to raise any concerns and would not feel like they were causing trouble or that it would have an adverse effect on them.

Staff we spoke with described how details of incidents were communicated in weekly messages form the chief of surgical services. They were then further shared and discussed in team safety huddles for those that hadn’t yet seen the messages.

Staff we spoke with were aware of the duty of candour (the duty of candour requires every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Staff we asked directly were able to describe what they would do in the event that something went wrong with a patient’s care. We were told about specific examples where this had happened. There had been 34 occasions in the period between 1 June 2017 and 31 May 2018 where the duty of candour had been exercised.

In accordance with the Serious Incident Framework 2015, the trust reported 16 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from July 2017 to August 2018.

A breakdown of these incidents by type is shown below:

- Eight treatment delays meeting SI criteria
- Five slips/trips/falls meeting SI criteria
- One diagnostic incident including delay meeting SI criteria (including failure to act on test results)
- One screening issue meeting SI criteria
- One surgical/invasive procedure incident meeting SI criteria
Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

We saw that safety thermometer information was displayed across the wards we visited.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 19 new pressure ulcers, four falls with harm and four new catheter urinary tract infections from July 2017 to July 2018 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Surrey and Sussex Healthcare NHS Trust

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)
Is the service effective?

Evidence-based care and treatment

Trust policies and guidance reflected current evidence based guidance. Staff had easy access to relevant policies and were aware of the guidance that underpinned them.

We saw that patients at risk of venous thromboembolism were assessed according to the National Institute for Care Excellence (NICE) Quality Standard 3, Statement 5. Patients were offered preventative treatment if required.

The surgical division had developed a fracture neck of femur (broken hip) pathway that met the NICE guideline CG124 Hip Fracture Management.

Sepsis management was in line with the NICE guidelines (NG51). Sepsis: recognition, diagnosis and early management. Staff we spoke with had a good awareness of how to manage suspected sepsis following a wide-ranging review that had been carried out.

All joints used for implants were entered into a registry. There were robust governance processes around who did the implant and when. Results were then discussed in consultant meetings.

The surgery division participated in a wide range of internal and external audits. We saw evidence that changes were following the audits carried out. Each audit had key successes, key concerns and key actions following the audit.

Handovers we observed discussed both the physical and mental wellbeing of patients being cared for across the surgical division.

Nutrition and hydration

Dietitians on the wards attended morning handover and reviewed each patients Malnutrition Universal Screening Tool (MUST) score. We reviewed nine records and saw that patients' nutrition and hydration needs were met and what was provided was recorded correctly.

Patients we spoke with told us that they had sufficient food and drink provided as and when required.

However, one member of staff in theatres told us that the availability and provision of food out of hours was poor. They only had access to vending machines which were often depleted from their use during the day.

We observed a lunchtime round where patients were being given their meals. The staff had identified those that required help with eating and served them last. This meant that those patients' meals would stay warm and they could then offer them assistance to eat. We also saw that a patient, living with dementia had not eaten their dessert when it was first given to them, and subsequently did not want to eat their dessert as it had cooled. Staff were quick to identify that when the patient was ready to eat the dessert, they got them one that was warm.

Pain relief

The surgical division had access to a pain team. The team consisted of a consultant, an anaesthetist, a band seven nurse and two band six nurses. They were available to call between 8am and 6pm, seven days a week, if staff on the wards had concerns regarding a patients' pain management. Different surgical procedures had different pain control pathways. The team were based in theatres but would attend the wards every day.
Staff told us that chronic pain assessments could take up to an hour to complete as there was no chronic pain nurse in the division.

Patients we spoke with told us that their pain was managed well and any medication needed was provided in a timely manner. Records we reviewed showed that pain scores were assessed and documented. We also saw visual prompt cards on the ward that showed the universal pain assessment tool that was in use across the surgical division. This could be used by patients that could verbalise and those that couldn't. This was a system which scored pain from zero to ten and mild, moderate or severe.

### Patient outcomes

#### Trust level

**Elective Admissions – Trust Level**

![Image of bar chart showing trust level for elective admissions.](chart1.png)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.*

From May 2017 to April 2018:

- All patients at the trust had a lower expected risk of readmission for elective admissions which was better than the England average.
- General surgery and urology patients at the trust had a lower expected risk of readmission for elective admissions which was better than the England average.
- Ophthalmology patients at the trust had a higher expected risk of readmission for elective admissions which was worse than the England average.

**Non-Elective Admissions – Trust Level**

![Image of bar chart showing trust level for non-elective admissions.](chart2.png)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.*
From May 2017 to April 2018;

- All patients at the trust had a lower expected risk of readmission for non-elective admissions which was better than the England average.
- General surgery and trauma and orthopaedics patients at the trust had a lower expected risk of readmission for non-elective admissions which was better than the England average.
- Ear, nose and throat (ENT) patients at the trust had a higher expected risk of readmission for non-elective admissions which was worse than the England average.

East Surrey Hospital

Elective Admissions - East Surrey hospital

![Elective Admissions Graph]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity

From May 2017 to April 2018;

- All patients at East Surrey hospital had a lower expected risk of readmission for elective admissions which was better than the England average.
- Urology patients at East Surrey hospital had a lower expected risk of readmission for elective admissions which was better than the England average.
- General surgery and ophthalmology patients at East Surrey hospital had a higher expected risk of readmission for elective admissions which was worse than the England average.

Non-Elective Admissions - East Surrey hospital

![Non-Elective Admissions Graph]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity

From May 2017 to April 2018;

- All patients at East Surrey hospital had a lower expected risk of readmission for non-elective admissions which was better than the England average.
- General surgery and trauma and orthopaedic patients at East Surrey hospital had a lower expected risk of readmission for non-elective admissions which was better than the
England average.

- Ear, nose and throat (ENT) patients at East Surrey hospital had a higher expected risk of readmission for non-elective admissions which was worse than the England average.

Crawley Hospital

Elective Admissions - Crawley hospital

From May 2017 to April 2018;

- All patients at Crawley hospital had a lower expected risk of readmission for elective admissions which was better than the England average.
- General surgery and ophthalmology patients at Crawley hospital had a lower expected risk of readmission for elective admissions which was better than the England average.
- Ear, nose and throat (ENT) patients at Crawley hospital had a higher expected risk of readmission for elective admissions which was worse than the England average.

(Source: Hospital Episode Statistics)

East Surrey hospital:

The table below summarises East Surrey hospital’s performance in the 2017 National Hip Fracture Database.

When compared to other trusts, performance was better in two of the audit measures, worse in none of the audit measures, and similar in four of the audit measures.

In this context, ‘similar’ means that the trust’s performance fell within the expected range of results. The national standard was met in none of the relevant audit measures.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment</td>
<td>98.4%</td>
<td>Similar</td>
<td>➡️</td>
</tr>
<tr>
<td>(Proportion of eligible cases included in the audit)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crude proportion of patients having surgery on the day or day after admission</td>
<td>82.4%</td>
<td>Better</td>
<td>➡️</td>
</tr>
</tbody>
</table>
(Proportion of patients having their hip fracture surgery on the day or day after admission to hospital)  

Crude peri-operative medical assessment rate  
(Proportion of patients who were assessed by a Care of the Elderly doctor around the time of their operation to ensure the best outcome)  

97.3%  Better  

Crude proportion of patients documented as not developing a pressure ulcer  
(Proportion of patients who are documented to be free of hospital-acquired pressure damage (grade 2 or above) during their admission.)  

98.4%  Similar  

Crude overall hospital length of stay  
(Average number of days patients stay in hospital)  

20.1 days  Similar  

Risk-adjusted 30-day mortality rate  
(Proportion of patients who die within 30 days of admission)  

6.2%  Similar  

(Source: National Hip Fracture Database 2017)

The table below summarises the trust's performance in the 2017 National Bowel Cancer Audit. When compared to other trusts, performance was worse in two of the audit measures, and similar in four of the audit measures.

In this context, 'similar' means that the trust’s performance fell within the expected range of results. There are currently no national standards for this audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment</td>
<td>74.7%</td>
<td>Within expected range</td>
<td>Good is over 80%</td>
</tr>
<tr>
<td>Risk-adjusted post-operative length of stay &gt;5 days after major resection</td>
<td>70.4%</td>
<td>Worse than national aggregate</td>
<td>No current standard</td>
</tr>
<tr>
<td>Metrics (Audit measures)</td>
<td>Trust performance</td>
<td>Comparison to other Trusts</td>
<td>Meets national standard?</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>----------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Risk-adjusted 90-day post-operative mortality rate (Proportion of patients who died within 90 days of surgery)</td>
<td>3.8%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted 2-year post-operative mortality rate (Proportion of patients who died within two years of surgery)</td>
<td>29.2%</td>
<td>Worse than national aggregate</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted 30-day unplanned readmission rate (Proportion of patients re-admitted to hospital unplanned within 90 days of surgery)</td>
<td>10.3%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection (Proportion of patients still with a stoma 18 months after surgery for rectal cancer)</td>
<td>42.4%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: National Bowel Cancer Audit 2017)
Surrey and Sussex Healthcare NHS Trust did not submit data to the national vascular registry.

(Source: National Vascular Registry)

(Audit of the overall quality of care provided for patients with cancer of the oesophagus [the food pipe] and stomach)
The table below summarises the trust's performance in the 2016 National Oesophago-gastric Cancer Audit.
When compared to other trusts, performance was similar in two of the trust-level measures.
In this context, ‘similar’ means that the trust’s performance fell within the expected range of results. There are currently no national standards set for this audit.
Age and sex adjusted proportion of patients diagnosed after an emergency admission

(Proportion of patients with food pipe or stomach cancer who are diagnosed following an emergency admission to hospital)*

<table>
<thead>
<tr>
<th></th>
<th>Trust performance</th>
<th>Audit’s Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.9%</td>
<td>Similar</td>
<td></td>
<td>No current standard</td>
</tr>
</tbody>
</table>

Risk adjusted 90-day post-operative mortality rate

(Proportion of patients who die within 90 days of their operation)

<table>
<thead>
<tr>
<th></th>
<th>Trust performance</th>
<th>Audit’s Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not eligible</td>
<td>Not eligible</td>
<td></td>
<td>No current standard</td>
</tr>
</tbody>
</table>

Strategic Clinical Network (SCN) level metrics

(Measures of performance of the wider group of organisations involved in the delivery of care for patients with oesophago-gastric (food pipe and stomach) cancer)

<table>
<thead>
<tr>
<th></th>
<th>Trust performance</th>
<th>Audit’s Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>40%</td>
<td>Similar</td>
<td></td>
<td>No current standard</td>
</tr>
</tbody>
</table>

* It is important that Trusts try and reduce diagnoses of food pipe or stomach cancer being made following emergency admission as patients referred by this route are less likely to receive treatment which is intended to cure their cancer.

(Source: National Oesophago-Gastric Cancer Audit 2016)

**East Surrey hospital:**

The table below summarises East Surrey hospital’s performance in the 2017 National Emergency Laparotomy Audit.

When graded by the audit body, performance was better in three of the audit measures and similar in three of the audit measures.

In this context, ‘similar’ means that the trust’s performance fell within the expected range of results. The national standard was met in three of the five relevant audit measures.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Audit’s Rating</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case ascertainment</td>
<td>73%</td>
<td>Similar</td>
<td>✗</td>
</tr>
<tr>
<td>Crude proportion of cases with pre-operative documentation of risk of death</td>
<td>75%</td>
<td>Similar</td>
<td>✗</td>
</tr>
<tr>
<td>(Proportion of patients having their risk of death assessed and recorded in their notes before undergoing an operation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

| Crude proportion of cases with access to theatres within clinically appropriate time frames (Proportion of patients who were operated on within recommended times) | 89% | Better | ✓ |
| Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre Proportion of patients with a high risk of death (5% or more) who have a Consultant Surgeon and Anaesthetist present at the time of their operation) | 93% | Better | ✓ |
| Crude proportion of highest-risk cases (greater than 10% predicted mortality) admitted to critical care post-operatively (Proportion of patients with a high risk of death (10% or more) who are admitted to a Critical/Intensive Care ward after their operation) | 100% | Better | ✓ |
| Risk-adjusted 30-day mortality rate (Proportion of patients who die within 30 days of admission) | 5.6% | Similar | No current standard |

(Source: National Emergency Laparotomy Audit)

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.
In 2016/17 performance on groin hernias was better than the England average, as was performance on varicose veins and knee replacements.

For hip replacements, performance was about the same as the England average.

(Source: NHS Digital)

Competent staff

From April 2017 to March 2018, 89% of all staff within surgery at the trust received an appraisal compared to a trust target of 90%.

The trust has provided the data for the following staff groups, but it did not include details of any medical staff for any core service.

Three of the six staff groups met the 90% appraisal completion target. Additional clinical services, administrative and clerical and allied health professionals did not meet the 90% target.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals completed</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>23</td>
<td>21</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>179</td>
<td>167</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>115</td>
<td>96</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>26</td>
<td>21</td>
<td>81%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>6</td>
<td>5</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

Staff on one ward told us how they were looking to develop and increase the competencies of their health care assistants. They arranged for training in venepuncture, male catheterisation, and blood collection. All staff eligible for the training had either been trained or had the training scheduled.

We spoke with three nursing staff about the sepsis pathway. All three knew what number they had to call, and the pathway they needed to follow.
In theatres a list of staff competencies was held electronically, however, at the time of the inspection the person that was responsible for maintaining the list was not in. There was no one else available who could access this list. ADR – List of competencies

**Multidisciplinary working**

During the inspection we observed many examples of multi-disciplinary working. These were at safety huddles, ward rounds and reviews of the patients. Morning patient safety huddles observed on the wards were attended by the consultant and other members of the medical team. Nursing staff, including ward sisters attended as did therapy staff including, physiotherapists, occupational therapists and dietitians. Although we did see pharmacists present on occasion, it was not always possible for pharmacists to attend all ward rounds. Pharmacy staff did not take part in any regular ward rounds or multi-disciplinary team meetings apart from in critical care.

We sat in on a multi-disciplinary briefing meeting in the anaesthetic department. This was held every day between 8am and 9am. This was attended by the theatre co-ordinator, medical and nursing staff. Each patient was discussed for co-morbidities and any other requirements that would need speciality input.

One safety huddle we observed on Newdigate ward involved the consultant handing out six cards, face down. They were then offered to random members of the team and each card had a small number of questions on them. The person that had card number one would have to read the questions which then needed to be answered. This was repeated until all the questions on all the cards that needed to be asked, had been answered. This ensured all members of the team were involved in the discussions and the structure ensured that no element of the safety huddle was missed. As a result, the meeting was focussed and efficient.

We observed the morning safety briefing in theatres. It was attended by the full range of theatre staff. We saw an in-depth discussion about each list. The team discussed all the variables from the day’s lists including, but not limited to information about patients with pacemakers, patients that may have airway difficulties and other issues that may arise.

We attended the recovery briefing which was thorough. The whole team discussed how the day would run. This included details of the patients, staffing issues and any potential problems that would need to be worked through.

**Seven-day services**

Most emergency admissions were seen and had a thorough clinical assessment by a suitable consultant as soon as possible and at the latest within 14 hours from the time of admission to hospital.

Following seven-day service audits that were done the trust identified that most of the time this standard was met. There were, however, challenges in the morning for patients who had been admitted at around about 9pm the previous evening who then required specialty consultant review within 14 hours. The 14 hour review time often coincided with ward rounds that were taking place and urgent cases being addressed.

The surgical services division had access to diagnostic services seven days a week. Interventional radiology was available 24 hours a day, seven days a week.

The surgical division operated a seven-day service with ten theatres in use, seven days per week. The surgery centre was also in use seven days a week.
The pain team were available to ward and theatre staff between 8am and 6pm seven days a week. There was access to a consultant anaesthetist out of hours for advice on pain relief.

There was pharmacist cover five days per week.

Health promotion

A newly appointed alcohol withdrawal nurse specialist provided advice and guidance to patients that were withdrawing from alcohol while in hospital. They could signpost patients to services in the community for those withdrawing from alcohol as well as contact the patient’s general practitioner.

Patients that had surgery at the trust were routinely provided with advice and information about smoking cessation if it was known that the patient was a smoker.

Patients were given advice following pre-assessment appointments if there were any issues that they needed to address, such as high blood pressure, before surgery.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The trust includes training for the Mental Capacity Act and Deprivation of Liberty Safeguards within the mandatory level 1 and level 2 safeguarding training modules. Please see the “Safeguarding” section for details of training compliance.

On Woodland ward we saw that there was a patient safety board in the clinic room. This showed details of all the patients and what the safety concerns were, including those that were subject to a deprivation of liberty safeguard and those that were living with dementia. Staff we spoke with across all the surgical wards knew of the procedure to follow if they needed to apply for a deprivation of liberty safeguard and how they could get a dementia assessment carried out. The service had a dementia lead nurse who could be contacted if necessary to carry out an assessment.

In three sets of patient records we reviewed in theatres we saw that consent was obtained and recorded correctly.

The surgical division staff could access a nurse consultant for dementia if they needed advice regarding consent, deprivation of liberty safeguards applications, or if they required their attendance on a ward. The nurse consultant would carry out mental health assessments in conjunction with the medical staff.

Staff we spoke with had good knowledge of deprivation of liberty safeguards and knew the process they needed to follow if one was required. In the records we reviewed we saw how deprivation of liberty safeguards decisions were made and recorded.

In the period 1 June 2017 to 31 May 2018 there had only been one application for a deprivation of liberty across the surgical division.

Is the service caring?
Compassionate care

Feedback from people who used the service, those who were close to them and stakeholders was consistently positive about the way staff treated people. People think that staff go the extra mile and their care and support exceeds their expectations. There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promotes people’s dignity. Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.

Staff recognised and respected the totality of people’s needs. They always took people’s personal, cultural, social and religious needs into account, and found innovative ways to meet them. People’s emotional and social needs were seen as being as important as their physical needs.

The Friends and Family Test response rate for surgery at Surrey and Sussex Healthcare NHS trust was 22% which was worse than the England average of 27% from July 2017 to July 2018.

The service consistently had a high percentage of patients and relatives that would recommend the service to others. All wards scored between 94% and 98%. On Brook ward the 98% average was achieved having received a 77% response rate.

A breakdown of response rate by site can be viewed below.

Friends and family test response rate at Surrey and Sussex Healthcare NHS Trust, by site.

(Source: NHS England Friends and Family Test)

East Surrey hospital
We observed discussions between patients, relatives and clinical staff. We saw that these were planned well and handled sensitively. Any decisions made were then communicated to the wider team providing care to the patient to ensure all were aware of them.

We were told how a patient that was receiving end of life care on a ward told staff about their passion for steam railways. Because the staff knew about this, they arranged for the patient to leave the hospital and spend the day at a nearby steam railway line. This involved having nursing staff arrange transportation and for the patient to be looked after by nursing and therapy staff while away from the hospital environment. The patient returned to the hospital for one day before being moved to receive end of life care at a local hospice. When we were told about this, the team explained that this was driven by the SaSH+ initiative. This was an initiative that the staff took to mean that they would do things that would stand out, going the extra mile for their patient and treating each patient as in individual.
We spoke with one patient and their spouse who told us that the care they had received was brilliant, there had been ‘no problems’ and that ‘all staff always tried to help’. We also saw the interactions the patient and their spouse had with staff were warm and friendly. However, when we asked the patient if they had completed a friends and family test card, they explained that they had never seen them and that no one had offered them one to fill in.

A number of other patients told us how the staff were all compassionate and did what they could for them. We also looked at some of the thank you cards that had been received across the surgical wards. These described how they or their loved ones had been cared for during their time in hospital and offered heartfelt thanks to the staff.

**Emotional support**

Staff on Charlwood ward told us about a patient that was recovering from a stroke. It was their wish to be able to spend some time outside of the hospital. The sister arranged for the nurses, physiotherapists and occupational therapists to ensure that the patient could sit up safely and be moved to the grounds of the hospital. Due to the benefits this had with the patient, they repeated this every day until the patient was discharged.

One patient described to us how the staff had treated them with compassion and that some of them had a similar sense of humour, they shared jokes and that they made the patient laugh.

We were also told about a patient that had had a fall from a horse. A senior nurse had considered that this may affect the patient’s confidence to get back on a horse. With the patient’s agreement they arranged for the patient to leave the hospital to visit the horse they had fallen off. This had a positive effect on the patient who could be discharged shortly after the visit.

**Understanding and involvement of patients and those close to them**

One patient we spoke with told us how they had felt that the process of admission was handled well, how they were told of their test results quickly and that they had sufficient opportunity to talk with the staff when they needed to. They went on to say that staff were approachable and that they were treated professionally. The patient had been told about their treatment plan and who their nurse and consultant were. They also commented that the staff speak with family when they visit and that visiting hours suited them and their visitors.

Another patient described how their transition through the system from the emergency department, to the surgical assessment unit had been efficient and that they were satisfied with the experience. However, the move to the ward had been delayed. They had not been given pyjamas and had to sleep in their own clothes. They went on to describe that even though the staff were busy, they were always sympathetic and would recommend the service to others.

We spoke with family members of one patient who described how they had been happy with the care their relative had received and that they were well informed about the therapy that would continue once the patient had left hospital. The patient and the family said that they would recommend the hospital as a place to receive care.

We spoke with one patient, who was with their spouse who said that they had not been given any information about what was wrong with them and that they had not had any conversations with doctors or consultants about what was going on. This had caused the patient some apprehension and uncertainty. Another patient told us that they hadn’t been sent at any great length by a doctor and that it was only ‘in passing.’ They had had an x-ray in the surgical assessment unit but had not received any information about the outcome since moving to the ward.
Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people. The importance of flexibility, informed choice and continuity of care is reflected in the services. People’s needs and preferences are considered and acted on to ensure that services are delivered in a way that is convenient.

In the summer of 2017 the hospital opened a seven day a week surgery centre. This was a dedicated area for patients who needed day case or short stay surgery. There were two treatment rooms, a recovery area with five reclining chairs and two five bedded bays, one male and one female. The centre was open seven day a week. This was done to ensure that those that only needed less complex surgery had a dedicated area and that the length of time in hospital was kept to a minimum.

Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

From June 2017 to May 2018;
- The average length of stay for all elective patients at the trust was 4.2 days, which was similar to the England average of 3.9 days.
- The average length of stay for trauma and orthopaedics elective patients at the trust was 4.8 days which was worse than the England average of 3.8 days.
- The average length of stay for general surgery elective patients at the trust was 4.8 days, which was worse than the England average of 3.9 days.
- The average length of stay for urology elective patients at the trust was 2.2 days, which was similar to the England average of 2.5 days.

Non-Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

From June 2017 to May 2018;
- The average length of stay for all non-elective patients at the trust was 5.8 days, which was worse than the England average of 4.9 days.
- The average length of stay for general surgery non-elective patients at the trust was 4.7...
days, which was worse than the England average of 3.8 days.
• The average length of stay for trauma and orthopaedics non-elective patients at the trust was 9.4 days, which was longer than the England average of 8.7 days.
• The average length of stay for ear, nose and throat (ENT) non-elective patients at the trust was 2.2 days, which was the same as the England average.

Elective Average Length of Stay - East Surrey Hospital

Note: Top three specialties for specific site based on count of activity.

From June 2017 to May 2018;
• The average length of stay for all elective patients at East Surrey hospital was 4.2 days, which was similar to the England average of 3.9 days.
• The average length of stay for trauma and orthopaedics elective patients at East Surrey hospital was 4.8 days, which was worse than the England average of 3.8 days.
• The average length of stay for general surgery elective patients at East Surrey hospital was 4.9 days, which was worse than the England average of 3.9 days.
• The average length of stay for urology elective patients at East Surrey hospital was 2.2 days, which was similar to the England average of 2.5 days.

Non-Elective Average Length of Stay - East Surrey Hospital

Note: Top three specialties for specific site based on count of activity.

From June 2017 to May 2018;
• The average length of stay for all non-elective patients at East Surrey hospital was 5.9 days, which was worse than the England average of 4.9 days.
• The average length of stay for general surgery non-elective patients at East Surrey hospital was 4.7 days, which was worse than the England average of 3.8 days.
• The average length of stay for trauma and orthopaedics non-elective patients at East Surrey hospital was 9.3 days, which was worse than the England average of 8.7 days.
• The average length of stay for ear, nose and throat (ENT) non-elective patients at East Surrey hospital was 2.2 days, which was the same as the England average.
Elective Average Length of Stay - Crawley Hospital

From June 2017 to May 2018;
- The average length of stay for all elective patients at Crawley hospital was 3.6 days, which was similar to the England average of 3.9 days.
- The average length of stay for breast surgery elective patients at Crawley hospital was 4.9 days, which was worse than the England average of 1.6 days.
- The average length of stay for ear, nose and throat (ENT) elective patients at Crawley hospital was 1.3 days, which was better than the England average of 2.0 days.
- The average length of stay for general surgery elective patients at Crawley hospital was 1.4 days, which is lower than the England average of 3.9 days.

(Source: Hospital Episode Statistics)

Meeting people’s individual needs

On all wards there were ‘don’t take you troubles home’ boards. This gave information about how patients and relatives could get support following their hospital admission and an opportunity to make comments and ask questions. The matron also held ‘meet the matron sessions’ where patients could ask questions directly. Although these meetings happened regularly, it was unclear what the exact frequency was.

There was a ‘you said, we did’ board on Copthorne ward. One area of concern was that medicines to take out were not ready when the patient was ready to be discharged. The ward had, following this, spoken with the multidisciplinary team, including pharmacy to ensure that medicines to take out were ready on the day of discharge.

Patient information leaflets provided with medicines to take out contained information where Pharmacists / pharmacy technicians provided guidance to patients on how to take their medicines at discharge. Patients were assessed to check if they needed to use a compliance aid for their medicines on discharge. These were dispensed by the on-site retail pharmacy. The pharmacy department had a patient information helpline available during working hours, Monday to Friday.

We were told how the service worked closely with a national charity that were based in the hospital. When a patient was ready for discharge from the ward, the charity workers would offer a take home and settle service. This ensure that the patient got home safely and had the basics for the initial period back in their own home.

When we visited Woodland ward, we were shown a bay where the patients living with dementia were cared for. It was a four-bedded bay that always had a member of staff positioned there to help if a patient tried to get out of bed. If patients had any confusion about why they were there and where they were, staff would place a small notice board at the end of their bed telling them that they were at East Surrey hospital, and how they got there, for example, if they had had a fall.
The bay also had a clock which told the time in different formats as well as the day and date. We were also shown the patients’ dementia passports. This detailed information about why they were, what they liked and other things that were important to them. We saw that staff had gone to great lengths to ensure they knew as much about the patient as possible.

We saw that each patient had a behaviour diary so there was a continuous record of how the patient behaved and how the behaviours were affected and how they may or had change over time. The ward matron had also made a dementia trolley that had items that could be used for the patients to reminisce, including books, games, CDs and, where possible, photographs of where the patient grew up. The trolley also had twiddle muffs which could be used to calm patients if they became agitated. There was also a tape recorder that relatives could leave messages on to be played to the patients to remind them of the voices of their loved ones.

In theatres there was an electric sports car that paediatric patients could travel to theatres in. When they reached theatres, there was a holding area that children could use so they didn’t go in to the theatre environment too soon. There was a designated bay in recovery for paediatric patients.

A member of portering staff, who was the dementia lead for theatres told us how they had been involved in creating two bay areas in recovery that were quieter. These could be used by patients with dementia or any patient whose recovery would be enhanced by being in a quiet area.

The inspection team were shown the quiet bay that could be used for patients with special needs. There was space for someone to be by their side when they recovered. There was a ‘this is what to expect’ booklet available for patients and carers. We saw a Makaton (Makaton uses speech with signs (gestures) and symbols (pictures) to help people communicate) sheet that could be used to assist those patients that used this as a form of communication, to express their feelings. There was a learning disabilities file which staff used to help communicate with patients with a range of communication needs. There were sensory products available but patients were encouraged to bring their own favourite items to the hospital.

During the inspection we saw that there was a range of information available for patients and relatives across the surgical division. This information related to the patient’s stay in hospital as well as ways they could be supported once they left hospital. However, none of these were immediately available in any language other than English. Although there was a sentence on the back of each leaflet that said that it was available in other formats such as braille or other languages, it would have required the person to have been able to read English to understand this. Staff told us that a telephone interpreting service was available for any patients that required it. On Woodland ward were shown a phrase book with common phrases in a range of different languages in it. However, this was kept in the staff area.

Staff told us that there were predominantly two communities locally that didn’t speak English as a first language. East Surrey hospital was also the designated hospital to receive patients in the event of a major disaster from a nearby international airport.

On Newdigate ward we saw that there was a large dementia friendly clock near the nurses’ station to assist patients orientate themselves to time. However, the clock was telling the wrong time as it was approximately 50 minutes slow.

One patient we saw in the surgical admission unit arrived at 7am. However, they were not taken to theatre until 2pm. They told us they would have liked to have a drink but had not been offered one. The matron explained that there was a breakdown in communication as they had not been able to contact the anaesthetist. The patient waited seven hours to go to theatre and was not offered a drink despite there only being a two-hour clear liquid fasting policy.
A list of patients due for surgery was produced each morning with a running order. On occasion there was a need to change the order of patients. However, we saw a patient that believed that they were first on the list but had not been told that the order had changed.

**Access and flow**

People can access the right care at the right time. Access to care is managed to take account of people’s needs, including those with urgent needs. Waiting times, delays and cancellations are minimal and managed appropriately.

We saw that all theatres were being utilised and were running to time. Although theatres were running to time, we did see that patients were not always kept up to date about any changes to the theatre list.

There were no medical outliers that we were aware of on any of the surgical wards that we visited. Patients were on occasion being held in recovery to await a bed. We saw that there were two patients that had stayed overnight in recovery as there was no bed immediately available.

From July 2017 to June 2018 the trust's referral to treatment time (RTT) for admitted pathways for surgery was consistently better than the England average.

In the latest month, June 2018, 76.9% of this group of patients were treated within 18 weeks compared to the England average of 66.8%.

(Source: NHS England)

A breakdown of referral to treatment rates for surgery by specialty is below.

Four specialties above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>83.8%</td>
<td>76.8%</td>
</tr>
<tr>
<td>General surgery</td>
<td>77.6%</td>
<td>72.7%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>74.4%</td>
<td>69.0%</td>
</tr>
<tr>
<td>ENT</td>
<td>66.5%</td>
<td>63.2%</td>
</tr>
</tbody>
</table>

Two specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>59.5%</td>
<td>60.4%</td>
</tr>
</tbody>
</table>
A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Over the two years, the percentage of cancelled operations at the trust that were not followed up within 28 days had consistently been above the England average. In Q4 2017/18 the trust cancelled 151 surgeries, of which 38% weren’t treated within 28 days, which was significantly worse than average. However, Q1 2018/19 has seen an improvement in trust performance, with 76 cancelled surgeries, of which 1% weren’t treated within 28 days. This was better than the England average.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Surrey and Sussex Healthcare NHS Trust**

<table>
<thead>
<tr>
<th>Oral Surgery</th>
<th>30.0%</th>
<th>60.5%</th>
</tr>
</thead>
</table>

(Source: NHS England)
Over the two years, the percentage of cancelled operations at the trust has tended to be above the England average, but from Q2 2017/18 to Q1 in 2018/19 the trust’s performance has been in line with or better than the England average.

Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

At the time of the inspection there were two patients that had stayed overnight in recovery. In September, nine patients stayed overnight in recovery because they needed HDU level care or a specific specialty step down bed which was not available.

Learning from complaints and concerns

People knew how to give feedback about their experiences and could do so in a range of accessible ways, including how to raise any concerns or issues.

The service uses the learning from complaints and concerns as an opportunity for improvement. Staff can give examples of how they incorporated learning into daily practice.

From June 2017 to May 2018 there were 176 complaints about surgery. The trust took an average of 41 days to investigate and close complaints. This was not in line with the trust’s complaints policy. Their complaints policy stated that under current legislation trusts have six months to resolve complaints, but that a response time is agreed for each complaint and is usually 25 working days, (35 calendar days).

Patient care was the subject with the most complaints, accounting for 55% of all complaints about surgery.

East Surrey hospital received the most surgery complaints with 140 (80%).

A breakdown of complaints by subject and site is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Crawley Hospital</th>
<th>East Surrey Hospital</th>
<th>Horsham Hospital</th>
<th>Oxted Health Centre</th>
</tr>
</thead>
</table>


Complaints could be made directly to staff in order that any immediate concerns could be rectified. However, formal complaints could be made in writing using standard form that was available on the trust website.

We reviewed three patient complaints made by patients and relatives for the surgical division. All three were acknowledged within 48 hours. The responses demonstrated that they had been adequately investigated. Responses were formulaic and a table was produced with showed the areas of complaint, what the response to each aspect of the complaint was and any learning that would be taken following the complaint. Although the responses were formulaic and could be viewed as lacking a personal touch, the depth that the response went into, as well as the sharing of the lessons learned with the patient demonstrated that the complaint had been taken seriously and thoroughly investigated.

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

From June 2017 to May 2018 there were 4,374 compliments within surgery. Brook ward at East Surrey hospital received the most compliments, accounting for 13% of all compliments made.

A breakdown of the number of compliments by ward and site is shown below:

<table>
<thead>
<tr>
<th>Ward/team</th>
<th>Crawley Hospital</th>
<th>East Surrey Hospital</th>
<th>Horsham Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brook Ward</td>
<td></td>
<td>588</td>
<td></td>
</tr>
<tr>
<td>Surgical Short Stay Unit (Crawley)</td>
<td>495</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endoscopy Suite (East Surrey)</td>
<td>485</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buckland Ward</td>
<td></td>
<td>385</td>
<td></td>
</tr>
<tr>
<td>Outpatients (Horsham)</td>
<td></td>
<td></td>
<td>349</td>
</tr>
<tr>
<td>Charlwood Ward</td>
<td>325</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Woodland Ward</td>
<td>299</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery Centre (East Surrey)</td>
<td>193</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leigh Ward</td>
<td>174</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copthorne Ward</td>
<td>174</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Count</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Assessment Unit (Ward)</td>
<td>167</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endoscopy Suite (Crawley)</td>
<td>159</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limpsfield Eye Unit</td>
<td>152</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Unit</td>
<td>146</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newdigate Ward</td>
<td>112</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Assessment Unit (Clinic)</td>
<td>93</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Pre-Operative Assessment</td>
<td>78</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,139</strong></td>
<td><strong>2,886</strong></td>
<td><strong>349</strong></td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Compliments tab)*
Is the service well-led?

Leadership

The surgical division was led by a triumvirate comprising the Chief of Surgery, the Associate Director, Clinical Services and the Divisional Chief Nurse. There were clinical leads for anaesthetics, ear, nose and throat, ophthalmology, trauma and orthopaedics, dental, gastroenterology and endoscopy, general surgery, breast and vascular and urology. We met with triumvirate as one group during the inspection. We found that they were an effective, cohesive team that were aware of their strengths and weaknesses. We saw that each had their own area of expertise and were respectful to each other when one person was better able to answer any questions.

We were told by all the staff that we spoke with, of all grades, that leaders were visible, approachable and had the requisite skills for their roles. This message was repeated from the most junior managers through to the Chief of Surgery. The inspection team were told, without prompting that the leadership team was strong and effective.

Leaders we spoke with told us that they had access to training and development that was designed to make them better leaders. We were told that leaders of all levels were provided with ‘Lean for Leaders’ training.

Vision and strategy

The surgical division had their own vision which was described in one sentence; we will pursue perfection in the delivery of safe, high quality healthcare which puts the people of our community first. The surgery division’s strategy consisted of five objectives, these were; Effectively identify and promulgate lessons learned from incidents, improve SAFER performance in all specialties and wards, improve friends and family test response scores and effective use of patient feedback, improve theatre, endoscopy and clinic utilisation and reduce ‘did not attend’ instances and reduce sickness caused by work related stress.

The priorities for the surgery division, at the time of the inspection flowed from their objectives. These were to reduce avoidable harm, improve discharge planning, create the best environment for patients, provide timely access to services and staff health, wellbeing and working lives. These in turn fed in to the trust values which were safety and quality, one team, dignity and respect and compassion. At the forefront of the objectives, priorities and values was the patient.

Each ward developed their own strategy, specifically tailored to their environment, patient group and challenges. The governance team also had a strategy of their own. All these were aligned to the wider surgical division strategy. These strategies were then aligned to the trust wide strategy.

Culture

We were told about SaSH+, an initiative to develop a culture of continuous improvement. SASH was just one of just five NHS trusts in England to work with healthcare experts at an external company, USA for a period of five years. During the five-years, which began three years before this inspection, the trusts staff were supported to develop a culture of continuous improvement based on lean principles. The SASH+ culture of continuous improvement always put the patient first. When we spoke with the leaders of the surgical division they told us that in practice this meant that staff were encouraged to suggest improvement and given the time to take ideas forward. The culture had been sustained as staff told us that they ‘own’ what they are doing.
The leadership team told us that most of the ideas for improvement come from those staff on the ground and not from the leaders.

Staff we spoke with told us that the culture was supportive and that they felt that could raise concerns with their managers. This didn’t just apply to junior members of staff. One member of staff told us how they would feel comfortable raising concerns with the chief executive officer and that they had good working relationships with the consultants. They also described that there was a ‘natural hierarchy’ but consultants were prepared to seek advice from nursing staff about nursing matters as and when necessary.

The freedom to speak up guardian had started to attend the quiet room in theatres for one hour per week to allow staff to meet them and raise any concerns they had. However, at the time of the inspection we were told that this had only happened once but it was hope that it would continue.

**Governance**

The surgical division had a well-defined governance structure. This was overseen by the Surgical Divisional Board. The aim of the Surgical Division board was to ensure local accountability for performance and risk management through regular review of its governance processes and oversight and review of local risk registers, incidents, complaints and clinical audit.

The Surgical Divisional Board was made up of the Chief of Surgery, Associate Director, Surgery, Clinical Leads, Divisional Chief Nurse, Surgery, Surgical matrons, Directorate Risk Manager, Surgical Service Managers, Clinical Governance Facilitator, Patient experience Co-ordinators, HR Business Partner and Finance Manager. The Surgical divisional board met weekly and reported to the Trust Executive Team – Executive Committee for Quality and Risk, Performance and Strategy. There then followed a quarterly performance review. We reviewed minutes of the monthly governance meetings. These were comprehensive and gave a good indication of what was discussed, what was resolved and what was agreed.

There were monthly ward managers meetings and full ward meetings were held quarterly. Any immediate issues that needed to be passed to staff from the Surgical Divisional Board or the ward managers meeting were discussed in the daily safety huddles.

The triumvirate of the Chief of Surgery, the Divisional Chief Nurse and the Associate Director of Surgery would also meet briefly on a Friday to reflect on the week that was ending and look forward to the week ahead.

We were told how the service had 10 audit afternoons per year where a wide range of data would be reviewed. This afternoon also incorporated the mortality and morbidity meetings.

**Management of risk, issues and performance**

Processes to ensure oversight and management of risks were well established. The service had a comprehensive risk register. This identified risks and categorised them using a Red, Amber, Green (RAG) system, defined by a method of scoring the risk by the likelihood of it happening and the impact. Each risk had a high, medium or low risk level attributed to it. Each risk had a title, open date, date for next review and a risk owner. The risk owner was the senior member of staff responsible for managing the risk. Risk types related to a wide variety of subjects including, but not limited to patient safety, financial management, staffing, health and safety and service access. The risk register was reviewed on a weekly basis and signed off as being accurate. The risk register was also reviewed at the monthly patient safety committee meetings.

Because the hospital was designated as the hospital that would receive patients from a major disaster at a local international airport, one ward was designated as a receiving ward for any
patients following surgery. This meant that the surgical division leadership team attended the trust's resilience meetings.

The inspection team was also provided with the Surgical Directorate’s root cause analysis Investigations report. This showed details of all the directorate’s open serious incidents. This gave a description of the incident, where the incident happened, who the investigator was and notes on the progress of the investigation.

During the inspection we were told how the service had had to close two theatres for major refurbishment in the summer of 2018. In response to this they had been able to build two temporary theatres and have them fully operational within four weeks. This meant that there was minimal disruption to the service provided.

We were told how the occupancy rate of the ward beds was over 95% and did present a risk and that if they had no other choice, they could use recovery to care for patients after surgery if there was no ward space. We saw the services policy for escalation in times of increased demand for bed capacity. This was wide ranging, thorough and fit for purpose.

The trust had made a commitment not to cancel any elective surgery due to the lack of bed space on the wards and from May to September 2018 they had only had to do so once. There had been 15 cancellations in April for a short period due to circumstances beyond their control.

**Information management**

The surgical division held quarterly performance review meetings. At these meetings the attendees would scrutinise the division’s clinical and financial performance. The agenda devoted most of the time to Performance and Quality Alerts / Issues and Finance and Activity. All items that were on the agenda were supported by documents that demonstrated their performance. The documents were then broken down into the CQC domains of Safe, Effective, Caring, Responsive and Well-Led. We saw that in each domain, data was provided that showed the divisions performance and was given a red, amber or green rating. The information shown included, but was not limited to details about never events and serious incident, mortality, readmissions, bed occupancy, complaints and concerns, waiting times and staffing.

Data regarding the division’s money and resources was also shown to the inspection team. This was a comprehensive suite of information that showed their income against expenditure for matters such as medical and nursing staffing, including agency spending, cost of maintaining theatres and outsourcing.

Time was also given at this meeting to review the division’s annual plan and their progress against it.

It was considered that the range and depth of information available to senior leaders in the division meant that they would have a clear oversight of their performance both clinically and financially.

**Engagement**

The surgical service ran a programme where a non-clinical member of staff from the complaints team would have a follow up telephone call with a random sample of patients that had had surgery performed at the trust. It would be a general call about their experience. A total of 274 follow up calls were made to surgical patients following discharge for the period May to September 2018. There were representative patients from each ward, the surgical centre, the surgical assessment unit and the discharge lounge. There were 163 respondents (59%).

Questions would be around general wellbeing, whether they had been given enough information and if they had any concerns. If there were concerns, they would be escalated to the matron and the consultant to review the patient notes.
The reviews and data around the number of calls and their outcomes would then be presented at the surgical division monthly governance meeting so the directorate can look at themes, trends and areas for improvement.

In theatres there was a 'what's bugging you board'. This was somewhere staff could place their concerns. This was part of the SaSH+ initiative which was aimed at giving everyone the opportunity to make a difference, reduce waste and think differently about their work.

**Learning, continuous improvement and innovation**

One ward matron told us how they were being supported to study for their two-year masters of business administration and that they could give 20% of their time to their studies. The time spent studying was then broken down further to give half of that time to learning in the workplace and half of the time given to classroom learning.

We were told about a scheme that was run by the education team at the trust. The scheme was called Springboard. It was developed to assist band five and band six nurses to obtain the skills needed for promotion to their next role and demonstrate leadership skills. The scheme ran for four months and included four study days over that period. The member of staff that was on the Springboard scheme would need to identify an area for change and lead the project to implement it. We were given an example where a member of staff had looked at ways to make the re-stocking of drug trolleys more efficient. Once the solution had been found, they had to complete a portfolio of evidence and present their findings to the senior managers. Participants in the scheme could use the work they had done to assist them in the process of revalidation with the Nursing and Midwifery Council. The only criteria applied was that you had to have 18 months post nursing qualification experience and have been identified through the appraisal system as a suitable candidate.

The staff on Copthorne ward told us how they had used a ‘Rapid Process Improvement Workstream’ methodology to improve their sepsis management. Their goal was to reduce the time spent between suspected sepsis being recognised and antibiotics being administered. They started by assessing the performance as it was. They then looked at where the blockers in the system were. To do this they formed a team, led by a member of staff from their Kaizen (Kaizen means continuous improvement in business) office, ward matron, who was the programme owner, junior doctor, band six nurse, deputy chief pharmacist, nursing assistant, radiologist, housekeeper and a patient that had previously stayed on the ward and developed sepsis. The team split into three groups and broke down the process. They found areas where time was wasted such as the how long it took to get to the blood gas machine. As a result, they acquired an unused blood gas machine from the pathology laboratory and move it closer to the ward. They also had a designated ‘sepsis drawer’ in the bedside emergency response trolley. This contained all the equipment they would need, including an oxygen mask, blood sampling tubes, IV fluids and blood culture bottles, if they suspected sepsis. The team also set up a new bleep specifically for sepsis. This would notify the site manager, medical staff, matron and the critical care outreach team.

The changes to the process were set to be reviewed at 30, 60 and 90 days intervals. It was established through audit that after 30 days the time taken from suspected sepsis to the start of antibiotics had reduced to 30 minutes, well within the Sepsis ‘golden hour and a dramatic improvement on the previous time taken. At the time of the inspection it was anticipated that the learning from the project would be rolled out across the trust. We reviewed the target progress report for this workstream which verified the results that were described to us.

In theatres there was a ‘what's bugging you board’. This was somewhere staff could place their concerns. This was part of the SaSH+ initiative which was aimed at giving everyone the opportunity to make a difference, reduce waste and think differently about their work.
We spoke with one member of staff who told us how they were being funded by the trust to complete their masters in advanced clinical practice. When qualified they could take their own caseload to take some pressure from the junior doctors. They had introduced a care plan/pathway for patients over the age of 60 and were assisting with the preparation of a business case to employ another geriatrician. This was to improve the care for fracture patients over the age of 60.
## Acute services

### Maternity

### Facts and data about this service

Surrey and Sussex Healthcare NHS Trust provide a maternity service throughout the whole maternity pathway; from the first point of contact (booking) to postnatal discharge in the community.

The maternity unit for all the trusts geographical area is based at East Surrey Hospital. The maternity team last year cared for around 5,000 women and was the location for 4,500 births. The service provided a range of obstetric and midwifery led services, antenatal, intrapartum (labour and birth) and postnatal care.

Community midwives were based in the maternity unit and provided antenatal care in GP surgeries. Obstetric led antenatal clinics were also facilitated at Horsham hospital, Crawley hospital and East Surrey hospital.

Except for home births, all intrapartum care was provided at East Surrey hospital, where there was an obstetric led unit, alongside a midwifery led unit.

The maternity unit consisted of the early pregnancy unit, antenatal ward, antenatal day unit, delivery suite, midwifery led unit and postnatal ward. The unit had two obstetric theatres and was also placed alongside the neonatal unit.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. We carried out our inspection on 16 and 17 September 2018 and reviewed all areas where maternity patients received care and treatment. These included the antenatal clinic (including the day assessment unit), antenatal, labour ward, maternity led unit post-natal ward, the triage service, obstetric theatres and recovery.

We spoke with 25 staff from across the department including the obstetric consultant, the consultant anaesthetist, junior doctors, SHOs, the maternity governance team, head of midwifery, deputy head of midwifery, lead midwives, screening midwives, maternity voices partnership, administrators, a community matron, and maternity care assistants.

We also spoke with seven patients and relatives and reviewed six sets of maternity records. Before, during and after our inspection we reviewed the hospitals performance and quality information. This information included meetings minutes, policies and performance data. There were designated specialist midwives for safeguarding, perinatal mental health and bereavement support. Women also had access to a debriefing service facilitated by senior midwives.

(Source: Trust Provider Information Request – Acute sites and context tabs)

From April 2017 to March 2018 there were 4,066 deliveries at the trust.
Number of babies delivered at Surrey and Sussex Healthcare NHS Trust – Comparison with other trusts in England.

(Source: Hospital Episode Statistics)

A profile of all deliveries and gestation periods from January to December 2017 can be seen in the tables below.

<table>
<thead>
<tr>
<th></th>
<th>SURREY AND SUSSEX HEALTHCARE NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Single or multiple births</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>3,763</td>
<td>98.7%</td>
</tr>
<tr>
<td>Multiple</td>
<td>48</td>
<td>1.3%</td>
</tr>
<tr>
<td>Mother’s age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>76</td>
<td>2.0%</td>
</tr>
<tr>
<td>20-34</td>
<td>2,750</td>
<td>72.2%</td>
</tr>
<tr>
<td>35-39</td>
<td>814</td>
<td>21.4%</td>
</tr>
<tr>
<td>40+</td>
<td>171</td>
<td>4.5%</td>
</tr>
<tr>
<td>Total number of deliveries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3,811</td>
<td></td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics January 2017 to December 2017

Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is ‘other’ or ‘unrecorded’. 
## Gestation periods (January 2017 to December 2017)

<table>
<thead>
<tr>
<th>Gestation period</th>
<th>SURREY AND SUSSEX HEALTHCARE NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Pre-term 24-36 weeks</td>
<td>267</td>
<td>8.2%</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>2,996</td>
<td>91.8%</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total number of deliveries with a valid gestation period recorded</strong></td>
<td><strong>3,263</strong></td>
<td><strong>490,944</strong></td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics January 2017 to December 2017

Note: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

The service provided mandatory training in key skills to all staff and made sure everyone completed it. The trust set a target for 80% completion of mandatory training. During our inspection we were provided with up to date mandatory training figures which showed that mandatory training figures for staff had improved and staff were mostly compliant with the trust target.

Staff we spoke with, had a clear understanding of key midwifery skills. There was a clear system to track and monitor staff mandatory training. Staff were alerted via email when mandatory training was due.

The unit provided a one week mandatory and essential skills training for medical and midwifery staff once a month. Staff had the opportunity to complete outstanding training as well as update their skills to remain competent and safe.

Simulation training took part in theatres as well as on the delivery suite. Newborn life support updates were provided. Topics such as recognising the deteriorating health of a woman, measurement of fetal growth, cardiotocography and infant feeding were facilitated. Newly qualified midwives would be provided with further training in key skills and complete key skills competencies. Cardiotocography is the recording of fetal heartbeat and contractions during pregnancy.

Clinical staff received mandatory training on how to recognise patients with mental health needs, learning disabilities, autism or dementia. The training was well attended by all staff groups, with protected time given.
Trust level

A breakdown of compliance for mandatory training courses as of May 2018 at trust level for qualified nursing and midwifery staff in maternity is shown below:

Please note the training modules have been merged to give overall figures for each module as the raw data included multiple entries of the same modules with training renewal dates.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>118</td>
<td>183</td>
<td>64%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety - 2 Years</td>
<td>105</td>
<td>183</td>
<td>57%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control - Level 2 - 1 Year</td>
<td>124</td>
<td>183</td>
<td>68%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Local Data Security Awareness - 1 Year</td>
<td>137</td>
<td>184</td>
<td>74%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>NHS Conflict Resolution (England) - 3 Years</td>
<td>104</td>
<td>184</td>
<td>57%</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Health, Safety and Welfare - 3 Years</td>
<td>166</td>
<td>183</td>
<td>91%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>In Hospital Basic Life Support (Adults &amp; Paeds)</td>
<td>95</td>
<td>95</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>In Hospital Resuscitation (Basic Life Support)</td>
<td>34</td>
<td>34</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>92</td>
<td>92</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Level 2 - 2 Years</td>
<td>155</td>
<td>183</td>
<td>85%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - Basic Life Support (Adults &amp; Paeds) ESU</td>
<td>8</td>
<td>8</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation ILS</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 80% target was not met for five of the mandatory training modules for which qualified nursing and midwifery staff were eligible. Conflict resolution was the module with the lowest compliance of 57%.

Obstetric data

There was no information obtained of obstetric mandatory training. However, 68% obstetric doctors had attended the maternity interdisciplinary training.

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

Safeguarding vulnerable adults, children and young people was given sufficient priority. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The trust had two safeguarding teams one for adults and the other for children and young people. Case discussions, practice reviews and safeguarding audits were monitored through the trust’s internal safeguarding committees for adults and children. A designated safeguarding midwife was in place and staff were aware of how to contact the midwife for advice and support.

All women were risk assessed on admission and we observed evidence of safeguarding referrals completed. Midwives we spoke with, knew the safeguarding processes, how to make a safeguarding referral and to contact the named safeguarding midwife for further support or advice.

Information was shared well between the safeguarding team and maternity staff. A flag was applied to the patient administration system for safeguarding concerns including a pre-birth child protection plan. The safety huddles occurred daily and were attended by ward and community midwives to highlight any safeguarding concerns or new referrals. Safeguarding concerns were discussed and ‘flagged’ using the colours red and amber. Red being a pre-birth child protection plan and amber a safeguarding concern.

There was an active and appropriate engagement in local safeguarding procedures and effective work with other relevant organisations. The named safeguarding midwife received supervision from the deputy safeguarding designated nurse from Surrey and West Sussex CCG. The trust had implemented an online child protection information sharing programme to enhance the safeguarding processes and sharing of information. The system checked national database to identify any pregnant woman who may be on a pre-birth child protection plan. The service did not have a designated midwife for teenage pregnancy in place. However, all teenage pregnancies and women at risk of sexual exploitation were referred to the safeguarding team. The children’s safeguarding team worked with Surrey risk management group and West Sussex missing and exploited operational group to share information.

All safeguarding referrals were reviewed and discussed at the weekly children’s safeguarding meeting and recorded on the safeguarding database for all multi agency professionals.

Women with specific support need such as learning disabilities, mental health or addiction were referred to the MAPLE team. MAPLE stood for multiple and complex needs; addiction; perinatal mental health; learning difficulties and early help team. Staff had a good awareness of supporting women who required further support and had a clear understanding of the processes of referral.

Risk assessments and safeguarding referrals were completed for any potential concerns regarding domestic abuse, child sexual exploitation and female genital mutilation (FGM).

A trust domestic violence pathway was in place for midwives to follow, with the community midwife asking the initial safeguarding questions at the first contact with mother. The pathway identified placing an alert sticker in the notes and on the safeguarding database.

The trust had in place a clear female genital mutilation (FGM) policy. All women were asked at their initial appointment about whether they were aware or had, had this procedure. FGM was also a mandatory field on the electronic booking form. All midwives were trained in how to ask sensitive questions to women regarding FGM and provided cultural information. Community midwives completed risk assessment questions to identify any immediate actions required. Staff we spoke to were aware of the referral process to the MAPLE team and social care. Staff also knew to report to female genital mutilation cases to the police if the woman was under the age of 18.
Trust data showed us that between July 2017 to July 2018 on average there were two cases of female genital mutilation reported per month.

All midwifery staff should be trained to level two and three safeguarding for adults and children. We found that all midwifery and medical staff met the trust target for 80%.

Trust level

A breakdown of compliance for safeguarding training courses as of May 2018 at trust level for qualified nursing and midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children - Level 2 - 3 Years</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults - Level 2 - 3 Years</td>
<td>168</td>
<td>183</td>
<td>92%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children - Level 3 - 3 Years</td>
<td>4</td>
<td>5</td>
<td>80%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Qualified nursing and midwifery staff in maternity met the 80% target in all three safeguarding training modules for which they were eligible.

A breakdown of compliance for safeguarding training courses as of May 2018 at trust level for medical staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children - Level 2 - 3 Years</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Medical staff in maternity met the 80% target for the one safeguarding training module for which they were eligible.

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

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

All departments within the maternity unit were considered high risk or very high risk for infection control. Staff told us that higher risk women or healthcare workers were screened for methicillin-resistant staphylococcus aureus (MRSA), and if screened positive they would be referred to infection control for further guidance with a risk assessment completed. Personal protective equipment was available in all clinical areas and staff followed the correct use. Side rooms were available for women who had an infection and needed isolation on the antenatal ward, labour or postnatal wards.

All midwifery and medical staff were compliant with the ‘Five moments for hand hygiene’, as set out by the World Health Organisation (2009) and with the trust’s own hand hygiene policy which followed the National Institute for Health and Care Excellence guidelines. We saw staff members following trust policy and National Institute of Care and Excellence guidance, QS61 statement 3: ‘People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care.’ Staff followed the trust policy on infection control, for example, long hair was tied back, no wrist watches observed and “bare below the elbows” at all times allowed effective hand washing.

We observed dedicated hand hygiene sinks available for staff to use before and after patient care. Gloves were available to protect staff and patients against infection and we saw that staff adhered to use of gloves where clinically indicated. Sanitising hand gel dispensers were available throughout the unit and at every entrance. There were signs above gel dispensers encouraging staff and visitor to use the gel to clean their hands.

Hand hygiene audits were completed weekly and staff were found to be 100% compliant. The trust participated in raising awareness on hand hygiene and glove use during world hand hygiene day and infection prevention and control week.

There was correct segregation of clinical and non-clinical waste in line with HTM 07-01, Control of Substance Hazardous to Health, and the Health and Safety at Work Regulations.

Sharps boxes were available in treatment areas, they were secure and labelled with the correct information. This was in line with Health and Safety Regulations 2013 (The Sharps Regulations), 5(1) d. This requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area.

Fridges containing breast and formula milk were observed to be locked and clean. Breast milk was contained in specific hospital bottles. All breast and formula milk were named and dated. Parents had to request access to the fridge as all fridges were securely locked for safety and to elevate any risk of contamination.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

The maternity department was clean, uncluttered with suitable lighting in all areas. Corridors were wide and had plenty of space for beds, cots and wheelchairs.
The midwife led unit had been refurbished at the time of our previous inspection and continued to be refurbished well and designed with the comfort of women in mind. During this inspection the delivery suite had been refurbished with side rooms made larger and all had en-suite facilities.

The maternity unit was in the process of having an extension and redesign of the neonatal unit and antenatal clinics. Work had started to move clinics but work for the neonatal unit was planned to go ahead in 2019. The extension would increase the size of the neonatal unit, providing two intensive care cots’, six high dependency cots and 17 special care cots’. The design was to be family centred with space for beds for mother’s next to the cots, in some of the special care areas. There was also a plan for two en-suite side rooms, a parent’s room, expressing room and a dedicated room for confidential conversations will also be in place.

The maternity unit had two obstetric theatres, one for planned elective caesarean sections and the second for emergencies. The theatres were adjacent to the labour ward and close to the neonatal unit. The obstetric theatres were well equipped and well organised. A resuscitaire was in place with all necessary equipment in place. This was in line with the Royal College of Obstetricians and Gynaecologists guidelines 6.4.1 recommends ‘Operating theatres dedicated for obstetrics should be close to the birth unit or preferably within it.

We found the maternity unit followed The Royal College of Obstetricians and Gynaecologists ‘Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour’ which states equipment must be maintained in good working order. The equipment was maintained in accordance with the trust’s medical devices and systems policy, which covered repairs and planned preventative maintenance. Equipment was kept clean with green ‘I am clean stickers’.

We checked 10 pieces of equipment within the maternity unit and all equipment had an asset barcode and log number. This ensured it had been registered onto the trust’s medical devices log and had up to date servicing and electrical safety testing.

Staff knew how to report faulty equipment and how to source a replacement for any essential items. We saw cardiotocography (CTG) machines were available throughout the unit and resuscitaire’s in all labour rooms and obstetric theatre. A resuscitaire is where babies are cared for whilst being assessed and if necessary, resuscitated.

There was the correct emergency equipment on the delivery suite and within theatre. However, following our checks of resuscitaires and postpartum haemorrhage trollies we found in the delivery and birthing suite there were dates where daily checks has not been completed.

The maternity environment temperature was well maintained and thermometers were seen around the unit with the optimum temperature observed.

Community midwives had their own equipment including baby scales and sonic aids. We were told that midwives (including community midwives) had access to specific equipment to meet individual needs, for example patients with raised body mass index and patients with learning difficulties.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. A risk assessment was completed at the initial booking assessment with some mandatory fields in place to ensure questions to assess risk were asked by midwives. Women were continued to be risk assessed during each antenatal contact and postnatally. This ensured up to date risks were considered at all times.
Risk assessments were completed for all women and contained social and medical information including maternal mental health. We observed risk assessments where women identified at risk or required additional support were referred to the appropriate services such as perinatal mental health midwife.

The department used the Modified Early Obstetric Warning Score (MEOWS) which was a nationally recognised, competency-based tool to trigger escalation when required. We found the MEOWS score had been completed for each of the records reviewed as well as management of health. We observed clear escalation in patient records of when an obstetrician was required.

There were clear guidelines on observations following an anaesthetic procedure as well as for women post-delivery and women with post-partum haemorrhage, possible sepsis and high blood pressure. Records demonstrated women’s and baby’s health were assessed on the postnatal ward every four hours. We observed evidence of regular checks documented in maternity notes. Comprehensive risk assessments were completed for women who used the maternity services and management plans were developed in line with national guidance. Neonatal notes included a comprehensive record including a new born examination and a neonatal early warning score (NEWS) incorporated into the baby’s notes.

Consultant obstetricians were responsive. They attended and supported difficult deliveries. We observed consultant clinics to discuss birth choices and to plan complex care for women with high risk pregnancies.

The service had access to a perinatal mental health midwife as well as the MAPLE team to access further advice or support regarding specialist mental health support.

The service had developed a new triage system after feedback received from women who had used the service. Senior managers recognised time was wasted due to women giving their detail and concerns to a number of midwives or professionals before receiving the advice they required. To ensure women were triaged quickly the service had in place a dedicated midwife for triaging women. There was one midwife available to triage during the day and book assessments onto the day unit and one midwife at night. The midwife triaging at night would invite the woman in to be assessed by them. This process allowed women to have consistency and provided a quick response to early assessment. Senior managers told us that the change in service had reduced calls and demand on the midwifery teams within the labour ward or the day unit.

Women could also access an early pregnancy unit if they had bleeding or were in pain up to 16 weeks of pregnancy. The early pregnancy unit helped women identify the cause of symptoms and offered advice, support and any treatment which may be needed.

Women were assessed for venous thromboembolism, in-line with National Institute of Health and Care Excellence, QS3 statement 1: All patients, on admission, receive an assessment of venous thromboembolism and bleeding risk using the clinical risk assessment criteria described in the national tool.
Staff had a clear understanding of recognising the signs of sepsis and the sepsis six bundle was part of the maternity mandatory training programme. A sepsis policy was in place and the trust had a sepsis clinical lead and champions. A maternity specific tool was used to ensure women were treated in line with recommended National Institute Health and Care Excellence guidelines. We observed an innovation meeting on the unit and the team discussed producing a specific sepsis pack ensuring all equipment and forms were in place together to ensure quick assessment and treatment.

Staff used the World Health Organisation’s, five steps to safer surgery checklist in maternity surgery. We observed completion of the WHO checklist in women’s records and during our inspection we saw a checklist completed in theatre.

A safety huddle took place prior to each obstetric procedure and all staff involved in the procedure completed a patient briefing. This highlighted any potential risks that may be faced during surgery and was an opportunity for equipment needs, and post-operative care to be discussed.

Safety huddles were embedded into the service. This was an opportunity for staff to raise concerns about any patient that may require additional oversight or clinical input. Safety huddles took place twice a day. However, we were told by senior managers that further safety huddles would take place to review the unit for risk and safety if the service was experiencing high demand.

There was clear communication between maternity teams in regard to assessing a woman and baby’s health. ‘Safety pins’ notices were designed and developed by the maternity team. They were used to share lessons learnt from incidents and risks to improve patient care. We observed staff discussing safety pins when monitoring pain relief, delay in suturing, midwife: birth care and when any issues with a supernumerary labour ward co-ordinator.

Guidance and a pathway was in place for any unbooked pregnant woman attending A&E or the maternity department. Staff were clear on the guidance and we were told this was a common occurrence due to the close proximity of Gatwick airport to the hospital. All unbooked women were treated as a high-risk pregnancy initially with urgent bloods completed. An ultrasound scan and plan of care would be completed with an obstetrician as well as a safeguarding referral if necessary.

Appropriate liaison with critical care took place. The service had 10 midwives who had completed the high dependency care course. There were two beds designated to high dependency care in the unit and the service aimed to have at least one midwife rostered who had completed the course. The critical care outreach team provided support and guidance to staff and multidisciplinary meetings were in place to assess whether a patient should remain on high dependency unit or transfer to intensive care.

The service had a number of escalation policies in place for deteriorating women or babies. Staff were aware of the guidance and policies included transfer of a deteriorating baby to neonatal unit, neonatal resuscitation, and a high dependency policy for deteriorating women. All midwives and obstetric doctors were trained in adult and paediatric life support.

**Midwifery and nurse staffing**

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

The midwife: woman ratio was currently 1:32 which was better than during our last inspection. The
The senior team recognised gaps in midwifery staffing. The service accommodated a 90:10 split of qualified midwives to band three support workers. Maternity support midwives were not taken into account within the midwife to birth ratio. Senior leaders recognised the importance of band three support workers but felt their priority was to recruit qualified midwives. However, the midwife: woman ratio would be lower than the current figure if the service had taken into account the number of maternity support workers rostered.

Band three maternity support workers performed a range of tasks such as taking observations, supporting women with breastfeeding, attending to the needs of the women, catheter care, taking bloods and cleaning.

Senior managers presented a case to the executive board requesting funding for more midwives and after a recent review, 4.5 extra midwives were recruited and due to start in October 2018. An external review of staffing using the nationally recognised tool Birth-rate plus had taken place. The outcome of the review had not yet been received but the unit were aiming the recommendation would be to recruit a further 7.6 midwifery staff, which would mean the midwife to birth ratio would be within national guidelines.

The trust had a target of 100% for one to one care in labour which is in line with NICE NG4 safe Midwifery staffing guidelines. Since June 2018 to the trust were compliant on average between 97%. However, we were informed by senior midwives that all women in established labour did have one to one care.

Staffing levels were seen displayed in unit areas. An assessment of staffing occurred during each safety huddle as well as an assessment of staffing levels for the following day. Staffing was marked as a red flag during safety huddles. However, during our inspection we observed no staffing issues and the labour ward co-ordinator was supernumerary.

We analysed staff rotas for the last two months and observed that staffing targets were mostly met and the labour ward co-ordinator was supernumerary. Matrons, specialist midwives and community midwives were used in times of heightened activity and staff flexed between antenatal, post-natal and delivery suite. The labour ward co-ordinator would be supernumerary and the rota reflected this.

Gaps in staffing were mainly filled by the midwifery team or bank midwives that knew the service well. Occasionally we were told gaps were filled with agency staff. We observed a temporary staff hand book for new bank midwives working on the ward to ensure they were competent and familiar with the unit.

The practice development team told us 17 preceptorship midwives were due to start with the trust next week. A full preceptorship plan was in place for each midwife and we could see that there had been a significant amount of work put in place to offer each midwife a supportive learning environment.

The trust provided specialist midwife services for maternity, in-line with National Institute of Care and Excellence guidance. Specialist midwives included practice development midwives, Perinatal Mental Health Midwife, infant nutrition midwife, bereavement midwife, diabetic midwife, e-midwife and safeguarding team.
The trust reported the following qualified nursing and midwifery staff numbers as of December 2017 and May 2018 for maternity:

<table>
<thead>
<tr>
<th>Location</th>
<th>December 2017</th>
<th>May 2018</th>
<th>Fill rate</th>
<th>December 2017</th>
<th>May 2018</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned WTE staff</td>
<td>Actual WTE staff</td>
<td>Fill rate</td>
<td>Planned WTE staff</td>
<td>Actual WTE staff</td>
<td>Fill rate</td>
</tr>
<tr>
<td>Trust level</td>
<td>147.2</td>
<td>143.6</td>
<td>98%</td>
<td>147.2</td>
<td>143.3</td>
<td>97%</td>
</tr>
</tbody>
</table>

The staff fill rate in May 2018 had dropped slightly since December 2017 with 0.3 less WTE staff in post.

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

From June 2017 to May 2018, the trust reported a vacancy rate of 2.7% for qualified nursing and midwifery staff in maternity. This was better than the trust target of 12%.

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

From June 2017 to May 2018, the trust reported a turnover rate of 18.1% for qualified nursing and midwifery staff in maternity. This was worse than the trust target of 12%.

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

From June 2017 to May 2018, the trust reported a sickness rate of 5.1% for qualified nursing and midwifery staff in maternity. This was worse than the trust target of 3%.

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

Bank and agency staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template, but was not provided in a format that would allow us to give bank usage as a percentage of activity.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

Midwife to birth ratio

From April 2017 to March 2018 the trust had a ratio of one midwife to every 27.5 births. This was worse than the England average of one midwife to every 25.68 births.

(Source: Electronic Staff Records – ESR Data Warehouse)

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

We found consultant staffing levels were better than the Safer childbirth (2017) recommendation of 40 hours per week. The average number of hours a consultant presented on the labour ward was 98, which was well above the trust target of 60 hours. There were 10 full time middle grade doctors in place. However, there were senior house officer vacancies and we were told by the medical teams that recruitment was in hand.

Consultants worked from 8am to 10pm, Monday to Friday. Saturday and Sunday there was a 24-hour resident middle grade cover from 8am to 5pm. Consultants were on call outside of the hours they were present on the unit. Midwifery staff told us consultants were always available and there were no barriers between the midwifery and obstetric teams.

There were 24-hour anaesthetics cover. If the anaesthetist was busy then the team could have access to the intensive care unit anaesthetist.

NB. The below medical staffing information relates to the obstetrics and gynaecology medical staff which the trust reported under the gynaecology core service, and no medical staffing figures were provided for maternity. However, as the staff group relates to obstetrics and gynaecology the information has been included below.

The trust reported the following qualified medical staff numbers as of December 2017 and May 2018 for obstetrics and gynaecology:

<table>
<thead>
<tr>
<th>Location</th>
<th>December 2017</th>
<th>May 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned WTE staff</td>
<td>Actual WTE staff</td>
</tr>
<tr>
<td>Trust level</td>
<td>37.9</td>
<td>37.6</td>
</tr>
</tbody>
</table>

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

From June 2017 to May 2018, the trust reported a vacancy rate of -3.2% for medical staff in obstetrics and gynaecology. This was lower than the trust target of 12% and the negative vacancy rate is due to an over establishment of medical staff.

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

From June 2017 to May 2018, the trust reported a turnover rate of 27.5% for medical staff in obstetrics and gynaecology. This was higher than the trust target of 12%.

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

From June 2017 to May 2018, the trust reported a sickness rate of 1.1% for medical staff in obstetrics and gynaecology. This was lower than the trust target of 3%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)
Bank and locum staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template, but was not provided in a format that would allow us to give bank usage as a percentage of activity.

It should be noted that the trust has said that it is “unable to provide the data in the requested format for medical staff bank and locum usage”.

(Source: Routine Provider Information Request (RPIR) – Medical agency locum tab)

In May 2018, the proportion of consultant staff reported to be working at the trust was slightly higher than the England average as was the proportion of junior (foundation year 1-2) staff.

Staffing skill mix for the 34.3 whole time equivalent staff working in maternity at Surrey and Sussex Healthcare NHS Trust.

![Staffing Skill Mix Chart]

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>45%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>6%</td>
<td>9%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>41%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior*</td>
<td>8%</td>
<td>6%</td>
</tr>
</tbody>
</table>

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

(Source: NHS Digital Workforce Statistics)

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

The service completed record keeping audits and we looked at six patient paper records and found them to be legible, dated, signed and contained full clinical details in line with NICE QS15
Statement 12: Patients experience coordinated care with clear and accurate information exchange between relevant health and social care professionals.

The records were well maintained and easy to navigate. Antenatal bookings were completed electronically and the women’s named midwife and named consultant was clearly noted on each of the hand-held records and booking. The information we observed in the records, reflected the care and treatment patients received.

Each woman had individualised care plans for pregnancy and labour. We observed evidence of antenatal screening and assessment of risk to promote safe treatment. Our review of care records showed women were advised of their options at every stage of their pregnancy including when complications occurred. Staff recorded when consent was obtained before carrying out procedures in line with women’s care.

Records were seen to have stickers or flags alerting to any safeguarding, mental health illness and allergies. Medical and obstetric history was present as well as any on-going health needs. Newborn assessment documentation was consistent, with information noted such as baby’s feeding and whether skin to skin had taken place.

Patient records and notes were kept safely in a locked cupboard or in a locked and secure notes trolley.

We saw good identification of infection and diagnosis, to antibiotic times. Patients were prescribed an antimicrobial as clinically indicated and we saw dose and duration of treatment, documented in their clinical records. This was in line with National Institute for Health and Care Excellence, QS121 Statement 3: People prescribed an antimicrobial have the clinical indication, dose and duration of treatment documented in their clinical record.

Mothers were given a Personal Child Health Record (known as the Red book) on discharge. Health professionals used the red books to record information on baby’s birth and health, including feeding assessments, new-born checks and new-born hearing screening.

**Medicines**

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

Medicines were stored well, guidance for the administration of opioid analgesia and fetal monitoring for women in early labour were followed by staff. Random checks of medication records were completed and we found patient information and allergies were recorded correctly.

Medicine cupboards and trollies were locked. The midwife in charge on the wards and department areas held the keys and only authorised staff had access to these. Medicines that needed to be stored within fridges were stored at the correct temperatures. Fridges were mostly checked daily and the minimum and maximum temperatures recorded. Staff signed to say these had been checked and we saw a protocol which should be followed if the fridges were not in the correct temperature limits. This protocol was in line with best practice guidelines. However, staff did not always follow best practice when checking and recording medication. We looked at checks completed for the medicines kept in the emergency fridge. Out of 90 days there were 15 days where checks were missed.
Daily checks of controlled medication had mostly been carried out on the maternity ward and delivery suite. However, we observed out of 88 checks there were three checks missing and with two on consecutive days.

Prescribed antimicrobials on patient’s medication charts were noted as to when the medication had started. Temperatures were recorded which were not in the required range and we could not see documentation to state that this had been reported to pharmacy.

Incidents

Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and felt supported to do so. Monitoring and reviewing activity enabled staff to understand risks and give clear, accurate and current picture of safety. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From July 2017 to August 2018, the trust reported one incident which was classified as a never event for maternity.

The incident occurred in January 2018 and related to a retained foreign object post-procedure at East Surrey hospital.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported nine serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from July 2017 to August 2018.

A breakdown of these incidents by type is shown below:

- Three maternity/obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)
- Three maternity/obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant)
- Two maternity/obstetric incident meeting SI criteria: mother only
- One HCAI/Infection control incident meeting SI criteria

(Source: Strategic Executive Information System (STEIS))

Staff we spoke with had a good understanding of recognising incidents and incident reporting. Senior managers encouraged staff to complete an incident reporting form and staff told us they received feedback.

A multidisciplinary team approach was used to investigate serious incidents. Meetings were prioritised when a serious incident had occurred with midwifery department leads, obstetric consultant, governance lead and the risk team in attendance.
Safety huddles were fully embedded into the service and provided an opportunity for staff to reflect on incidents. The maternity team designed and developed safety pins in a response to provide learning from incidents. Safety pins are used to share lessons learnt that improve patient care. They are displayed within all clinical areas and are included in the daily safety huddles and are sent as weekly updates to all staff across the organisation.

The service had a never event in January 2018, where a swab was left within the vagina following an instrumental delivery and perineal suturing. Following the incident, the trust completed an investigation which included a root cause analysis and action plan. We observed documentation of the trust investigation and of the immediate action which took place. Lessons learnt, discussions and training took place for obstetric and midwifery staff. A new initiative called ‘shout out for the count’ was introduced to all staff. The new guidelines in place stated two people to be involved in counting in and out of swabs used. A poster was seen in all delivery suite rooms with ‘shout out for the count’ and a safety pin alert.

Serious incidents were reviewed monthly by the maternity governance team. Learning from incidents were shared with teams through safety pins which were placed around the maternity unit. Learning from incidents also took place during mandatory training days.

We reviewed the root cause analysis for three serious incidents. We clearly observed an electronic incident reporting form had been completed following each incident and the severity of the incident and effect the incident had on the patient was evident. Clear documentation showed duty of candour had been correctly applied. The Duty of candour is a regulatory duty under the Health and Social Care Act (Regulated Activities Regulations) 2014, where as soon as reasonably practicable after becoming aware that a notifiable safety incident had occurred a health service body must notify the relevant person that the incident had occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. We observed clear action plans and evidence incidents had been shared with midwifery and obstetric staff.

We observed the last three months morbidity and mortality meeting minutes and each meeting was well attended by consultant obstetricians, head or deputy head of midwifery, and patient risk team. This followed the Safer Childbirth: Meetings involving all relevant professionals are held to review adverse events.

**Safety thermometer**

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

The service had a maternity specific dashboard which monitored specific safety results. The trust measured metrics for induction rates, planned and emergency caesarean sections, low intervention deliveries, degree of perineal tear and blood loss. Risk management of procedures of 3rd and 4th degree tears, shoulder dystocia and post-partum haemorrhage were monitored with a red flagging system. Shoulder dystocia is a rare emergency where a baby's shoulder becomes stuck during the second stage of labour. A red flag would be in place if the incidence of a risk was higher than the trust target.

The unit had experienced high rates of induction of labour and an audit was due to take place to assess why the high increase had occurred. National guidelines show induction of labour to be 29%, the average for the maternity unit was 34%.
Elective caesarean section was less than the national guidelines of 14.7%. However, the emergency caesarean section rate was worse and way above the 12.4%. The service was also better than the national average for 3rd and 4th degree tears being considerably less than 5% nationally. It was reported that the percentage of women with a blood loss over 1500mls was 2.3% better than the national target of 2.7%.
Is the service effective?

Evidence-based care and treatment

There was a truly holistic approach to assessing, planning and delivering care and treatment to people who use services. The service provided care and treatment based on national guidance. New evidence-based techniques and technologies were used to support the delivery of high quality care. Managers checked to make sure staff followed guidance.

A clinical facilitator monitored policies and ensured clinical updates were monitored. Audits were reviewed yearly and updated in line with any clinical updates from the National institute for health and clinical effectiveness (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG) guidelines.

All policies we reviewed were current and a review date was seen. Policies observed were the fetal growth, treatment of sepsis, shoulder dystocia, obstetric emergency eclampsia, obstetric haemorrhage, newborn blood spot screening and thromboprophylaxis in pregnancy.

Women were cared for by a named midwife and named consultant throughout their pregnancy and evidence of this was observed within the woman’s antenatal notes.

Staff were committed to provide and promote a normal birth. The birth options team worked collaboratively with women to personalise their birth choices and a woman’s individualised needs were reflected when planning how care was delivered. The ‘bumps to birth’ initiative was in place to provide women information regarding the birth options available to them at the trust. For example, obstetric led, delivery suite or midwifery led in the midwifery unit or homebirth. This was in line with National Institute for Health and Care Excellence (QS22) antenatal care.

Women were risk assessed for gestational diabetes and offered glucose tolerance testing in line with National Institute for Health and Care Excellence (NG3,2015). There was a link midwife for diabetes who supported and encouraged women with gestational diabetes throughout their pregnancy. A monthly antenatal class was facilitated where colostrum harvesting was discussed and kits provided. A midwife led diabetes clinic ran alongside the diabetic consultant clinic. Colostrum harvesting is expressing colostrum before birth as a backup in case the newborn baby has difficulties feeding for the few days following birth.

Staff measure and recorded fundal height from 24 weeks and there was a clear escalation policy and pathway for abnormal findings in line with MBRRACE-UK (2015) and current National Institute for Health and Care Excellence (CG62). The antenatal screening team worked alongside obstetric sonographers and two consultant obstetricians with a special interest in fetal medicine to develop a care pathway for any high-risk group.

Midwives and obstetricians emphasised the importance of fetal movements to women at each antenatal contact as a method of fetal surveillance. Midwives documented the details of the conversation in the antenatal records. As highlighted by MBRRACE-UK (2015) and in line with the current Royal College of Obstetricians and Gynaecologists guideline (Green-top Guideline No. 57), and document the detail of this conversation in patient records.

We found women with a multiple pregnancy had care planned and provided in accordance with National Institute of Health and Care Excellence quality standards for management of twin and triplet pregnancies in the antenatal period. Women had a dedicated consultant lead and midwife. A plan of care was in place and postnatally the woman was discussed during each safety huddle to review health and possible risk to mother and babies.
Women who needed a caesarean section, whether planned or not, received care in line with The National Institute for Health and Care Excellence recommendations (QS32) – 9 quality statements. Women were offered a choice of a vaginal delivery following previous caesarean sections. Pregnant women who requested a caesarean section with no clinical cause had a documented discussion at a ‘birth options’ clinic to discuss the overall risks and benefits of a caesarean section compared with a vaginal birth.

The service used a growth assessment protocol (GAP) and gestation related optimal weight (GROW) assessment is completed as part of the perinatal organisation protocol. The aim of strategy was to implementation of antenatal detection of fetal growth restriction. The service had found that since the introduction of the growth assessment protocol the rates of lower segment caesarean section had increased along with induction rates. An induction of labour pathway group was in place to review the current fetal movement policy and to decide whether the induction could have been prevented.

The staff in the midwife led unit for women were committed to providing and promoting a normal birth. Women were offered a choice of birthing options including midwife led and if women requested no consultant presence on labour ward, this was adhered to as long as it was safe to do so.

Women and their partners were supported and encouraged to have skin on skin contact with their babies following birth. Skin-to-skin contact with babies soon after birth supported parental bonding and improved temperature regulation of new-born infants. The service had posters around the unit promoting the advantages of skin to skin contact with babies. Delayed cord clamping was evidenced and promoted in theatre and labour ward. Delayed cord clamping meant more blood reached the baby immediately after birth and may help to prevent anaemia. This is in line with National Institute for Clinical Excellence (QG190) intra-partum care for healthy women and babies.

The National Institute for Clinical Excellence Quality Standard 37 was adhered to in respect to post-natal care. Examples included staff discharging patients with appropriate checks and with correct medicines. All women we spoke with had been given feeding advice and support. The department had increased the numbers of midwives undertaking New-born Infant Physical Examination (NIPE) training, with 60% of the midwives trained and examinations were provided 7 days a week.

The service took part in the NHS improvement maternal and neonatal health safety collaborative. Five staff were trained as quality improvement leads and undertook quality improvement projects. The aim was to contribute to the national agenda for reducing stillbirths. Following the project, the team had since used the quality improvement drivers across the maternity service.

The maternity service worked closely with the neonatal unit to review term admissions. This was measured and reported at a divisional and network level. The neonatal matron and Clinical audit facilitator undertook a national survey on behalf of the jaundice working group of the Avoiding Term Admissions Into the Neonatal unit (ATAIN) programme. The results were published in a specialist neonatal journal.

The maternity service followed a bereavement pathway for women and families. We saw a flowchart for follow up bereavement support for parents which outlined the responsibilities and role during initial contact through to discharge.
Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences.

Women helped themselves to breakfast and staff would serve breakfast to women who were unable to move around easily. The midwifery led birthing centre had a lounge facility for making refreshments and partners could make themselves a snack if required.

Women received support to breastfeed after birth and this continued onto the post-natal ward. The trusts breastfeeding initiation target was 85% and the service over the six months was delivering between 83% to 87%.

There was an infant lead in place and three infant feed support workers trained to support women with feeding their babies and offering feeding advice. Women spoke positively about the care they received. All maternity staff received infant feeding training provided by the lead and staff we spoke with knew the importance of offering feeding choices and supporting women with feeding choices.

World Health Authority and UNICEF baby friendly breastfeeding initiatives were in place within the trust. The initiative was designed to support breastfeeding and parent infant relationships by working with public services to improve standards of care. The trust was currently at level one, and had not achieved level two standards at our inspection. However, the infant feeding lead told us that the trust had just two objectives to complete to reach level two status. The trust was to submit the new data to reach level two by November 2018. The trust aimed to reach level three breastfeeding accreditation.

There were leaflets on breastfeeding and artificial feeding available on the trust website, within the wards and displayed on notice boards. We saw posters giving guidance on responsive and effective feeding, as well as advertising the drop-in breast-feeding service. There was access to breast pumps and a fridge to store breastmilk. If women wished to bottle feed, sterilisers were readily available. Staff knew which women required support with feeding their baby as staff discussed baby feeding regime at handover. This included the women’s feeding preference, their progress with feeding their baby and babies who had artificial feeding.

The neonatal unit had created pocket size breast feeding cards. On admission parents had access to breast feeding logs and expressing kits.

Burstow babies was an infant feeding service provided by the infant feeding team. The sessions helped women with feeding issues they may be experiencing. The service was available to all families from the day of discharge home until baby was 28 days old. The service was available seven days a week on an appointment system.

Pain relief

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

A pain audit was completed within the maternity department to identify a woman’s choice and timeliness on receiving pain relief. Women had access to a range of pain relief methods in accordance with National Institute for Health and Care Excellence (NICE) guidance CG190. This
included pharmacological pain relief such as entonox (gas and air), pethidine (a morphine-based injection) and epidurals during labour. Epidurals were available 24 hours, seven days a week.

Women who had an intrapartum death had a plan in place to ensure pain relief was adequate for labour. Staff discussed women’s level of pain and subsequent management plans during handover. This ensured all staff knew which women required review of their needs in relation to pain. Intrapartum death is the death of a baby in the uterus.

Non-pharmacological pain relief were available such as birthing pools and birthing balls. Alternative pain management was encouraged including the use of transcutaneous electrical nerve stimulation (TENS) machines, (these are machines which are used as an alternative to medication, and they can ease pain in some people with certain types of pain). Beds could also be adjusted to be at different heights and angles.

The midwifery led unit had midwives trained in hypnobirthing and one midwife had recently been trained in aromatherapy and acupuncture and was currently being supported to produce a policy for ratification to provide classes and treatment to women.

Patients had access to information regarding pain relief. There were posters in the central delivery suite outlining pain relief options to patients as well as leaflets in the antenatal clinics and on the trust website.

**Patient outcomes**

All staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer review, accreditation and research were proactively pursued. High performance was recognised by credible external bodies.

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

We observed evidence to show the service regularly reviewed the effectiveness of care and treatment through local and national audits to improve outcomes. The service developed safety pin notices from areas of concern highlighted, following review of audits. The safety pins were used to share lessons and guidance with all staff to improve patient care. Safety pins were displayed in all clinical areas, discussed within safety huddles and weekly updates sent to staff.

The service had a high incidence of induction, with rates worse than the trust target of 29%. This was found to have a detrimental impact on the neonatal unit. An induction of labour pathway group had recently started an audit to look at whether the induction was appropriate and whether the induction meant there was a higher risk of intervention.

The department had maternity specific tools throughout the department as women’s maternity needs were different to that of other patients within the hospital. For example, the maternity department had a maternity specific dashboard which detailed types of birth, maternity unit closures, breastfeeding rate and neonatal unit admissions.

Women who had used the service completed a ‘walk the patch’ to collect feedback from women on the antenatal and postnatal wards, as well as women using the midwifery led unit, or had given birth at home. The information was collated and audited and presented with the maternity voices partnership, a forum for maternity service users, commissioners and providers of care to ensure women’s views were incorporated into the planning and delivery of services.
The service had seen a rise in the number of home births. We found 23.5% of women birth outside of the labour ward. Safer birth reported home births safer practice than on a high-risk labour ward. In the 2017 National Neonatal Audit East Surrey Hospital’s performance in the two measures relevant to maternity services was as follows:

- **Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?**

  There were 113 eligible cases identified for inclusion and 90.3% of mothers were given a complete or incomplete course of antenatal steroids.

  This was within the expected range when compared to the national aggregate, that 86.1% of mothers were given at least one dose of antenatal steroids.

  The hospital met the audit’s recommended standard of 85% for this measure.

- **Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?**

  There were 11 eligible cases identified for inclusion, 36.4% of mothers were given magnesium sulphate in the 24 hours prior to delivery.

  This was lower than the national aggregate of 43.5%, and put the hospital in the middle 50% of all units.

  *(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)*

From January to December 2017 the total number of caesarean sections and elective and emergency section rates were all similar to expected.

<table>
<thead>
<tr>
<th>Standardised caesarean section rate (January 2017 to December 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of caesarean</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Elective caesareans</td>
</tr>
<tr>
<td>Emergency caesareans</td>
</tr>
<tr>
<td>Total caesareans</td>
</tr>
</tbody>
</table>

*Note: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries. Delivery methods are derived from the primary procedure code within a delivery episode.*

In relation to other modes of delivery from January to December 2017 the table below shows the proportions of deliveries recorded by method in comparison to the England average:
Proportions of deliveries by recorded delivery method (January 2017 to December 2017)

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>Surrey and Sussex Healthcare NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections1</td>
<td>1,112</td>
<td>29.2%</td>
</tr>
<tr>
<td>Instrumental deliveries2</td>
<td>465</td>
<td>12.2%</td>
</tr>
<tr>
<td>Non-interventional deliveries3</td>
<td>2,234</td>
<td>58.6%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>3,811</td>
<td>100%</td>
</tr>
</tbody>
</table>

Notes: This table does not include deliveries where delivery method is ‘other’ or ‘unrecorded’.
1 Includes elective and emergency caesareans
2 Includes forceps and ventouse (vacuum) deliveries
3 Includes breech and normal (non-assisted) deliveries

The profile of deliveries at the trust is broadly similar to England averages.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

As of the 10 September 2018, the trust had no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

The trust took part in the 2018 MBRRACE audit (2016 data) and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 4.8.

This was up to 10% lower than the average for the comparator group rate of 5.0 and better than expected.

(Source: MBRRACE UK)

Competent staff

The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

The service had two dedicated education facilitators, who each had their own roles in the development of staff. One education facilitator took the lead on midwifery students and preceptorship midwives and the other developed key skills training and development for all midwifery and medical staff. Staff spoke highly of the education provided and felt well supported by the education leads. We observed a comprehensive and supportive induction plan for all new midwives starting. This provided new midwives the opportunities to complete key skills training as well as the practical opportunities to support this learning.
Maternity services had introduced a new model of midwifery supervision. All supervisors of midwives were transferring to the professional maternity advocate (PMA) role. The new model was seen to be clear and concise with the emphasis on providing more personalised and meaningful appraisal. There were 10 PMAs in place with one PMA being the head of midwifery. All were experienced practising midwives trained to support and guide midwives to deliver care developed nationally and locally. Staff told us that this new method of appraisal was more focused to their individual needs.

Midwives rotated around the different areas of the maternity unit every three months to ensure they were continuously using and keeping up to date with midwifery skills. However, on the midwife led unit we were told that 50% of the midwives moved around different areas of the department and 50% were based full time in the midwifery based unit. The senior team felt it was beneficial to have continuity of midwives within the department.

Midwife support workers had the opportunity to attend training to increase their knowledge and skills. For example, there were maternity support workers who had specialist training in breastfeeding support, taking bloods, and doing routine observations of patients.

Midwives told us they felt well supported by the head of midwifery and senior team to develop their skills and interests. Most of the specialist midwives within the department told us their role developed from having an interest in the specialist subject such as bereavement and perinatal health to specialised midwifery roles.

Key skills and mandatory training were provided each month for staff and included regular scenario training, which midwifery and medical teams attended. Midwives told us they had enough opportunities for continuing professional development to be able to complete their revalidation.

There was training in place for cardiotocography, assessment of fetal growth and newborn assessments. We found midwives clinical knowledge was continuously assessed. For example, there was a cardiotocography masterclass for staff and all cardiotocography assessments were reviewed 24 hourly to identify any possible concerns. Midwives at random were asked to review the CTG test to ensure midwives knew adequately how to read it. The service used gestational related optimal weight (GROW) to assess fetal growth, all staff were given training to be competent to complete this.

From April 2017 to March 2018, 92% of all staff within maternity at the trust received an appraisal compared to a trust target of 90%.

The trust has provided the data for the following staff groups, but it did not include details of any medical staff for any core service.

Administrative and clerical were the only staff group who did not meet the 90% appraisal completion target. This equated to just two members of staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals completed</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Clinical Services</td>
<td>25</td>
<td>23</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>129</td>
<td>120</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>13</td>
<td>11</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)
Multidisciplinary working

Staff, teams and services were committed to working collaboratively and had found innovative and efficient ways to deliver more joined-up care to people who use services. The woman’s care was delivered and reviewed in a coordinated way when different teams were involved in patients care.

We observed obstetric staff and midwives working well together. There were systems to manage and share information. Effective care was fully integrated and provided real-time information across teams and services.

There was a 24-hour multidisciplinary review of specific high-risk cases as well as twice daily safety huddles. Safety huddles were short, multidisciplinary briefings designed to give, clinical and non-clinical, staff opportunities to escalate and discuss any operational concerns. Staff felt these briefings were beneficial and inclusive to all staff.

We heard from managers and staff that multidisciplinary working was essential for the smooth running of the department. We heard good examples of community midwives engaging with midwives and consultants on the hospital site. For example, a weekly innovation huddle took place with midwifery and obstetric staff. We observed professionals sharing ideas and working together to produce working groups and projects to improve services within the maternity unit.

We observed good practice in line with Safer Childbirth which states there must be 24-hour availability in obstetric units of senior paediatric colleagues, who have advanced skills for immediate advice and urgent attendance, who would attend within 10 minutes. The neonatal unit liaised closely with staff in the intensive care unit regarding any baby that required urgent transfer of care.

There was good communication and working relationships between midwives in the unit and community midwives. All midwives worked well with the MAPLE team to prevent avoidable harm in safeguarding. Midwives liaised with perinatal mental health teams, safeguarding, social care, GP’s and health visitors. There were mental health joint clinics in place run by the perinatal mental health service. It was a community based service for mothers with severe mental health difficulties now or in the past, during pregnancy and up to a year after birth. The service comprised of four teams which included perinatal mental health professionals including psychiatrists, mental health nurses, psychologists, parent-infant psychotherapists and nursery nurses. All were trained and specialised in perinatal adult and infant mental health.

Seven-day services

Midwives, consultants and anaesthetists were available on site. Consultants were available from 8am to 18.00pm, Monday to Sunday. During all other times there was a consultant on call from home available 24 hours a day, seven days a week. An on-call system was in place and we reviewed the medical rotas and found sufficient cover was in place. This was in-line with The Association of Anaesthetists of Great Britain and Ireland, Obstetric Anaesthetic Guidance: An anaesthetist must be immediately available for emergency work on the delivery suite 24 hours seven days a week, and National Health Service, Seven Days a Week, Priority Clinical Standards.
There was an on-site pharmacy and pathology services that were available at all times day and night. Maternity services offered a 24-hour telephone triage service. This service could be accessed at any stage of pregnancy.

**Health promotion**

Information was displayed on boards throughout the unit for women and visitors to read. For example, smoking cessation, infant feeding, dietary advice and diabetes in pregnancy. The service had a social media page which gave health advice and the maternity page on the trust website showed video clips and information for women. A perinatal mental health video showing parents the signs of depression and post-natal mental health was observed on the trust website. The perinatal mental health midwife was also in the process of producing an information booklet to give to women at their initial booking to recognise the systems and signs of mental health.

Staff supported women to live healthier lives. At the initial antenatal visit, staff risk assessed women for immunisations and past medical history. Women were offered the flu and pertussis (whooping cough) vaccination. Health promotion including healthy eating and smoking cessation was discussed and documented in antenatal records.

Women were all invited to antenatal classes by midwives; classes included health promotion initiatives and lifestyle choices.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

Staff knew about consent and decision-making requirements of legislation and guidance. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

There was mental health joint clinics in place run by the perinatal mental health service which supported mothers with severe mental health difficulties during pregnancy or up to a year after birth.

Mental health assessments and specific wellbeing questions were included in the booking and pregnancy assessments at 28 weeks between patient and midwife. Women at risk were easily identified on the computer system and risk sections were visible. We saw evidence that these sections had been completed for women with concerns.

The perinatal mental health midwife was in the process of ratification for a mental health booklet she had developed for all women on their first antenatal booking. The booklet contained information on mental health as well as signs and symptoms. It also gave women the opportunity to ask specific questions around their wellbeing.
Women were given opportunities to understand their options and give informed consent. The midwives and obstetricians understood best interests for women. A birth options team work collaborated with women and their partners to personalise their birth preferences. This allowed women to have a voice.

Staff training included an e-learning module for mental capacity act (MCA) and deprivation of liberty safeguards (DOL’s). The trust included training for the Mental Capacity Act and Deprivation of Liberty within mandatory level 1 and level 2 within their safeguarding training.

Please see the “Safeguarding” section for details of training compliance.

(Source: Routine Provider Information Request (RPIR) – Quality statement)
Is the service caring?

Compassionate care

People were truly respected and values as individuals and were empowered as partners in their care and feedback from patients confirmed this. This was in line with the National Institute of Health and Care Excellence guideline QS15, Statement 1: Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.

There was a strong, visible person-centered culture. Staff were highly motivated and inspired to offer care that is kind and promotes people’s dignity.

During our observation around the unit we observed staff ensuring women’s dignity was maintained and we observed staff taking the time to interact with patients. For example, we observed kind and supportive advice given to a woman who required breastfeeding support.

Staff introduced themselves and made women and their families aware of their role and responsibilities. During theatre we observed a woman and her partner being treat in a kind manner by all staff and all members of the team introduced themselves to the patient and her partner. This was in line with NICE QS15 statement 3: patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.

Midwives and obstetricians displayed an understanding and a non-judgemental attitude when talking about women who had mental ill health or a learning disability. Staff recognised when extra time and support may need to be given to a woman who had an additional need.

The women and partners we spoke with during the inspection were very complimentary about the care and attention they had received. For example, women and partners described their care as ‘outstanding’. Other comments included ‘staff were amazing’, ‘my midwife listened and was supportive’ and ‘staff were caring and listened’.

Friends and family test performance (antenatal), Surrey and Sussex Healthcare NHS Trust

From July 2017 to August 2017 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) were similar to the England average.

From September 2017 to March 2018 the trust achieved 100% recommended for their maternity Friends and Family Test (antenatal) performance and were better than the England average.

From April 2018 to July 2018 the trust had less than five eligible responses and therefore data was supressed and no percentage recommended figures were available.
Friends and family test performance (birth), Surrey and Sussex Healthcare NHS Trust

From July 2017 to July 2018 the trust’s maternity Friends and Family Test (birth) performance (% recommended) varied. Five months in the period saw the trust with a lower percentage recommended than the England average (July, October, December 2017, April and June 2018).

For the remaining six months performance was better than the England average, with five of the six months achieving 100% recommended (September 2017, January, February, March and May 2018).

For August 2017 the trust had less than five eligible responses and therefore data was suppressed and no percentage recommended figure was available.

Friends and family test performance (postnatal ward), Surrey and Sussex Healthcare NHS Trust

From July 2017 to July 2018 the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was similar to the England average.

Friends and family test performance (postnatal community), Surrey and Sussex Healthcare NHS Trust

From July 2017 to July 2018 the trust’s maternity Friends and Family Test (postnatal community)
performance (% recommended) was in line with or better than the England average.

The trust achieved 100% recommended for eight months in the period (September and October 2017 and from February 2018 to July 2018)

Please note that for the above four questions no data for the maternity friends and family test was published by NHS England in November 2017 due to data quality concerns.

(Source: NHS England Friends and Family Test)

The trust performed better than other trusts in three of the 19 questions in the CQC maternity survey 2017. The remaining 16 questions were about the same as other trusts.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>9.2</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>8.0</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>9.9</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.9</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>8.1</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.6</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If attention was needed during labour and birth, did a staff member help you within a reasonable amount of time</td>
<td>9.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.6</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.9</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.6</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>9.0</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>7.1</td>
<td>About the same</td>
</tr>
</tbody>
</table>
### Emotional support

People’s emotional and social needs were highly valued by staff and embedded in their care and treatment of women. Staff provided outstanding emotional support to patients to minimise their distress and offered. The service provided an appointment based weekly listening service for parents called ‘maternity birth reflections’. Women were offered a 1:1 appointment with a senior midwife to discuss their birth experience and feelings.

Women undergoing termination of pregnancy were offered support and counselling before and after procedures.

We found the bereavement resources and care offered to women, partners and their families were outstanding. The services provided were in line with the SANDS guidelines; Pregnancy and Loss. The trust had a specialist bereavement midwife, covering a full-time role and had recently advertised for 10 bereavement champions to support the service. Staff could contact the bereavement specialist midwife by mobile. Support included home visits, telephone calls as well as help with funeral arrangements and referrals to counselling.

The bereavement midwife worked closely with the gynaecology team to ensure women received sensitive care following a pregnancy loss at any gestation. Pathways of care had been designed to support women and partners with contact and support was offered up to two years following the birth of their baby. We observed examples where parents were supported to take their baby home for a few hours, for a walk outside or given the time to hold, bathe and dress their baby.

There was a dedicated bereavement room for delivering baby. The room was away from the delivery suite and was well thought out. It provided a homely environment that was non-clinical. There were two cold cots available, with packs providing plaster casts of hand and footprints and
photographs. There was also a specific pack given to women who had had a miscarriage with guidance for support and keepsakes.

Information was provided to parents in regard to funeral arrangements and advice. Clear guidelines were in place and all maternity training had received bereavement training on how to deliver advice and guidelines to parents. There was also a sensitive card placed on the door identifying a bereaved family. The aim of the card was so that the family were not disturbed and staff could be sensitive in their discussions.

Bereavement training took place monthly. A recent band six ‘workshop’ out of the box took place and highlighted a mother’s perspective on losing her baby and the care given. Training also covered supportive listening skills, breaking bad news and creating memories.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment. A ‘bump to birth’ clinic was provided for women to learn about the different birth options available. Maternity staff provided advice and explanations tailored to women’s needs about the benefits and risks of each location for birth.

We observed consultants and midwives in the antenatal clinic discuss birthing options, explain the risks and benefits of each to expectant mothers. This was in line with NICE QS15 statement 5: patients are supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences.

The service provided a focus group for partners and fathers to listen about their experiences of maternity care and views from their perspectives.

Across the maternity services women, their partners, friends and relatives had access to a variety of information. For example, there was breastfeeding and artificial feeding information displayed. There was also a social media page with guidance and information for mothers and partners.

The neonatal unit holds an annual reunion for babies who had an inpatient stay for one week or more. The families were invited for the first two years after baby’s birth. The neonatal staff get involved and organise games and stalls for parents and siblings. The money raised goes towards the higher of the hall and provides refreshments. Any other money raised goes towards purchasing Christmas stockings for babies on the neonatal unit.

Is the service responsive?

Service delivery to meet the needs of local people

People’s individual needs and preferences are central to the planning and delivery of tailored services. The maternity unit offered a consultant led and midwifery led birthing unit. The services are flexible, provide choice and ensure continuity of care. Home births were encouraged and the service provided a team of specialist home birth community midwives.

The unit provided facilities for partners or relatives to stay overnight to support the woman. In the postnatal ward reclining chairs had been introduced and curtains were used to maintain privacy. Staff found women preferred partners to stay for support.
There were innovative approaches to providing integrated person-centred pathways of care that involve other service providers, particularly for people with multiple and complex needs. The service had a birth options team. The team met with women and their partners to offer choices around the birth of their baby. Senior managers told us the birth options clinic gave women a voice and an active part in their birth.

Some midwives in the community chose to work longer days. We were told this worked well to accommodate women who wished to book antenatal appointments outside of working hours. All women had hand held maternity notes which they took to each appointment. We observed coloured stickers in the maternity notes which flagged any potential concerns. For example, a green sticker highlighted a mental health concern.

At our last inspection the unit was starting to introduce a paging system for women who were experiencing long waits. This was so they could wait in the café or gardens without losing their appointment time. We found this to now be fully operational and reported to be working well with women waiting for appointments.

The antenatal day unit provided care for women who were more than 16 weeks pregnant and had pregnancy related concerns. For example, reduced fetal movements, vagina spotting, and abdominal pain. The service offered appointments seven days a week from 8.30am to 6pm. Information on the antenatal unit was found on the trust website along with emergency contact numbers for any pregnancy related concerns outside of opening hours.

Interpreters and 24-hour translation services were available for women who did not speak English. The trust had a service in place which provided British sign language.

There was a proactive approach to understanding the needs of vulnerable women or women with complex needs. The service delivered care in a way that met their needs and promoted equality. Women living in vulnerable circumstances, such as those who were drug dependent, living with learning disabilities or complex needs were referred to the MAPLE team. The service provided early help assessment and continuity of care. MAPLE team worked closely with the perinatal mental health service to provide additional support.

A maternity voices partnership group took place monthly. The group had representation from mothers who had previously used the service. The group included the head of midwifery and women from minority groups, fathers, teenagers and bereaved parents. Maternity leads attend the group to listen to the views of mothers and women using the service. The information we received from the group was that it was well attended and the group felt listened to and well supported by senior maternity managers. The head of midwifery and managers listened to concerns raised within the group. For example, women said there was nowhere to put their clothes in the bathroom and had to place them on floor. Staff listened and the service put shelves in all bathrooms.

The service provided continuity of care and support to women when transitioning from the ward through to discharge. A communication tool ‘Situation, Background, Assessment and recommendation’ (SBAR) had been introduced for staff handovers, advice calls, transfer and discharge. Midwives used the communication tool to handover from labour ward to postnatal ward verbally. The ‘SBAR’ was also kept within the body of the patient records. The ‘SBAR’ was used to ensure assessment, plan and any potential risks were communicated well. An electronic discharge summary was sent to GP the same day as mother and baby’s discharge. A 24-hour ward clerk had responsibility for completing electronic discharge of women. Notification was then sent to the health visiting teams.
From Q4 2016/17 to Q1 2018/19 the bed occupancy levels for maternity were generally higher than the England average, with the trust having 70.1% occupancy in Q1 2018/19 compared to the England average of 58.1%.

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

**Meeting people’s individual needs**

The service took account of patients’ individual needs. The unit provided support and arrangements for women whose first language was not English. The maternity unit was aware of the local demographic and knew there was a high population of Asian and Polish women using the service. Two midwives recognised the need to support these patients and produced national birth records in Urdu and Polish. We observed care pathways in place for women who did not speak English. Translated breast feeding and safety leaflets were seen and there was a plan in place to provide antenatal classes to Asian and Polish women, to provide information on birth place choices, when they go home with their baby and parenting skills.

An e-midwife ‘Sasha’ was in place for women who had any non-urgent questions or concerns about pregnancy, birth, breastfeeding or postnatal issues. A senior midwife led on the service. Messages to ‘Sasha’ via email and were responded to within three working days. The service had received 450 messages within the past 12 months.

Women’s hand-held records were observed to have information on the women’s physical and social needs and referrals for appropriate support. Women with specific needs such as disabilities were referred by their community midwife and appropriate plans of care were put in place.

A birth reflections service was set up last year to provide a listening service offering a one to one appointment with a senior midwife. The service saw up to seven women each week. The service provided women who had experienced a traumatic labour and birth to review their birth records,
talk about their birthing experience and to talk about their feelings. The birth reflections group was well attended and women found it a good source of support.

The midwifery led unit was for women who were planning on birthing their babies as naturally as possible and for women who did not want a home birth. The unit had three rooms all with birthing pools and one with en-suite facilities. It was located closely to the delivery suite which ensured easier access if required. Women had to fit certain criteria to use the midwifery led unit. Mother had to be full term (37-42 weeks pregnant), wished to have a pregnancy without an epidural, expecting a single baby and had not had any previous complications in pregnancy or labour. All the midwifery led unit midwives were experienced in normal birth, hypnobirthing, water birth, massage and active birth. Pain relief available included hydrotherapy, entonox, pethidine, paracetamol, and dihydrocodeine.

Safer childbirth standard 2.2.20 states ‘Women have the right to choose where to give birth. If a woman chooses to give birth at home or in a midwifery unit contrary to advice from midwives and obstetricians, there needs to be clear documentation of the information given’. Senior midwives told us that they would accommodate women’s birth choices. However, if it was felt that the woman’s birth choices were outside of current safety guidelines then the risks and information would be given to give the woman an informed choice. Information was documented clearly in patient records.

A specialist perinatal mental health midwife provided support to women with mental health issues and tokophobia. Women had access to a perinatal mental health clinic which provided advice, assessment and treatment for women with a past or current history of severe mental illness, for example, bipolar disorder, schizophrenia or severe depression. There were appropriate discharge arrangements for women with complex health and social care needs. At discharge, staff discussed signs of post-natal depression with women and their partner. Tokophobia is an intense anxiety or fear of pregnancy and childbirth.

Women with multiple pregnancy had a dedicated consultant lead who planned care for women alongside named midwife. Twin packs had been created by the unit with information specifically on parenting twins.

We observed ‘Babi carts’ in place in the postnatal ward. These were two electric monitors on wheels which could be used by mother’s who had multiple births. One could be placed in the postnatal ward with mother and baby, whilst the other was in the neonatal unit. This meant that mother could keep a visual eye on both her babies.

Electronic tablets were also used for women who were unwell in the maternity high dependency unit, the staff used ‘facetime’ so mums could see their babies in the neonatal unit. The unit provided ‘we miss you cards’ to ensure women visiting their babies in neonatal units had adequate access to food and ongoing care. For women who had suffered the loss of a twin the unit used butterfly cot cards to symbolise the twin status for the surviving baby.

Women reported they were confused with who was who in the theatre team as everyone wore the same uniform. The service provided badges for theatre staff to identify who they were. A plan was also in place to provide a unique colour scrub for partners to ensure they would be supported and involved.

Parent information packs were provided alongside the personal child health record (PCHR) or ‘red book’. Information included bliss information (charity for babies born prematurely or sick), safer sleep information, immunisation information, registering births, slings and hand expression.

Discharge information was sent electronically to the community midwives and GP on day of discharge. A 24-hour ward clerk was in place to complete this.
The neonatal outreach service was a team who worked closely with neonatal babies following discharge. Prior to discharge a member of the team would meet and get to know families. The group followed babies after discharge. All babies born under 30 weeks were visited and had a detailed plan of care. Visits were tailored to the needs of the family and babies. Families were taught basic life support and parents had access to the child assessment unit in the community.

**Access and flow**

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

An antenatal care programme was in place. This policy outlined what risk assessments and appointments women with an uncomplicated pregnancy should have. The dashboard showed us that on average 90% of women receiving care at the hospital saw a midwife for their booking appointment before 12 weeks. This met the trust target and the target agreed with the local health authority. This was in line with NICE QS22 statement 1. To improve the service offered to women the maternity unit offered an online booking process. This minimised delay in appointment allocation.

There were two combined, specialised antenatal clinics facilitated at East Surrey and Crawley hospital. Screening tests took place timely and the service had two consultant obstetricians with a special interest in fetal medicine who worked closely with the antenatal screening team.

Women pregnant with fetal abnormalities had the choice to be referred to London hospitals for their antenatal care or delivery. Appointments were readily available at the early pregnancy unit and the planned assessment unit. Women we spoke with had no problem accessing the services.

Women had access 24 hours, seven days a week to a triage phone line for advice. The triage system for all women went through a dedicated triage midwife on the labour ward.

The dashboard showed us over the last six months there had been 11 unit closures and within the last month there had been two. Senior managers told us they thought this was a reflection to the neonatal units limited capacity rather than staffing levels. However, the neonatal unit had a planned expansion in 2019. This expansion would increase the service to two intensive care, six high dependency and 17 special care cots which would be an increase of five cots overall.

In October 16% of the 413 babies born were under emergency caesarean section and 18% planned caesarean section. Women undergoing a caesarean section were reviewed by the obstetrician within 24-hours. Discharge of patients was managed well with the woman given an estimated discharge date on arrival.

**Learning from complaints and concerns**

There was an active review of complaints. The service treated concerns and complaints seriously, investigated them, learned lessons and improvements were made as a result. People who use services and staff were involved in the review.

There were leaflets available in the maternity department which showed patients how to make a complaint about the service. This included speaking to the patient advice and liaison service (PALS). Patients could seek further information on how to raise a complaint on the trust’s website.
A notice board was seen on the unit which identified how to make a complaint and whom to contact.

We reviewed three recent complaints within the six months prior to inspection. All three complaints met the trusts agreed timeframe for responding to complaint. The head or midwifery and deputy head of midwifery reviewed all complaints. All complainants were offered the opportunity to discuss the complaint with the head of midwifery and two of the complainants did. The head of midwifery spoke with the relevant staff involved in the complaint as part of the investigation process. Lessons learnt and actions taken were discussed with complainants and brought to staff in team meetings and safety huddles as part of lessons learnt.

All complaint outcomes were published on the trust website for all staff to learn from. Staff we spoke with said complaints were taken seriously. The safety pins were designed following on from incidents and complaints. The safety pins share lessons learnt that improve patient care.

From June 2017 to May 2018 there were 37 complaints about the maternity service. The trust took an average of 60 days to investigate and close complaints. This was not in line with the trust’s complaints policy. Their complaints policy stated that under current legislation trusts have six months to resolve complaints, but that a response time was agreed for each complaint and was usually 25 working days (35 calendar days).

Patient care was the subject with the most complaints, accounting for 46% of all complaints about maternity. East Surrey hospital received the most maternity complaints with 32 (86%).

A breakdown of complaints by subject and site is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Caterham Dene</th>
<th>Crawley Hospital</th>
<th>East Surrey Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Communications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Integrated care (inc delayed discharge due to absence of care package)</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitude/courtesy</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1</strong></td>
<td><strong>4</strong></td>
<td><strong>32</strong></td>
</tr>
</tbody>
</table>

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

From June 2017 to May 2018 there were 1,200 compliments within maternity.

A breakdown of the number of compliments by ward is shown below:

<table>
<thead>
<tr>
<th>Ward/team</th>
<th>East Surrey Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burstow Ward</td>
<td>780</td>
</tr>
<tr>
<td>Postnatal Community Care</td>
<td>281</td>
</tr>
<tr>
<td>Antenatal Community Care</td>
<td>139</td>
</tr>
<tr>
<td>Total</td>
<td>1,200</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care. Senior managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. The leaders within the maternity unit showed they had integrity. They were knowledgeable, experienced and well respected by all staff we spoke to during our inspection.

The women and children's health division was led by a three-person leadership team including the associate director, chief of women and children’s health and the head of midwifery/divisional chief nurse. The division incorporated maternity, gynaecology, neonatology and paediatric medicine and surgery.

The midwifery senior leaders and matrons had an inspiring shared purpose to deliver and motivate staff to succeed. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture.

We found the head of midwifery to be highly respected by all staff we spoke with. Staff felt valued and listened to and told us the head of midwifery was visible daily and would offer support whenever asked. Feedback we received about the head of midwifery included ‘She is a great leader’, ‘very much about normalising birth and natural birth’, ‘the head of midwifery does not sidestep anything, I believe she wants to provide the best possible service’ and ‘is so open and accessible. Always has time’. ‘Absolutely believe she is always listening and wants to hear’. ‘She and her team are never dismissive and I feel really well respected’.

Staff were empowered to make changes to the service and to push forward ideas they had for improvements to the department alongside their own personal development. The head of midwifery spoke about the importance of the whole team developing ideas for the maternity unit from band five midwives to senior managers. Midwives in specialist roles told us that they had been encouraged to develop their areas of interests further and were given the time to develop their area of interest.

We spoke with the head of midwifery and deputy head and both felt well listened to by the executive team. We were told executive leaders were invited to the maternity unit to observe the work taking place. The senior midwives felt they were listened to by the board and felt confident that if they provided information and evidence regarding funds or requirements then the trust would provide.

A ‘sharing matters’ session had been introduced encouraging staff engagement in service development and delivery. The head of midwifery attended sessions once a month to provide staff the opportunity to speak face to face about any concerns or ideas that were important to them. The management team would then explore the ideas or suggestions discussed and feedback to the staff member.

The department had direct access to the trust board every month through the divisional governance board meeting. Several meetings fed into this meeting including the patient safety team, audit meeting and safety and quality meeting. This allowed information to be fed up to the board and back to the frontline staff.
A supportive model of clinical supervision had been introduced through professional midwifery advocates. There were 10 midwives including the head of midwifery trained to complete the new approach. All midwives were attached to a professional midwifery advocate.

**Vision and strategy**

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. We were told that the maternity department had a good relationship with the board and the head of midwifery had direct access.

There is strong collaboration and support across all functions and a common focus on improving quality of care and people’s experiences.

The strategy and supporting objectives were stretching, challenging and innovative whilst remaining achievable. The vision and values for the trust were visible around the maternity unit and the head of midwifery was focused in ensuring staff worked by the values set. The values were dignity and respect, one team, compassion and respect and compassion. Staff we spoke to knew the values and they were clearly embedded into their practice. The appraisals were aligned to the trusts vision and values and were part of the staff supervision which were now the professional midwifery advocate (PMA) meetings.

**Culture**

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

The inspection team were welcomed onto the unit. Staff were willing to talk to us and wanted to show us the services they provided. Staff told us they were happy and felt part of the service development. This showed an open work force who welcomed review.

There were strong working relationships between the midwifery and medical teams. There was a clear respect for each other’s roles and consultants were said to be responsive to any concerns raised. Multidisciplinary working was evident across the unit with midwives having clear links with gynaecology and tissue viability.

Staff were encouraged to report any incident of bullying or racism to senior managers and through the trusts ‘speak up guardian’. Staff we spoke with told us they felt confident to be able to raise any bullying concerns and knew who their ‘speak up guardian’ was. We saw a clear process for escalating any concerns over performance issues and staff felt able to challenge each other.

Hospital and community midwives worked well together. Community midwives had the opportunity to work two weeks hospital based and two weeks within the community. This was reported to work well and had promoted better communication and working relationships between the teams.

There was a plan to provide reflection session for all maternity staff. Senior staff felt that this would be a good way of supporting staff following traumatic deliveries or difficult cases. Staff were receptive to this idea and felt this would be a good way of support and reflection.

Boards were in place around the maternity unit showing learning from incidents and promoting incident reporting. There was a good reporting culture and staff were clear on how to complete an electronic reporting form.
Governance

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. The service had leadership structures in place and staff were clear about their roles and accountabilities. Midwives and maternity support workers (MSWs) reported to the ward sisters who then reported to the matrons. The matrons reported to the deputy heads of midwifery who reported to the head of midwifery.

The divisions completed a monthly quality report which detailed performance against safety metrics. This information was presented on boards around the unit.

There were two main governance meetings which took place monthly with executive leaders from the divisional directorate as well as head of midwifery and senior managers. The meeting was a divisional board meeting focusing on risk and another meeting which covered auditing.

The governance meetings covered a number of areas:

- Feedback from trust committees
- Audit and effectiveness
- Research and development
- Complaints
- Infection control
- Business continuity
- Clinical focus
- Care quality commission standards, current NICE guidelines, national documents and surveys
- Key performance indicators
- Standards
- Safeguarding
- Policies for ratification
- Recruitment

We reviewed several meeting minutes and found that they had a clear role in the oversight of maternity services. The minutes showed actions were taken in a timely manner. Information was clearly disseminated through information boards and meetings.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. A risk management policy was in place with clear guidance on reporting and documenting risk in line with Safer childbirth: There was a written risk policy, including trigger incidents for risk and adverse incident reporting. Risk was monitored through monthly local and trust wide meetings. We found there were assurances in place and performance issues were escalated appropriately through clear structures and processes.

The maternity department took part in the national maternal and neonatal collaborative, training five staff to become quality improvement leads. They undertook quality improvement projects with
the overall aim of contributing to the national agenda of reducing maternal, neonatal deaths and stillbirths by 2020. Following on from the project the team had since rolled out the quality improvement methodology as the basis for all quality improvement projects across the maternity service. For example, a quality improvement project is underway to see how service users could be involved in investigations following serious incidents. The aim being to co-design a pathway with maternity staff and women and families who use the service.

During the clinical focus week within the trust the management team worked in the clinical setting observing practice and work alongside clinical staff. This provided an opportunity to audit and monitor safety and quality within each of the clinical areas. The management team provided feedback to the maternity staff of good practice as well as any areas for improvement.

We reviewed the divisions risk register and obstetrics consisted of eight risks. Risks included insufficient capacity for provision of maternity service, midwifery staffing levels and lack of neonatal capacity resulting in increased likelihood of partial or complete suspension of maternity services. We found these risks were consistent to the concerns shared by maternity staff and there were current plans to address these risks. The maternity risk register was reviewed monthly to identify any issues within performance. Information from the review meetings were fed through into the trust risk and governance monthly meetings. For example, the maternity unit was undertaken an external review of staff using the birth plus review of staffing and a group was in place to look at the high levels of induction.

**Information management**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. Staff told us there was good access to information at the trust. The Head of Midwifery told us they received an updated maternity dashboard every month and could access a range of data from the trusts intranet facilities.

The annual maternity report was available for staff and patients to review. The report was based upon hospital demographic and performance data.

Relevant information was displayed on notice boards within the maternity unit. We saw posters about training opportunities, development opportunities for staff, infection control, parenting advice and educational material for new parents.

Guidelines were stored electronically on the intranet and provided the most up to date policy. Guidelines could be accessed and found easily by staff.

We saw effective arrangements to ensure that data or notifications were submitted to external bodies as required. We saw arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards. This included an alert system to inform staff where patients may require additional mental health or emotional wellbeing support.

The maternity departments page on the trust website was informative. The page gave women and partners guidance throughout the pregnancy and birth journey with links to videos and clips. A social media page was also in place and this offered women and partners to comment and interact with midwives. Breastfeeding advice and current guidance was seen, as well as information on signs and symptom of perinatal mental health. Women used the social media page and we observed positive comments and interactions noted on there. Patients confidentiality was protected and we found all computers were password protected and staff locked the computers before walking away.
**Engagement**

There was a strong collaboration and support across all maternity services and a common focus on improving quality of care and people’s experiences. The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

A ‘friends and family’ survey was completed for the maternity department. Comments and feedback from women and family were positive, staff were praised and they liked the service and support provided. Overall care and support was rated as excellent or very good.

The unit had a learning forum of excellence called GEMS (great practice, excellent communication, multidisciplinary team working, safety first). GEMS were developed to share excellent practice that was reported on electronic incident forms. Staff who submitted a nomination for a GEMS award received a thank you letter. Staff nominated through GEMS received a certificate which could be used towards their revalidation.

The maternity voice partnership prior to their forum with maternity staff attend local drop in sessions at local children centres and were involved with the local positive birth movement groups in Surrey and Sussex to gain views about the maternity facilities from local women in the community. Social media had also been a way for the service to gain information and feedback from users. Maternity users were invited to comment on local guidelines and patient information leaflets. The chair of the maternity voice partnership attends the divisional board meetings and forums such as the labour ward forum and guideline development group.

The service engaged with women when undertaking service development projects. For example, following feedback regarding women’s experiences on the postnatal ward, maternity focus groups were facilitated. The service had plans to develop these focus groups further for surrogate parents and fathers.

Staff were consulted of any changes across the department and felt they had a voice. Staff were invited to sharing matters to discuss with senior manager any current ideas or changes observed examples of ‘you said, we did’. They were told the unit did not provide comfortable enough chairs, so new chairs were purchased.

**Learning, continuous improvement and innovation**

The leadership focused on continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care. The introduction of the innovation huddle encouraged maternity teams to integrate ideas and improvement into their practice. The huddle took place on the delivery suite and was complemented using a visual management board.

A midwife had recognised the importance of staff wellbeing and spoke to the head of midwifery with ideas for activities that staff could access. The midwife was supported to take the idea further by the senior managers and had created wellbeing sessions such as relaxation and meditation and well as an upcoming yoga session.

The maternity team were shortlisted as finalists at the Health Service Journal (HSJ) awards under the maternity safety category for design and development of safety pins. Safety pin notices are used to share lessons learnt that improve patient care. These were displayed in all clinical areas,
including safety huddles and were sent as weekly updates to all staff across the organisation. The initiative had been shared and adopted by NHS trusts across the country.

A clear and supportive preceptorship programme was developed that provided components that focused on vision of wellness as well as personal and professional growth was used. Having a more supportive environment during the years preceptorship programme aimed to build more confident midwives prepared for challenging cases.

The preceptorship midwife told us they hoped the supportive preceptorship would have a positive impact on recruitment and retention, sickness and absence and team effectiveness. We observed a welcome bag that the preceptorship had made for 18 new starting midwives to welcome them into the service. The bag was thoughtful and included items such as a name badge, a map of the hospital and unit, guidance, notebook and pen for new learning. Feedback from previous preceptorship students included ‘I cannot fault the support from everyone, I have loved working with the team’, ‘feeling supported by a specialised lead helped me become more confident in myself and my ability to provide individualised care’ and ‘I couldn't have done it without knowing someone is always there, no matter what, to share their knowledge, support and kind words’.

Work was underway in the midwifery led unit to provide more holistic care for women in labour. Midwives were keen to complete training on hypnobirthing and aromatherapy. A task and finish working party set was in place to arrange hypnobirthing classes which will be offered to antenatally to women at a reduced cost. The plan was to utilise the trained hypnobirthing practitioners and investing in more training staff.

A review of the layout of the obstetric theatre had recently been completed from a patient perspective, following patient engagement. The aim was to promote the visibility of the neonate during care in neonatal resus.

Midwifery and obstetric staff were involved in innovation and change. For example, innovation huddles took place once a week in the delivery suite. All midwifery and obstetric teams were invited to attend. The aim was teams to engage together to look at performance and continuous improvement. Staff were asked to contribute and think of solutions for improvements and change.
Surrey and Sussex Healthcare NHS trust offers outpatient appointments for all specialties where assessment, treatment, monitoring and follow up are required. These include medical, nurse or therapy led clinics and are delivered from a number of locations, including East Surrey hospital, Crawley hospital, Earlswood, Horsham, Oxted and Caterham. At East Surrey hospital, clinics are available until 8pm Monday to Friday and 6pm at weekends.

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

The graph below represents how this compares to other trusts.

The trust had 380,040 first and follow up outpatient appointments from June 2017 to May 2018.

(Source: HES - Outpatient)

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from June 2017 to May 2018.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Surrey Hospital</td>
<td>385,547</td>
</tr>
<tr>
<td>Crawley Hospital</td>
<td>123,829</td>
</tr>
<tr>
<td>Horsham Hospital</td>
<td>49,085</td>
</tr>
</tbody>
</table>
The chart below shows the percentage breakdown of the type of outpatient appointments from June 2017 to May 2018.

Number of appointments at Surrey and Sussex Healthcare NHS Trust from June 2017 to May 2018 by site and type of appointment.

(Source: Hospital Episode Statistics)

The outpatient department at the East Surrey Hospital is part of the Surrey and Sussex Healthcare NHS trust.

Between June 2017 and May 2018 there were 385,547 appointments at East Surrey Hospital, which equated to 67% of the overall appointments across the trust during the same period.

Outpatient services at East Surrey Hospital were located throughout the site, with the main outpatient department located on the ground floor.

As part of our announced inspection we visited the main outpatients’ department; ophthalmology outpatients; the therapies department; the fracture clinic; phlebotomy (taking blood for testing); the breast clinic; the ear, nose and throat clinic; maxillofacial; dental clinics; the Kaizen (Kaizen means continuous improvement in business) office; cardiology; medical records; and, the booking office.

The hospital provides outpatient services covering a range of specialities including but not limited to: medicine, cardiology, neurology, rheumatology, diabetes, respiratory and dental.
The service provided both consultant and nurse led outpatient clinics across a range of specialities. Outpatient clinics were held between 08:00am and 8:00pm with some additional clinics on a Saturday and some ad hoc clinics on a Sunday.

During our inspection we spoke with nine patients and one carer. We spoke with 35 members of staff including nurses, health care assistants, consultants, therapists, phlebotomists, divisional leads and managers. We reviewed three patient records and three complaint records. We reviewed performance information about the department and the trust.

The service was previously inspected in 2016. That inspection also included diagnostic imaging services. Diagnostic imaging services are now inspected separately and have a separate report and therefore we cannot directly compare ratings. During this inspection, we only looked at services provided within outpatients.

The last inspection rated the service as requires improvement overall. On this inspection we rated this service as good.

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Staff received effective training in safety systems, processes and practices. The service provided mandatory training in key skills to all staff and made sure everyone completed it. General outpatient services operated within the surgical division of the trust and mandatory training figures were reported on this group of outpatient staff. This included outpatient nursing, allied healthcare professionals and administrative staff working in the general outpatient department. The trust target of 80% compliance for all mandatory training was met or exceeded in the general outpatient department.

The trust did not have dedicated medical staff working within the general outpatient department. All medical staff running clinics were assigned to different specialities within the trust and mandatory training was reported within those specialities.

Staff we spoke with told us the online training resource was easily accessible and up to date. The system flagged when staff were approaching their refresher date and some of the training sessions were also available as face to face sessions.

Mandatory training covered a variety of topics including fire safety, medicines management, conflict resolution, information governance, manual handling and safeguarding adults and children.

The trust set a target of 80% for completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses as of May 2018 at trust level for qualified nursing staff in outpatients is shown below:

Please note the training modules have been merged to give overall figures for each module as the raw data included multiple entries of the same modules with training renewal dates.
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Safety - 2 Years</td>
<td>19</td>
<td>23</td>
<td>83%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Local Data Security Awareness - 1 Year</td>
<td>19</td>
<td>23</td>
<td>83%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS Conflict Resolution (England) - 3 Years</td>
<td>20</td>
<td>24</td>
<td>83%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control - Level 2 - 1 Year</td>
<td>21</td>
<td>23</td>
<td>91%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic Life Support (Adults &amp; Paeds) Level 2</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>23</td>
<td>23</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, Safety and Welfare - 3 Years</td>
<td>23</td>
<td>23</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>In Hospital Basic Life Support (Adults &amp; Paeds)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - Clinical Update</td>
<td>8</td>
<td>8</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - MaST Clinical Update</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management – Update</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management Core Update</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Level 2 - 2 Years</td>
<td>23</td>
<td>23</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - Basic Life Support</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital BLS (Adults &amp; Paeds) - BLS/ILS</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus In Hospital MaST BLS &amp; AED Awareness Training</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation ILS</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In outpatients the 80% target was met for all mandatory training modules for which qualified nursing staff were eligible.

**East Surrey hospital:**

A breakdown of compliance for mandatory training courses as of May 2018 for qualified nursing
Qualified nursing staff in outpatients at East Surrey hospital met the 80% target for all mandatory training modules for which they were eligible.

**Crawley hospital:**

A breakdown of compliance for mandatory training courses as of May 2018 for qualified nursing staff in outpatients at Crawley Hospital is shown below:
<table>
<thead>
<tr>
<th>Training Module</th>
<th>YTD</th>
<th>Staff (YTD)</th>
<th>Compliance (%)</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Data Security Awareness - 1 Year</td>
<td>5</td>
<td>7</td>
<td>71%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety - 2 Years</td>
<td>6</td>
<td>7</td>
<td>86%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS Conflict Resolution (England) - 3 Years</td>
<td>6</td>
<td>7</td>
<td>86%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health, Safety and Welfare - 3 Years</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>In Hospital Basic Life Support (Adults &amp; Paeds)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control - Level 2 - 1 Year</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - Clinical Update</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management - MaST Clinical Update</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management – Update</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling - Level 2 - 2 Years</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - In Hospital BLS (Adults &amp; Paeds) - BLS/ILS</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation ILS</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Qualified nursing staff in outpatients at Crawley hospital met the 80% target in all but one of the mandatory training modules for which they were eligible. Local data security awareness was the one module they didn't meet the target for with 71% compliance.

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

**Safeguarding**

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it. All the staff in the general outpatient department had received safeguarding adult training. Staff working in more specialist areas of outpatients, where children may be treated routinely were trained to safeguarding children level three. For example, nurses we spoke with working in the fracture clinic where children would regularly be seen were trained to level three.
According to the Safeguarding children and young people: roles and competencies for health care staff Intercollegiate document, all non-clinical and clinical staff who have any contact with children, young people and or parents and carers require level two safeguarding children training. In addition to this, staff should be able to access a level three trained professional at any time during their work.

There were no adult safeguarding referrals made in the 12 months between June 2017 and July 2018 by outpatient staff. However, there were more than 8000 child safeguarding referrals made in the 12 months between June 2017 and July 2018 by outpatient staff working across the trust. For example, a staff nurse working in the fracture clinic told us they routinely referred children to the safeguarding team for follow up if they failed to attend an appointment. Staff told us that ‘did not attend’ appointments accounted for a high proportion of referrals to the safeguarding team.

Staff we spoke with had a good understanding of who the named safeguarding lead for the trust was and they could describe how they would raise concerns. For example, one member of staff told us of a referral to the safeguarding team of a child that was identified as regularly missing school. Another had made a referral because of suspected abuse. Information on safeguarding was visible throughout the department for staff, patients and visitors to see. This included the details of who to contact to raise concerns.

The trust set a target of 80% for completion of safeguarding training.

**Trust level**

A breakdown of compliance for safeguarding training courses as of May 2018 at trust level for qualified nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults - Level 2 - 3 Years</td>
<td>22</td>
<td>23</td>
<td>96%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In outpatients the 80% target was met for the one safeguarding training module for which qualified nursing staff were eligible.

**East Surrey hospital**

A breakdown of compliance for safeguarding training courses as of May 2018 for qualified nursing staff in outpatients at East Surrey hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults - Level 2 - 3 Years</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Qualified nursing staff in outpatients at East Surrey hospital met the 80% target for the one safeguarding module for which they were eligible.
Crawley hospital
A breakdown of compliance for safeguarding training courses as of May 2018 for qualified nursing staff in outpatients at Crawley hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults - Level 2 - 3 Years</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Qualified nursing staff in outpatients at Crawley hospital met the 80% target for the one safeguarding module for which they were eligible.

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

Cleanliness, infection control and hygiene

Standards of cleanliness across the department were generally maintained, with systems to prevent healthcare associated infections. Staff kept the environment, premises and most of the equipment clean, however we did view an accumulation of dust on the resuscitation trolley in the main outpatient clinic.

Cleaning schedules were maintained in all clinical areas. For example, schedules for each consulting room were stored on the back of the door. Those we viewed included details of the frequency and extent of cleaning within the room and were signed off as completed. Nursing staff took responsibility for monitoring the cleanliness of the rooms.

Toys used within the ear, nose and throat clinic for children in the waiting area were not subject to routine cleaning schedules. We raised this with staff during our inspection and as a result this was discussed in a safety huddle. The matron told us that because most children take their own toys with them a decision had been taken to remove the toys and offer colouring materials for children instead. Toys within the trauma and orthopaedic outpatient department were subject to a weekly cleaning schedule.

Monthly cleaning audits were undertaken and showed high levels of compliance, with the general outpatient department achieving scores between 92% and 100% between January 2018 and September 2018. We observed re-usable privacy curtains in treatment areas which had been changed in the last six months in line with national guidance. Records showed that all outpatient areas, including speciality clinics had records of six monthly curtain changes. This complied with Hospital Building Note 00-09, infection control in the built environment. This demonstrated that staff regularly changed the curtains to minimise the risk of the spread of infection.

We observed staff following national guidance on infection control. For example, staff with long hair had tied it back and all staff were ‘bare below the elbows’ at all times to enable effective hand hygiene and minimise the risk of contamination. We observed staff following National Institute of Health and Care Excellence (NICE) QS61: Statement 3: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of
direct contact or care. Alcohol hand sanitiser was seen throughout the department and staff and visitors were observed using it.

In the phlebotomy department we observed staff taking blood without the use of gloves. Staff we spoke with told us that this was a decision for individual phlebotomists, however this was not in line with trust policy that clearly stated gloves should be worn when handling sharp or contaminated devices. Spill kits were available throughout outpatient clinics for the cleaning of body fluid spillages.

Patient feedback in the general outpatient department had included that patients did not always report seeing staff wash their hands. As a result, hand washing had been identified as an area for improvement within the department. As part of the outpatient team annual priority to reduce avoidable harm a team objective included the adoption of good hand hygiene techniques. Staff told us they had received hand hygiene training as part of their infection control training. Results of monthly hand hygiene audits showed that compliance was between 96% and 100% between September 2017 and September 2018.

There was sufficient personal protective equipment (PPE) available in line with trust policy. There were sufficient hand washing facilities available with sinks with lever arch taps in clinical/treatment areas. This was in line with Health Building Note (HBN) 00-09: Infection control in the built environment. Soap and hand towels were available next to hand basins to facilitate effective hand washing. Information was displayed by hand washing sinks, demonstrating the World Health Organisation (WHO) guidance (2009) ‘Five moments for hand hygiene’.

Waste was seen to be handled in line with national guidance. Waste bins were emptied regularly and seen to not be overfilled. Sharps bins included completed labels with the signature of staff and the date they were assembled. Sharps bins were available in treatment rooms and areas where sharps may be used. Sharps bins were not overfilled and were managed in line with Health and Safety Regulations 2013 (the sharps regulations), 5 (1) d. This requires that appropriate and secure sharps containers for the safe disposal of medical sharps, be placed close to the work area where sharps are being used.

We spoke with staff in the ear, nose and throat clinic who could describe a process of decontamination of reusable medical equipment in accordance with Department of Health Decontamination of surgical instruments (CFP 01-01) (chapter 6) and trust policy. We observed labelled and packaged equipment waiting to be collected for decontamination by the central sterile services department (CSSD).

Infection control improvements were identified. For example, in the breast clinic we were told that a review of issues and teaching around the cause of post-operative infections had led to improved scrubbing techniques and ventilation within theatres.

Infection control risks were identified and action taken to mitigate them. For example, the service’s inability to meet the Department of Health’s CFP 01-06 gold standard guideline on the decontamination of nasal endoscopes was on the surgical risk register. Essential quality requirements were met through the cleaning of endoscopes between patients and regular audits to ensure that cleaning procedures were adhered to. However, the trust’s infection control team had recommended the implementation of the gold standard guideline. This required a six-hour turnaround time from the central decontamination service which would necessitate the purchase of an additional 20 nasal endoscopes to meet the current demand on the service. A business case was due to be submitted to the capital bid group within the trust by April 2019 to address this issue and purchase additional nasal endoscopes.
Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. The outpatient service was provided from a range of areas throughout the hospital. Space was seen to be limited in some areas. For example, staff working within the Speech and Language Therapy (SALT) service told us that a lack of clinic rooms impacted on waiting times for patients. Specialist staff working in Chipstead clinic told us there was limited space for breaking bad news to patients which had sometimes resulted in them having to use rooms that were not suitable to have the privacy required. Staff working in the general outpatient department told us they were unable to accommodate trolleys in outpatients for any length of time. Wheelchairs were also difficult to manoeuvre in some areas.

Capacity issues within the ophthalmology clinic were identified as a risk on the surgical division risk register. The risk included issues around patients manoeuvring around the department as well as the impact on patient waiting times. Action to address issues within the environment included the development of additional clinic space, more efficient use of existing space and external capacity solutions. Pathology and haematology risks were also on the risk register. Waiting areas for haematology and pathology patients were separated by a partition to mitigate risks to immunocompromised haematology patients. There were long term plans to separate haematology and pathology. Risks were additionally mitigated by severely neutropenic patients being offered appointments at quieter times. Patients also advised to avoid public areas. We were told that a business case had been approved but waiting for ventilation issues to be resolved in pathology. However, staff working in phlebotomy told us they were concerned about space as the longer-term plans did not include the development of additional space for patients. Staff told us that some phlebotomy patients had to wait standing up as there was not enough space in the waiting areas. Staff working in the cardiology clinic also told us that patients would sometimes have to stand in the waiting area.

We viewed control of substances hazardous to health (COSHH) risk assessments within the outpatient department. We found the COSHH risk assessments and safety data sheets pertaining to all the cleaning chemicals used within the department.

Resuscitation trolleys were available in all areas of the outpatient department and in all outpatient clinics throughout the hospital. The trolleys included tamper resistant seals on each of the drawers for additional security while ensuring that the emergency medicines and equipment were easily accessible to staff. Emergency equipment and medicines stored on the resuscitation trolleys were subject to regular checks. This included daily checks that included ensuring that the seals were secure and that oxygen cylinders were sufficiently full. Weekly checks of the trolleys included expiry dates of medicines and a detailed check of all equipment and single use items that may be required in a medical emergency.

We checked resuscitation trolleys in general outpatients, the fracture clinic and cardiac clinic. All resuscitation medicines and consumables kept on the trolley were in date. Oxygen cylinders next to the trolleys were in date, more than half full and there were both child and adult masks easily accessible. Daily and weekly checks of the resuscitation trolleys were consistently clearly recorded in general outpatients and the fracture clinic and there were no gaps in checks. However, within the cardiac clinic there were a number of gaps in checks in the months of September and October 2018, sometimes for two or three days in a row.

Medical devices maintenance was carried out by the in-house medical engineering team. Medical devices were registered to an equipment management database where planned maintenance and demand maintenance work was recorded. We checked three items of equipment in general
outpatients and found that all had up to date maintenance stickers attached, indicating they had been appropriately serviced as part of a preventative maintenance schedule. We saw four electric fans that had been taken out of service and had red stickers on them indicating they needed to be tested before they could be used.

Disposable items were in use throughout the outpatient services. All disposable equipment was seen to be in date with arrangements for stock replenishment clear.

**Assessing and responding to patient risk**

There were systems and processes to assess, monitor and manage risks to patients. Staff had a good understanding of how to respond to risk and had clear pathways and processes to follow, including the use of urgent referrals if required.

Reception staff had sight of patients sitting in the waiting area and reported to the nursing staff if anyone appeared to be unwell or needed support. We also saw nursing staff monitoring the waiting areas. Reception staff had a good understanding of how to manage risks in relation to patients, including how to call for help and alert staff to an emergency. They were also aware of the location of the resuscitation equipment should they need to access it and the emergency call number to use in this situation.

Nursing staff had received training in sepsis management, managing low blood sugar levels and basic life support, with some additional nursing staff having received intermediate life support training.

Staff were made aware of processes for escalating concerns about deteriorating patients as part of their induction. Clinicians working in various outpatient clinics had access to information on the wall in clinic rooms on how to put out a cardiac arrest (or other emergency) call.

Safety huddles were held every morning in general outpatients and briefly again at lunchtime. All staff working in the outpatient clinic met at the same time every day to discuss current safety issues relating to the premises, patient care and other relevant issues that could impact on patient safety.

We saw evidence of learning from safety discussions and changes to practice. For example, staff reflected on the previous day’s clinic as part of the daily safety huddle. This included discussions when things have gone wrong or situations where patients had been unwell or at risk. Staff told us of situations where patients had deteriorated while in clinic. We were told of situations where patients had been transferred back to ward areas or to the accident and emergency department and in some cases fast tracking patients through clinic.

Nursing staff told us they would support patients around specific monitoring of their health while in clinic. For example, using blood sugar monitoring where patients were diabetic. Staff could access refreshments quickly in the case of patients having episodes of low blood sugar.

Staff had a good understanding of referral pathways for use in situations where patients were displaying signs of mental ill health. They had access to a mental health liaison team.

An outpatient procedure care plan was in use that incorporated the principles of the World Health Organisation (WHO) five steps to safer surgery checklist. We reviewed records that showed the safety checks were carried out and recorded for patients undergoing minor surgical procedures within the outpatient department.
Nurse Staffing

The trust reported the following qualified nursing staff numbers as of December 2017 and May 2018 for outpatients:

<table>
<thead>
<tr>
<th>Location</th>
<th>December 2017</th>
<th>May 2018</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned WTE staff</td>
<td>Actual WTE staff</td>
<td>Fill rate</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Trust level</td>
<td>21.9</td>
<td>17.3</td>
<td>79%</td>
<td>21.9</td>
</tr>
</tbody>
</table>

The staff fill rate in May 2018 has improved since December 2017 with 1.1 more WTE staff in post.

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

From June 2017 to May 2018 the trust reported a vacancy rate of 20.0% for qualified nursing staff in outpatients. This was higher than the trust target of 12%.

- East Surrey hospital: 27.1%
- Crawley hospital: 1.7%

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

At the time of our inspection the vacancy rate at East Surrey Hospital had significantly reduced and we were told there was just one vacancy. Senior staff were shortlisting for the post at the time of inspection and told us they would then have met their nursing establishment within the department.

From June 2017 to May 2018, the trust reported a turnover rate of 14.8% for qualified nursing staff in outpatients. This was higher than the trust target of 12%.

- East Surrey hospital: 21.3%
- Crawley hospital: 19.8%

Turnover at Horsham (which is not an independently-registered site), was zero.

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

From June 2017 to May 2018, the trust reported a sickness rate of 5.6% for qualified nursing staff in outpatients. This was higher than the trust target of 3%.

- East Surrey hospital: 6.8%
- Crawley hospital: 1.8%

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

Senior staff told us there was no agency nurse usage within the general outpatient department and data provided by the trust showed that the last time agency staff had been used was in December 2017. We were told that bank staff were used to cover specific shortages in clinics and that these staff were sourced from a pool of bank staff with relevant experience.

Medical staffing
Medical staff working within outpatients were employed within different divisions based on their speciality areas. There were no medical staff directly employed within general outpatients. Some clinics we visited had experienced medical staffing difficulties that were impacting on areas such as appointment waiting times. We were also told of areas where improvements had been made. For example, the recruitment of additional respiratory medicine consultants had seen an increase from three to six in recent years.

**Vacancy rates**

The trust has provided the information, but it did not include details of any medical staff for outpatients. This was because medical staff were not directly employed to work solely within the outpatient department.

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

**Turnover rates**

The trust has provided the information, but it did not include details of any medical staff for outpatients. This was because medical staff were not directly employed to work solely within the outpatient department.

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

**Sickness rates**

From June 2017 to May 2018, the trust reported a sickness rate of 0.8% for medical staff in outpatients. This was lower than the trust target of 3%.

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

**Bank and locum staff usage**

It should be noted that the trust has said that it is “unable to provide the data in the requested format for medical staff bank and locum usage”. This was because medical staff were not directly employed to work solely within the outpatient department.

(Source: Routine Provider Information Request (RPIR) – Medical agency locum)

**Records**

People’s individual care records, including clinical data was written, stored and managed in a way that kept people safe. Recent upgrades had been made to the medical record service, resulting in improved flow of medical records across the trust. In the year before our inspection less than 0.1% of patients were seen in the outpatient department without their full medical record. Medical records were tracked via electronic sensors around the hospital. Staff told us they could locate records anywhere within the trust using a bar code scanner. Senior staff within the medical records department told us there had been a focus on transforming the service to make it more patient centred. Specific actions to develop this had included collaborative improvement meetings with representatives from different departments. Staff feedback about the changes to the record system was positive. Staff told us they had clear work plans to access records one to two days ahead of schedule and that this had led to improved efficiency and greater role clarity for staff. A morning huddle within medical records was held to ensure records were prepared in a timely way. Data seen at the time of inspection showed that medical records had been obtained for clinics
within the two-day advanced target. The trust told us that since 2015 there had been a significant reduction in the use of temporary notes within outpatient clinics. For example, this had reduced from 100 a week to less than five a week.

When the full medical record was not available, staff could access most of results such as radiological and haematological results on electronic systems, and referral letters could be printed from other electronic patient information systems. Staff told us that access to patient’s full medical record was consistent and that they rarely had incidents where notes were unavailable. Staff consistently told us that access to records had improved. However, at the time of our inspection there was a patient in the department whose records had not been accessed prior to their appointment. This led to an extended wait for the patient as without their record the staff working within the clinic were unaware that they were waiting.

Staff we spoke with in outpatients told us that access to electronic information systems was consistent and they reported having few problems with them. As part of our inspection we reviewed three sets of patient’s notes all of which were legible, contained appropriate demographic information, consent documented where appropriate (circled on template) and signed and designated.

Patient records were stored securely and were easily accessible. This had improved from the previous inspection where there had been issues with medical records regularly not being available for clinics in a way that was timely. Notes were stored within a medical records store with a tracking system in place. All notes we saw in the clinic areas were in secure cabinets within consulting rooms. The majority of those we viewed were locked securely; however, there was one unlocked cabinet in general outpatients that could have been accessed without authority. This was raised with senior staff at the time of our inspection. We saw that this was then raised as a safety issue within the daily safety huddle and that staff were reminded of the importance of security and confidentiality. Staff told us this would be raised as a reminder to all staff at safety huddles over the coming days.

**Medicines**

Medicines in outpatients were managed safely. Medicines were kept in a treatment room that was locked when not in use. Cupboards containing medicines were locked, and the keys for these were held by a registered nurse.

FP10 and hospital prescription pads were stored securely in locked cupboards with serial numbers recorded within pharmacy so that all forms could be tracked throughout the department. This was in line with NHS Counter Fraud Authority Management and control of prescription forms: A guide for prescribers and health organisations, March 2018. FP10 prescription pads were not in use within the department as medicines were generally issued using hospital prescriptions, however FP10 pads for issue to outlying outpatient clinics were stored there ready for staff from those clinics to collect when needed.

Not all outpatient areas had pharmacy input for stock control. For example, in the general outpatient department stock control was the responsibility of nursing staff. Monthly stock audits were undertaken and records maintained of who carried them out. All medicines viewed at the time of our inspection were stored securely and in date.

Fridge temperatures were monitored to ensure that medicines were stored within the correct temperature range. We reviewed temperature monitoring records in general outpatients and saw that these were within range and that records were completed including checks of minimum and
maximum temperatures. Staff were clear that any issues with the cold chain were to be escalated to pharmacy and advice sought about the storage of medicines.

Patient Group Directions (PGDs) were not used in general outpatients, PGDs are written instructions to administer medicines to patients in planned circumstances in place of an individual named patient prescription. Medicines for patients being seen in clinic were prescribed to take home or by prescribing clinicians in the patient’s notes if medicines were to be administered in clinic. Patients were prescribed medicines to take home using a hospital prescription that could be filled at the outpatient pharmacy that was located opposite the outpatient department. Controlled drugs were not in use within the department.

Incidents

Lessons were learned and improvements made when things went wrong. Staff understood their responsibilities to raise concerns, record safety incidents and report them internally and externally.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From July 2017 to August 2018, the trust reported no incidents classified as never events for outpatients.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in outpatients which met the reporting criteria set by NHS England from July 2017 to August 2018.

(Source: Strategic Executive Information System (STEIS))

The serious incident related to a treatment delay meeting SI criterion in the ophthalmology outpatient’s clinic. The trust provided us with additional information about a further four ophthalmology SIs that were under investigation or with the Clinical Commissioning Group for closure. Staff told us it had been identified that patients were not always returning their outcome forms to reception following their appointment. This meant that follow up appointments had not always been made. Action taken to prevent further repeat incidents included closer daily monitoring of outcome forms within outpatients so that patients without a clear recorded outcome following an appointment would be identified and action taken to address this. In addition, within the ophthalmology department action had been taken to review their database on a weekly basis to identify all patients with a deteriorating sight who may not have completed treatment as planned.

Staff we spoke with demonstrated a good understanding of their responsibilities for reporting when things went wrong. Staff were aware of the reporting system and knew how to use it. Daily safety huddles every morning included time for staff to discuss any incidents and how to ensure improvements as a result. We viewed summaries of huddle meetings and staff gave examples of changes to practice as a result. For example, at the time of our inspection staff had discussed ways to remind clinicians to lock consulting room doors and ensure that medical records are always stored securely in their locked cabinets. We also observed nursing staff monitoring and reminding other staff about the security of medical records.
Data provided by the trust during inspection showed that between April and September 2018 there had been 102 incidents reported under the outpatient category. Themes identified included appointments, clinical documentation, staffing and transport to and from the hospital. Data provided by the trust following inspection identified that the top issues were cancelled appointments, booking errors and incorrect filing. Thirty-one incidents resulted in no harm to patients, three resulted in moderate harm to patients and the rest resulted in no harm. In order to address issues with booking errors and cancelled appointments the trust had progressed a clinic utilisation programme and improved booking management.

Staff told us that transport issues had been an issue within outpatients. We were told that these were reported and that changes had been made as a result. For example, due to limited space patients being transported on a stretcher were unable to be accommodated within the department for any length of time. As a result, a decision was taken to ensure that patients on a stretcher would be seen in clinic straight away and that transport staff were asked to wait with them. Staff told us there continued to be issues with transport, generally relating to patients in wheelchairs having to wait for several hours. Action taken to minimise the impact on patients included transferring them to the discharge lounge where they could wait more comfortably and be given a hot meal. However, staff told us that delays in transport were an ongoing issue and they were not aware of action being taken to improve this.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. There were no incidents in general outpatients that were scored as causing moderate harm and therefore triggering the duty of candour.

Is the service effective?

Evidence-based care and treatment

The department provided care and treatment based on national guidance. Policies and procedures were available and accessible to staff via the trust intranet. Policies we viewed as part of our inspection were in date. Clinical guidance was also available as part of the trust intranet and some via smartphone apps for use at the point of care.

Staff in the outpatient department participated in external audits as part of divisional reviews and assessments of compliance against relevant guidance. Audits were developed against the quality standards and clinical guidelines from the relevant guiding body, for example The National Institute for Health and Care Excellence (NICE). The clinical effectiveness committee monitored where guidance was not fully complied with. In ophthalmology an audit into wet age-related macular degeneration identified that the appointment system did not meet the standards set for a small group of patients and subsequently this subset of patient’s visual outcomes were poorer than those in patients who were seen at predetermined intervals. As a result, the service explored ways to reduce the length of time between follow up appointments for these patients.

We spoke with an osteoporosis nurse specialist who told us that the trust followed guidance from the National Institute for Health and Care Excellence (NICE) and the National Osteoporosis Society. For example, the service had implemented components of a fracture prevention pathway that included identifying those at risk, assessing the risk, providing information and support, interventions, follow up and service developments.
Staff working in the breast clinic followed National Institute for Health and Care Excellence quality standard (QS12) for breast cancer treatment and care, and NICE guideline NG101 for diagnosis and management.

**Nutrition and hydration**

Patient’s nutrition and hydration needs were identified and met. Water machines and free tea and coffee were available in the waiting areas. Patients could also access refreshments from a café close to the outpatient clinic. Staff told us that patients who were waiting for a long time or delayed due to transport issues were offered lunch boxes which could be accessed via the catering department. In addition, patients who were transferred to the discharge lounge while waiting for transport were offered a hot meal.

**Pain relief**

Patients’ pain was assessed and managed. As part of outpatient assessment processes staff told us they would assess patient’s pain level as appropriate depending on their condition and symptoms, or procedures they were having done. Staff told us that pain was assessed as part of holistic assessments, however one patient told us they had tried to talk to the doctor about their pain as part of their consultation and was told it was unrelated to the appointment.

Stocks of simple analgesia such as paracetamol were available in general outpatients. Staff told us that if a patient was in pain they were assessed and a one-off prescription was issued by a medical practitioner and analgesia supplied. Pain clinics were held within the general outpatient service.

**Patient outcomes**

Outpatient services had processes in place to record patient outcomes after each clinic appointment. The service used an outcome form which medical and clinical staff completed at the end of each appointment. The outcome recorded whether the patient required another appointment and whether this should be with a consultant, middle grade or junior doctor, nurse or allied health professional. Other outcomes recorded included any blood tests, scans, further investigations or discharge and was used to monitor patient follow up from consultation.

Staff told us there had been some issues with the outcome forms, generally due to patients not taking them to reception staff at the end of their appointment. This had resulted in a serious incident relating to a delay in treatment for an ophthalmology patient. As a result, staff were in the process of reviewing the format and processes relating to the outcome forms. There were plans to digitalise forms in the new year where actions relating to future appointments and follow up tests would be automatically populated by the clinician at the end of the consultation. In the meantime, administrative staff working in the outpatient department were undertaking daily monitoring of the forms to identify any that were missing. This meant that any outcomes that had not been processed would be identified and followed up by staff.

The outpatient service had a number of one stop clinics in operation where patients could receive tests alongside their consultation rather than having to make additional appointments. For example, the one stop breast clinic enabled patients to receive their consultation, ultrasound scan and mammogram in one appointment. In addition, there were one stop clinics within the fracture clinic and for osteoporosis. One stop pilot clinics were in operation within endoscopy, pre-assessment clinics, phlebotomy and bowel preparation. Plans were in place for a one stop glaucoma clinic in 2019.
Follow-up to new rate

From June 2017 to May 2018 the follow-up to new rates for East Surrey, Crawley, Horsham and Caterham Dene hospitals were all lower than the England average.

Earlswood community diabetes and endocrinology centre’s follow-up to new rate was highly variable throughout the period but was lower than the England average in all months in the period except, October 2017 to December 2017 and in April 2018.

Follow-up to new rate, Surrey and Sussex Healthcare NHS Trust.

(Source: Hospital Episode Statistics)

Competent staff

Staff had the skills, knowledge and experience to deliver effective care, support and treatment.

Staff had access to appraisals, ongoing training and assessments of competency.

Appraisal rates

Trust level

From April 2017 to March 2018, 97% of all staff within outpatients at the trust received an appraisal compared to a trust target of 90%.

The trust has provided the data for the following staff groups, but it did not include details of any medical staff for any core service.

All three staff groups met the 90% appraisal completion target.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals completed</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Clinical Services</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>26</td>
<td>24</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>18</td>
<td>18</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
East Surrey hospital

From April 2017 to March 2018, 93% of staff within outpatients at East Surrey hospital received an appraisal compared to a trust target of 90%.

Administrative and clerical staff were the only group that did not meet the 90% appraisal completion target.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals completed</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Clinical Services</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>16</td>
<td>14</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Crawley hospital

From April 2017 to March 2018, 100% of staff within outpatients at Crawley hospital received an appraisal compared to a trust target of 90%.

All three staff groups had 100% appraisal completion.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals completed</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Clinical Services</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>8</td>
<td>8</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

All new staff and volunteers attended a trust induction programme and were provided with additional role specific training as needed. The trust induction included mandatory training and an introduction to the trust as a whole as well as the individual hospital sites. The outpatient department had local induction processes in place for new staff, student nurses and bank and locum staff.

Staff consistently told us they received support with their professional development within the service. One healthcare assistant working in ophthalmology told us they had opportunities to develop their skills, for example in relation to vision tests and eye measurements and access to fully funded ophthalmology courses relevant to their work.

Sisters working within the outpatient department had attended a leadership course in the use of lean methodologies, developing their skills through project based scenarios to ensure the department ran as efficiently as possible. Clinical staff had access to clinical skills training. This included supernumerary time to learn essential skills and meet competency assessments. Examples of competency assessments included phlebotomy skills, use of specific equipment, wound care and the administration of intravenous medicines.
Monthly audit meetings were held within the outpatient department and included training elements relevant to practice. This included internal and external specialist speakers, for example in relation to Parkinson’s disease.

Medical staff told us that consultants supervised trainee doctors in specialist clinics and that time was allowed for teaching and case discussions. Nursing staff working in the outpatient department had been identified as speciality champions. For example, in relation to breast care, dermatology, infection control, dementia, neurology, safeguarding and disabilities. Staff were given time to access training in their specialist area and to provide teaching for other staff as relevant.

Clinical supervision was available to all clinical staff. Access to this varied across different specialities and included group and one-to-one formats.

**Multidisciplinary working**

All necessary staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. There were one stop clinics in operation within some speciality areas such as the breast clinic, osteoporosis and the fracture clinic. The one stop approach allowed patients to have their consultation, diagnostic tests and some results on the same day. This meant that care was coordinated and patients could see a range of professionals in one appointment.

Staff working within other areas of the outpatient clinics also told us there was a multidisciplinary approach to care across the different specialities. For example, a weekly multidisciplinary meeting was held within the breast clinic where care and treatment plans were discussed. We observed an oncology multidisciplinary meeting that was attended by multidisciplinary coordinators, a chest physician, clinical nurse specialists, radiologists and radiographers. Discussions centred around referral processes and cross team working. We observed open discussions where consensus was sought and the best options for the patient considered. The meeting was structured and staff had a good knowledge and understanding of the patients.

Weekly multidisciplinary meetings were held to review cancer patients. We were told that treatment and cancer wait times were discussed at these multidisciplinary meetings and that patient tracking lists were used.

We observed multidisciplinary working in outpatient clinics where specialist staff worked with outpatient staff to provide care for patients. This included specialist nurses in cancer and osteoporosis working with staff within outpatients to review patients.

We were told of plans to further develop multidisciplinary working across the trust. For example, in the fracture clinic there were plans to develop a multidisciplinary virtual clinic where imaging results would be reviewed virtually by multidisciplinary team members and the patient contacted to attend in person when necessary.

Daily outpatient safety huddles in a range of clinics were multidisciplinary where all staff were involved in the review of safety within the clinics.

**Seven-day services**

General outpatient clinics were in operation between 8.00 and 8.00pm Monday to Friday. Additional clinics were also run regularly on a Saturday and sometimes on a Sunday. Phlebotomy and x-ray services were provided across the seven-day week.
Health promotion

National priorities to improve the population’s health were supported by the service. Information about issues such as stopping smoking and improving heart health were available.

There was educational literature for patients, placed around different parts of the outpatient department. Information based on national guidance and best practice was provided by clinics and given to patients as part of their consultation.

For example, there were comprehensive patient and carer resources for cancer and other long-term health conditions such as Parkinson’s and diabetes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The trust includes training for the Mental Capacity Act and Deprivation of Liberty within the mandatory level 1 and level 2 safeguarding training modules.

Please see the “Safeguarding” section for details of training compliance.

(Source: Routine Provider Information Request (RPIR) – Quality statement)

Staff had a good understanding of the Mental Capacity Act and Deprivation of Liberty and the presumption of capacity. There was information displayed within the department to remind staff to undertake capacity assessments and best interest decision making as appropriate. We observed the use of a clear mental capacity algorithm to guide staff on the action they should take through the process of capacity assessments.

Consent was sought prior to care and treatment. For example, in the breast clinic staff sought the patient’s consent prior to a breast examination and treatment and patients were given copies of their consent forms. In the minor operations procedure room within the outpatient department patients were asked for their consent once in the procedure room. This meant that the patient was only asked for consent immediately prior to a procedure at a time when they may feel vulnerable.
Is the service caring?

Compassionate care

People were treated with compassion, kindness, dignity and respect, when receiving care. Feedback from people who used the service, those who were close to them and stakeholders was positive about the way staff treated people.

Staff understood and considered people’s personal, cultural, social and religious needs. We observed patients arriving in the department and being supported by reception and nursing staff. Staff were observed to greet patients with kindness and respect. We also witnessed staff identifying and introducing themselves and asking patients if they needed help with anything when being collected from waiting areas. This is in line with NICE QS15 Statement 1: Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.

Staff interacted with patients and those close to them in a respectful and considerate manner. Patients throughout all outpatient areas consistently reported that staff were kind and respectful and that the service offered was good. We observed staff within the department providing support and advice to patients and their families whilst using the automated check-in service and providing guidance on where to wait for their appointment.

Staff were sensitive and supportive towards people using their services and those close to them. Patients reported that staff had been patient and kind and had taken the time to fully explain things to them.

Staff understood and gave good examples of how they would raise concerns about disrespectful, discriminatory or abusive behaviour. Staff were familiar with safeguarding policies and conflict resolution procedures. Staff had been trained in dealing with conflict and we were given examples of when these skills had been used to diffuse situations.

Staff ensured people’s privacy and dignity was always respected. Outpatient appointment letters explained what the appointment was for, what time and date it was happening and what the procedure consisted of. In the appointment letter, there was a contact number to ensure any queries or personal preferences may be addressed prior to the appointment. During each appointment, a nurse or healthcare assistant accompanied the patient and acted as their advocate during appointments. The trust’s chaperone policy set out the requirement for all patients to have access to a chaperone of the same sex if required. Nurses or healthcare assistants acted as chaperones when necessary and they told us they had received training in this. Where a patient had a personal preference with regards to the sex of the person that was accompanying or examining them staff would make every effort to accommodate the patient’s request.

Staff demonstrated the need to respond in a compassionate, timely and appropriate way to people’s experience of physical pain, discomfort or emotional distress. Patients with a life changing diagnosis were offered specialist support from trained nurses. This was in line with NICE QS15 Statement 2: Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills. However, in some outpatient areas there was limited space for such conversations to be held. For example, in the Chipstead outpatient service we spoke with specialist cancer nurses who told us that they struggled to find space to meet with patients privately and that this made difficult conversations, including those where bad news was being shared, even more difficult.

The NHS friends and family test is a nationwide initiative to gain feedback from patients about the care and treatment they receive in hospital. Patients were asked whether they would recommend NHS services to their friends and family if they needed similar care or treatment. Test results
recorded and displayed within the outpatient department showed percentage of patients who would recommend the service was 90%. Survey data provided by the trust between July 2017 and July 2018 showed that 92% of patients had trust and confidence in the staff treating them in the outpatient department.

Since our previous inspection the service had developed a room where patients could have their height and weight measured in privacy rather than in a public area.

**Emotional support**

Patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. Staff communicated well with patients so they understood their care, treatment and condition. A healthcare assistant or nurse was present with patients during their appointments. This ensured that the patient had an advocate during their appointment who would check that they understood what was being said. Staff we spoke with told us they would always check patient’s understanding at the end of the appointment before they left the department. Staff told us they would try and take patients to a different area if they needed extra support or time, however this was sometimes limited by a lack of space within the department.

Written information was available for patients about their condition and the support services available to them. Staff we spoke with demonstrated an understanding of the need to assess and support patients from a psychological and social perspective as well as a physical one. We saw that assessment processes in the breast clinic included the assessment of patient’s general health and wellbeing and that support was available for psychosocial issues in addition to physical ones. This was in line with NICE QS15 Statement 10: Patients have their physical and psychological needs regularly assessed.

Staff told us they could signpost patients to psychological services for support. Sometimes these services were accessible within one stop clinics and other times staff would give information about support services and how to access them to the patient.

There was a team approach evident to supporting patients in the clinics. Reception staff told us they were vigilant in looking out for patients who were struggling or in distress.

**Understanding and involvement of patients and those close to them**

Patients we spoke with told us they felt involved in their treatment and care. They told us that clinical staff were open in their approach and that information was readily available, both verbally and in written formats to help them understand their condition and treatment plans.

Speciality clinics had different approaches to supporting patients throughout their journey. For example, patients in the breast clinic had a named nurse for consistency and to ensure their involvement. This meant that all patients had a named nurse to contact with concerns and that relationships were developed over time to ensure that trust was built. Patients were given care and treatment plans within the breast clinic to take away. The care plan had been developed by staff working within the breast service and included contact details, information about the multidisciplinary team, information about the specific condition and treatment plan and details about follow up appointments and additional support available.

In a glaucoma clinic within ophthalmology, the consultant wrote letters addressed to the patient with the GP copied in. This meant that the language used was easy to understand and the patient had access to the information shared when they needed it.
Patients told us they had the time and opportunity to talk to staff about any concerns or treatment options. This was in line with NICE QS15 Statement 5: Patients are supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences.

Patients were supported by staff who had the communication skills to ensure effective interactions with patients in line with NICE QS15 Statement 2: Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills. For example, a patient visiting the glaucoma clinic told us they had received a good explanation of their treatment and care. They also told us that staff checked their understanding before the end of the consultation.

There was information in the waiting area about safeguarding from abuse and this was displayed where patients and people accompanying them could see it.

Staff could communicate with patients by using their own preferred methods of communication. Patients were asked to alert the department to any communication issues prior to their appointment so that staff knew in advance. Referral forms included information about the accessible information standard.

Patients we spoke with told us they felt listened to and respected by the staff working in the outpatient department. Patient feedback was displayed within the department, for example, the topic of the month related to waiting times and staff were seen to be openly communicating delays and the reasons for them.

Is the service responsive?

Service delivery to meet the needs of local people

Outpatient services ensured people’s needs were met through the way services were organised and developed.

The outpatient department environment was appropriate to the needs of patients and provided comfortable seating, sufficient toilets, free tea and coffee and a water dispenser. There was also a café located near to the department which served a variety of refreshments.

General outpatient clinics operated between 8:00am and 8.00pm Monday to Friday. There were some additional clinics run on Saturday mornings and ad hoc Sunday’s which staff told us were usually run by the specialities staff although one member of the outpatient nursing team was scheduled to help coordinate.

Patients had two options to check-in for outpatient appointments. One option was an outpatient check-in booth with administrative staff completing the check-in process. The second method was an automated self-check-in system. The automated system presented patients the options in a variety of different languages and included the option for patients to identify if they had additional learning needs. Reception staff were also nearby and could provide support if needed. The service had plans to develop the booking in area to make it easier for patients.

Patients told us that car parking had not been an issue. Public transport to the hospital was good and there was information about this in the hospital and on the hospital website. Information included a downloadable transport information leaflet and online and telephone journey planning support.
The department was clearly signposted and we observed staff helping to direct patients to where they needed to go. We observed staff interacting with patients in a way that was supportive and helpful. Signposting within the department had improved since our previous inspection, with clear signage in a colour that was more visible to patients with impaired vision. All areas within the hospital, including outpatient areas, were colour coded. These colours corresponded to the hospital site map to make it easier for patients and visitors to navigate the site.

The service made use of telemedicine appointments via telephone and video link appointments as an alternative to face to face appointments. This included a virtual fracture clinic where all new fracture clinic patients were assessed virtually by a consultant orthopaedic surgeon. In addition, patients were signposted to video links about self-management. This had an impact of reducing routine face to face appointments and increasing capacity for patients who require face to face consultations.

There were notice boards in clinic waiting areas advising who the relevant nurse and healthcare assistant attached to that clinic was. The notice boards all had standard text printed and displayed advising patients of the potential for delays in clinics and apologised for this.

Patients received text message reminders of their appointments. Patients told us the reminders were helpful and two-way texting meant that patients could personalise their queries and receive a personalised response.

A phlebotomy service was available in the main outpatient department for patients being seen in clinic. This was a recent development, designed to reduce the waiting times for patients who required blood tests alongside their clinic appointment.

A patient paging system was in use within the fracture clinic so patients could wait elsewhere in the hospital, such as restaurant areas, without missing the call for their appointment.

**Did not attend rate**

From June 2017 to May 2018:

- The ‘did not attend’ rates for East Surrey, Crawley and Caterham Dene hospitals were all generally lower than the England average.
- The ‘did not attend’ rate for Horsham hospital was higher than the England average in June and July 2017, but was then reduced to below the England average for the rest of the period.
- The ‘did not attend’ rate for Earlswood community diabetes and endocrinology centre was consistently higher than the England average.
The chart below shows the ‘did not attend’ rate over time.

Proportion of patients who did not attend appointment, Surrey and Sussex Healthcare NHS Trust

![Chart showing 'did not attend' rate over time](chart.jpg)

(Source: Hospital Episode Statistics)

While the ‘did not attend’ rate at East Surrey Hospital was lower than the England average there were some clinics where the rate was higher. For example, staff working in an osteoporosis clinic told us that the ‘did not attend’ rate was around 20%. They told us that this was due to patients who did not attend their appointment being automatically given a further appointment by the booking office. Senior staff told us that this was a clinical decision rather than one made by booking office staff. We were told that the booking team was contacting patients to ask why they did not attend to reduce the rate.

Meeting people’s individual needs

The service took account of patients’ individual needs. The trust had a dementia strategy with the aim of becoming a dementia friendly organisation. There were clear objectives identified around improving the patient experience, training for staff, better engagement and improving the environment. At the time of our inspection there were no dementia friendly signs within the outpatient department. However, a working group was in place reviewing how the environment within the outpatient department met the needs of a variety of patients including those with physical and learning disabilities and those with dementia. Staff told us that dementia friendly signage had been discussed and would be in place in due course. All staff working within the trust received dementia training as part of their induction. A member of outpatient staff had been identified as the dementia lead and those in this lead role had access to additional training. For example, one member of staff working in the fracture clinic had received training in being a ‘dementia friend’. The trust used a symbol in patients’ medical records that identified them as someone with dementia.

The trust was aware of the Accessible Information Standard. The Accessible Information Standard came into effect in 2016 and requires that all NHS trusts offer reasonable adjustments to help support people with disabilities or sensory loss to fully understand the information given to them. Referrers were asked to complete Accessible Information Standard information as part of referral processes so that staff were aware of patients with additional needs. Staff had access to communication resources and the use of a trust wide communication book and communication prompts. The service had access to multiple language and British Sign Language (BSL) interpreting for appointments, listening devices, and braille for patients with visual impairment.
Staff told us they could access interpreters on the same day if needed. Staff knew about translation services for patients who did not speak English as a first language and interpretation services could be arranged either to be face to face or via a telephone device.

A disabled access toilet was located opposite the outpatient department. The service had adjusted the environment within the outpatient department to better meet the needs of patients with disabilities. For example, a panel had been removed from the reception desk in main outpatients to make it easier for reception staff to communicate with patients in wheelchairs.

There was no bariatric equipment held in general outpatients, however, staff told us they could access equipment from other departments as needed.

Staff working in outpatients had access to a learning disability liaison nurse. They would contact the liaison nurse for advice and input about how best to support the patient. There was a learning disability resource folder for staff reference within the department. A task group for outpatients was looking at how patients with disabilities could access services and identify areas for improvements.

Access to the department for patients with physical disabilities was difficult due to limited space. Patients on stretchers were prioritised to be seen straight away due to limited space in waiting areas. Staff requested that transport staff waited with the patient so that they could take them home immediately following the appointment. Patients in wheelchairs would be transferred to the discharge lounge where they could wait in a more comfortable environment and where they would be given refreshments if there were delays transporting home. Waiting area facilities was an area being reviewed by the task group with the aim of improving access for these patients. Improvements to one part of the waiting area had been made because of this work by removing a table to create better access for patients in wheelchairs.

As part of a trust wide initiative to improve the care of patients with Parkinson’s disease the service had reviewed the information available to patients who attended neurology clinics. This included a stock of booklets produced by Parkinson’s UK that included information about the disease, treatments and additional resources available. Feedback from patients with Parkinson’s had helped to inform the staff of areas for improvement, this included a talk from a patient to staff to help them better understand patient’s needs.

Access and flow

From 1 October 2018 all outpatient referrals nationally were to be received via the NHS e-Referral System (ERS). Senior staff told us they had worked with clinical commissioning groups (CCGs) to improve the uptake of e-referrals. This work had involved senior staff attending local practice manager forums and engaging with GPs to improve relationships and team working on referral processes. Local GPs had been invited to participate in a working group and the trust had worked with NHS Digital to improve uptake. Prior to this work e-referrals uptake had been at zero. Following the work and prior to the October 2018 deadline uptake had increased to 80%.

Improvements had been made to the booking office to improve key performance indicators relating to appointment bookings. For example, huddles were held in the department twice daily to review booking statistics, waiting times and outstanding issues. The booking office had received input from clinical staff around these improvements and to make the booking centre more patient focused. Specific action included the implementation of text reminders for patients, a patient feedback survey and patient reminders in the days leading up to their appointments.

Other action that the trust had taken included using a company to provide support to specialities with short term workforce constraints that had affected the 18-week pathways. Insourcing
services had been used in areas such as ophthalmology and neurology. In addition, the trust had outsourced for some cataract surgeries and were using locum doctors in ophthalmology to address waiting times. Different specialities met weekly to discuss their referral to treatment times (RTTs) and identify action to address them.

Staff working in speech and language clinics told us that waiting times for assessment were an issue. This involved patients waiting for more than seven months to see a specialist and for between four and six weeks for an initial assessment. The service had appointed locum staff to help with capacity issues but ongoing issues with space continued to have an impact. The concerns had been escalated to managers and were on the risk register.

The trust monitored the percentage of cancelled clinics. At our inspection in 2014 32% of clinics had been cancelled with short notice. At this inspection data from the trust showed that the rate of hospital cancelled clinics was between 14% and 17%.

Staff told us that overbooking of clinics was sometimes an issue, particularly in ophthalmology clinics. However, this was generally undertaken with the agreement of relevant clinicians and senior outpatient staff. Senior sisters told us they took responsibility for late running clinics and worked to identify ways of improving the patient flow throughout the department.

Waiting times in some departments were long. For example, in the cardiology clinic patients and staff reported lengthy waiting times. Staff told us that a lack of consulting rooms meant that even when they had the staff to manage the clinics they did not always have the space. Action taken to address this issue included trying to identify alternative rooms to use and running some Saturday clinics. The improvement of cardiology and ophthalmology waiting times formed part of the outpatient improvement programme and we saw that this was routinely reviewed and discussed at outpatient board meetings.

The service was exploring the use of virtual clinics to improve patient access and flow. For example, in the fracture clinic a business plan had been developed to increase the use of virtual clinics for patient assessments. This involved a review of images with the patient contacted by phone or signposted to alternative support when a face to face medical review was not required.

An independent pharmacy service was located opposite the outpatient department. The pharmacy dispensed all hospital outpatient prescriptions from a range of clinics. The pharmacy monitored the amount of time patients had to wait for their prescriptions. Between January 2018 and May 2018, the average waiting time for outpatient prescriptions was 12 minutes. Patients and staff reported that waiting times for prescriptions was satisfactory and that staff were helpful. Pharmacy opening times were between 8 a.m. and 8.30 p.m. on a Monday to Saturday and between 10 a.m. and 4 p.m. on a Sunday.

Patients could access the service when they needed it. Overall waiting times from referral to treatment had seen an improvement since April 2018 with performance improving for non-admitted pathways. June 2018 data showed that the trust was 3% above the national average for non-admitted pathways. June 2018 data showed that the trust was 2.5% above the national average for incomplete pathways.

From July 2017 to June 2018 the trust’s referral to treatment time (RTT) for non-admitted pathways was below the England overall performance. The trust has seen an improvement in performance from April 2018 onwards.

In the latest month, June 2018, 91.4% of this group of patients were treated within 18 weeks compared to the England average of 88.5%.
Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Surrey and Sussex Healthcare NHS Trust

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

Seven specialties were above the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic surgery</td>
<td>100.0%</td>
<td>91.0%</td>
</tr>
<tr>
<td>General medicine</td>
<td>94.7%</td>
<td>91.7%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>93.6%</td>
<td>87.5%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>93.5%</td>
<td>86.5%</td>
</tr>
<tr>
<td>ENT</td>
<td>93.2%</td>
<td>86.6%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>89.3%</td>
<td>88.7%</td>
</tr>
<tr>
<td>Urology</td>
<td>89.3%</td>
<td>87.6%</td>
</tr>
</tbody>
</table>

Eleven specialties were below the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynaecology</td>
<td>90.7%</td>
<td>92.9%</td>
</tr>
<tr>
<td>Other</td>
<td>89.0%</td>
<td>91.1%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>87.5%</td>
<td>95.6%</td>
</tr>
<tr>
<td>Specialty</td>
<td>This Trust</td>
<td>England Avg</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td>General surgery</td>
<td>85.9%</td>
<td>89.0%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>83.6%</td>
<td>89.3%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>82.6%</td>
<td>84.4%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>80.3%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>76.7%</td>
<td>89.6%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>76.2%</td>
<td>84.2%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>75.5%</td>
<td>86.5%</td>
</tr>
<tr>
<td>Neurology</td>
<td>56.3%</td>
<td>80.5%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From July 2017 to June 2018 the trust’s referral to treatment time (RTT) for incomplete pathways performance was below the England average for the first half of the period. December 2017 to April 2018 saw the trust’s performance improve to higher than the England average.

In the latest month, June 2018, 90.0% of this group of patients were treated within 18 weeks compared to the England average of 87.4%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Surrey and Sussex Healthcare NHS Trust.

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Nine specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>97.3%</td>
<td>93.2%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>92.7%</td>
<td>89.4%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>92.5%</td>
<td>90.5%</td>
</tr>
<tr>
<td>ENT</td>
<td>92.3%</td>
<td>86.9%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>91.7%</td>
<td>89.4%</td>
</tr>
<tr>
<td>Urology</td>
<td>91.5%</td>
<td>87.1%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>89.2%</td>
<td>84.8%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>85.3%</td>
<td>84.8%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>83.8%</td>
<td>82.5%</td>
</tr>
</tbody>
</table>

Eight specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>93.5%</td>
<td>96.2%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>92.5%</td>
<td>92.9%</td>
</tr>
<tr>
<td>Other</td>
<td>88.9%</td>
<td>90.3%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>87.6%</td>
<td>88.5%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>86.6%</td>
<td>89.9%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>86.5%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>84.1%</td>
<td>85.4%</td>
</tr>
<tr>
<td>Neurology</td>
<td>64.9%</td>
<td>87.5%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust has performed in line with the England average and better than the 93% operational standard for people being seen within two weeks of an urgent GP referral from Q3 2017/18 to Q1 2018/19. Performance in the first quarter of the period had been below the operational standard and the England average.

Action taken to improve performance around two-week cancer waiting times included the recruitment of additional respiratory physicians with an increase from three to six employed by the trust. The trust was also reviewing how they addressed patients on the two-week pathways booking themselves into appointments that fell outside of the two weeks.

The performance over time is shown in the graph below.
Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Surrey and Sussex Healthcare NHS Trust

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

The trust has consistently performed better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat), and has been similar to the England average throughout the period.

The performance over time is shown in the graph below.
Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Surrey and Sussex Healthcare NHS Trust

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust performed better than the England average and the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral from Q2 2017/18 to Q4 2017/18. In the latest quarter trust performance fell below the operational standard but was similar to the England average.

The performance over time is shown in the graph below.

Learning from complaints and concerns

From June 2017 to May 2018 there were 18 complaints about outpatients. The trust took an average of 34 calendar days to investigate and close complaints. This is in line with the trust’s complaints policy. Their complaints policy states that under current legislation trusts have six months to resolve complaints, but that a response time is agreed for each complaint and is usually 25 working days, (35 calendar days).

Appointments was the subject with the most complaints, accounting for 72% of all complaints about outpatients.

East Surrey hospital received the most outpatient complaints with 16 (89%).

A breakdown of complaints by subject and site is shown below:
<table>
<thead>
<tr>
<th>Subject</th>
<th>Crawley Hospital</th>
<th>East Surrey Hospital</th>
<th>Horsham Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointments</td>
<td>1</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Communications</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>16</td>
<td>1</td>
</tr>
</tbody>
</table>

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

From June 2017 to May 2018 there were 4,487 compliments within outpatients.

A breakdown of the number of compliments by ward and site is shown below:

<table>
<thead>
<tr>
<th>Ward/team</th>
<th>Crawley Hospital</th>
<th>Earlswood Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main outpatients/Chipstead</td>
<td></td>
<td>3,041</td>
</tr>
<tr>
<td>Outpatients</td>
<td>572</td>
<td></td>
</tr>
<tr>
<td>Fracture clinic and orthopaedics outpatients</td>
<td></td>
<td>331</td>
</tr>
<tr>
<td>Children’s outpatients</td>
<td></td>
<td>158</td>
</tr>
<tr>
<td>Gynaecology outpatients</td>
<td></td>
<td>121</td>
</tr>
<tr>
<td>Earlswood centre</td>
<td></td>
<td>120</td>
</tr>
<tr>
<td>Children’s outpatients</td>
<td>85</td>
<td></td>
</tr>
<tr>
<td>Haematology outpatients</td>
<td></td>
<td>59</td>
</tr>
<tr>
<td>Total</td>
<td>657</td>
<td>120</td>
</tr>
</tbody>
</table>

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

During our inspection we reviewed three complaints relating to the outpatient services. Two of these related to waiting times. We saw that apologies were given and that learning and action was identified. Responses were timely and in line with trust policy.

A further complaint related to a patient who had been seen in the breast clinic who was distressed after being sent home with a drain. Because of this complaint staff reviewed the processes for patients being sent home following interventions. As a result, patients were then routinely given information about community staff available to support them and contact numbers should the patient or their family need to get in touch.
Is the service well-led?

Leadership

The outpatient services had the leadership capacity and capability to deliver high-quality, sustainable care. Leaders had the skills, knowledge, experience and integrity needed and there were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership.

The outpatient department at East Surrey Hospital was managed by a general outpatient matron who worked across the trust-wide outpatient services. Staff reported there had been an increase in nursing leadership in recent years and that there was a band seven senior sister and band six sisters working within the department. A reception appointments manager had been recently appointed to provide direct management support to reception staff. Senior sisters were available at each outpatient location across the trust and were available to provide support across site as necessary. Staff we spoke with told us they were supported operationally by the lead staff and that operational leaders were approachable and supportive. For example, nurses working in the breast clinic reported that the matron was supportive and communicated openly with them. Staff working in the fracture clinic reported that senior staff were helpful and encouraging and always accessible.

Staff told us they had consistent contact with divisional leads who visited the department on a regular basis, undertaking walkaround visits as well as being available to respond to situations. Staff told us they felt well informed about trust and divisional level decisions. Executive leaders communicated well and were visible to staff. Staff reported that senior managers had an open-door policy and that communication was transparent. Staff received regular updates on plans through e-bulletin updates. A non-executive director visited the department on a regular basis to listen to staff and focus on quality improvement.

Staff were consistently positive about the leadership of the trust, the division and the department. For example, a specialist nurse working in an outpatient clinic told us that there was strong leadership across the trust and this had resulted in better consistency and everyone pushing in the same direction.

Vision and strategy

There was a clear vision and set of values, with quality and sustainability as the top priorities. There was a trust wide vision to ‘pursue perfection in the delivery of safe, high quality healthcare which puts the people of our community first’. Staff had a good understanding of the trust values of safety and quality, one team, dignity and respect and compassion. The outpatient service had developed their own local priorities which were aligned to the trusts vision and values and objectives using a structured planning process in collaboration with staff. Strategic objectives and annual priorities were aligned across the trust. For example, in relation to reducing avoidable harm, improving discharge planning, creating the best environment for patients, improving efficiency of elective care and staff health and wellbeing.

There were clear objectives identified for the outpatient department. These included improving handwashing and the use of patient outcome forms, addressing patient delays and improving the security of medical records, maximising opportunities for patient feedback and customer care training and ensuring that staff took regular comfort breaks and participate in feedback questionnaires.
The outpatient ‘strategy on a page’ was visible within the department and included in departmental communications. Staff demonstrated a good understanding of the priorities and we observed team objectives being monitored throughout the department.

**Culture**

The culture within the outpatient department was centred on the needs and experience of people who use the service and staff felt supported, respected and valued.

Staff reported there had been a change in culture under the current leadership of the trust and the outpatient department as a whole and that staff morale had improved as a result. Senior staff told us there had been a particular focus on improving the culture in order to develop a more cohesive and collaborative atmosphere.

We observed staff focusing on the experience of patients and striving to make this as positive as possible. There was a patient focus across all departments we visited, including the booking hub and medical records departments.

Staff told us there were increased opportunities for reflecting on their practice and development and that the team objectives were used to structure daily huddles so that everyone had a clear focus. This had helped to improve the culture within the department and ensure that all staff were focused on learning and improvement.

Staff we spoke with reported that they felt valued and that the team was a happy one. There was evidence of cross divisional working and strong team dynamics. Leaders told us that improved communication within teams and across the trust leadership had resulted in the improvements to the culture.

**Governance**

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. Staff at all levels were clear about their roles and understood their accountabilities.

The outpatient service sat within the surgical divisional structure. The outpatient matron reported to the divisional chief nurse. The medical records and outpatient booking service sat within the cancer and diagnostics divisional structure. The head of medical records and outpatient booking office reported to the divisional deputy chief operating officer/associate director.

There was an outpatient board in operation with membership from across the trust that was chaired by the chief operating officer. This included the medical director, chief nurse, associate directors, divisional chiefs of service, director of information technology and facilities and the director of corporate affairs. There was also attendance from a range of senior staff including the chief executive officer, Kaizen, outcomes, education, service development, finance and strategy and clinical informatics.

The outpatient board were responsible for delivering the outpatient strategy and key performance indicators and the provision of a governance framework. The governance framework included safety and quality, access and responsiveness, performance and productivity, patient experience and information, risk management and regulatory compliance.

Weekly divisional board meetings were attended by the outpatient matron. At these meetings areas such as health and safety, infection prevention and control, policies, updates, good practice
and case reviews were discussed. Minutes from these meetings were cascaded to senior outpatient sisters who would share information with outpatient staff in monthly audit meetings and daily huddles as appropriate.

Weekly senior sister’s meetings were held where all the senior outpatient sisters from across all locations within the trust would meet. Monthly audit meetings were held where performance and quality improvement issues were discussed with all outpatient staff and where specific education events would be held.

We reviewed minutes of daily huddle meetings and saw that discussions were structured around the team objectives and that communication was shared with staff around issues of governance and performance.

**Management of risk, issues and performance**

There were processes to manage current and future performance and robust arrangements for identifying, recording and managing risks, issues and mitigating actions.

Senior outpatient staff were clear about the areas where improvements needed to be made and improvements were demonstrated. There was a systematic programme of internal operational audit to monitor quality and operational processes. Monthly performance reporting was conducted. An outpatient performance scorecard showed data collated for many areas of activity and performance. This included data relating to referral to outpatient cancellations, clinic utilisation and telephone call statistics. Performance was reported to the outpatient board.

There were environmental risk assessments, including those for control of substances hazardous to health (COSHH). A band six sister was the health and safety lead and represented the outpatient department at health and safety committee meetings.

An identified area of risk within the outpatient department was a lack of space to accommodate patients waiting on stretchers in the department. Action to mitigate the risk included ensuring the patient was seen in clinic straight away and arranging for transport staff to wait so they could transfer the patient as soon as their appointment ended. Within ophthalmology outpatients a risk had been identified on the risk register relating to insufficient space within the department. There was a risk of patients with restricted mobility being harmed due to the lack of space available and the area being utilised not at times having enough seating for the numbers of people attending. The potential for harm was increased due to tight spaces and the number of people attending who were elderly with impaired eye sight. Action taken to mitigate the risk included revising clinic times and relocating some clinics and exploring external capacity solutions. The risk had initially been rated as red on the risk register with a residual amber rating with mitigating actions implemented.

A serious incident in ophthalmology where a patient had a treatment delay due to their outcome form not being processed was not identified on the risk register. However, the service had acted to mitigate the risk by reconciling outcome forms at the end of each clinic. This ensured that staff identified where forms had not been returned to reception staff before the patient left the department and enabled staff to follow this up with the relevant clinical team. Longer term plans included digitalising the outcome form so that the clinician submitted them through an electronic system at the end of the appointment.
Information management

There were clear and robust service performance measures which were reported and reviewed. The trust used secure electronic systems with appropriate security safeguards. It was widely recognised that paper based information needed to be transferred into electronic formats to ensure a more accurate and timely capture of data to support patient pathways. While the trust patient record system was currently paper based they had invested in new buildings, infrastructure and staff to improve their medical records service and the way that clinical information was managed. This had improved the consistency and quality of medical records so that patient information was more accessible within the outpatient department. Quality audits of patient records was carried out to ensure ongoing accessibility.

Referral processes from GPs were fully electronic and clinical staff had access to pathology results, imaging results and referral letter via electronic systems. Staff told us that the systems worked well generally and that the information was accessible when they needed it. Nursing staff working within the general outpatient department had attended information governance training.

There were arrangements for information used to monitor, manage and report on quality and performance across the outpatient department. We observed data being used through an outpatient dashboard that monitored performance in areas such as waiting times, cancelled clinics and other information relating to service performance measures.

Engagement

The trust had systems and processes in place to engage with patients, staff, the public and local organisations to plan and manage services.

Staff told us there were opportunities to engage with senior leaders and that information was shared in a helpful and collaborative way.

Staff demonstrated an awareness of the role of the freedom to speak up guardian and some were aware of who this was. Those staff who did not have an awareness of who the freedom to speak up guardian was, told us they felt confident to raise concerns with their direct line managers and that these concerns would be addressed.

The trust’s score in the national staff survey in relation to how engaged staff felt in 2017 at 3.96 was similar to their 2016 score of 3.97 and better than the national average for similar organisations. The overall engagement score for the surgical division in which the outpatient department operated was 3.98.

Staff working in the outpatient department told us they regularly attended meetings and that information was shared in a number of forums. This included daily huddles, monthly meetings and through online sources.

A quarterly outpatient news sheet was developed by the outpatient matron. Information contained in the news sheet included general outpatient updates for staff, information on the strategy and updates on objectives and feedback on activities within the department.

Patient information boards were in use in the waiting areas of outpatients and included feedback comments from patients in a ‘you said, we did’ format. Staff demonstrated areas of improvement as a result of patient feedback. For example, there was a focus on handwashing because of some patients providing feedback that they had not seen staff washing their hands.
The outpatient department participated in the Friends and Family Test which gave patients an opportunity to feedback simply whether they would recommend their department to their friends and family. At the time of our inspection the most recent results showed that 92% of patients would recommend the service to their friends and family. Results over time dating back to September 2017 showed the results were between 88% and 92%. This was below the trust target.

Senior staff told us they had worked to engage more openly with patients about areas for improvement within the department. For example, we were told that patients had been consulted about the layout and décor within the breast clinic. In addition, a member of staff who had also been a patient had undertaken a talk to the outpatient team about their long-term condition and ways to improve the outpatient experience for patients.

Patient representatives were invited to participate in rapid improvement workshops as part of the trust’s Kaizen (Kaizen means continuous improvement in business) improvement methodology. At the time of our inspection a rapid improvement workshop was in process for ophthalmology with a patient representative involved. Senior staff from medical records and the booking office had engaged with patients to identify areas for improvements as part of their transformation programme. This had been done by working collaboratively with the local Health watch service.

Learning, continuous improvement and innovation

There were standardised improvement tools and methods, and staff had developed the skills to use them.

A trust-wide continuous improvement approach SASH+ programme had been developed and was in operation within the outpatient department. The matron and band seven nurses working within the outpatient department had undertaken the local ‘lean for leaders’ continuous improvement training course. The course taught staff aspects of improvement methodology and equipped staff to make positive improvements within their own departments. The course included a module where different approaches were taught and taken into the workplace to help leaders support their teams to develop solutions to problems or find innovative ways to take forward solutions.

The lean for leaders course taught a range of improvement tools which were then utilised within normal service delivery. These tools include; service mapping, timed observations, ideas to PDSA (Plan, Do, Study, Act), Rapid Improvement Workshops, and the use of production boards to track delivery and share learning.

Specific improvement projects had been undertaken as a result. For example, by improving the patient journey by offering phlebotomy within the department to reduce burden on phlebotomy dept. Staff had also developed the use of procedure packs so as not to spend time looking for individual items when undertaking a procedure. For example, in the breast clinic staff monitored the number of steps it took for them to access items for a specific procedure, then later monitored the number of steps taken with the use of procedure kits. This had resulted in a reduction in steps from 77 to 17. Staff reported that this meant they didn’t have to leave the patient for as long and had more time with them which was particularly important if patients were distressed or anxious.

At the time of our inspection a five-day rapid process improvement workshop was being held for the ophthalmology department. Staff involved ranged from those at a band two grade up to consultant level and included patient representation and the workshop was led by staff within the Kaizen office. The focus of the improvement work was from the patient perspective and included a deep dive analysis of the service and the development of value streams (a lean-management method for analysing the current state and designing a future state for the service). The initial part
of the workshop involved teaching staff the tools, generating improvement ideas and increasing awareness for all staff. The workshop team then tested out ideas and reviewed them using a PDSA (Plan, Do, Study, Act) approach. By the end of the workshop week a report would be compiled and information shared on the intranet by video and other formats. The ophthalmology team we observed in the workshop at the time of our inspection included the full range of ophthalmology staff. Their focus was on testing out improvements to the outcome form and looking at new ways of working to improve patient access, capacity of the service and the patient experience.

We viewed the plans of the Kaizen office and saw there were future schedules that included plans to continue the improvement work within general outpatients. Staff involved in the ophthalmology rapid improvement workshop were positive about the experience and hopeful that improvements would be made.

There were new ways of working evident across outpatients which included the co-design of services involving patients and families for those with long term conditions. A project for patients with chronic obstructive pulmonary disease and asthma had been developed. The project included group sessions for up to 10 patients and a shared medical appointment where both the patient and those close to them could be involved in the consultation.

In ophthalmology staff had worked with guidance from the Royal National Institute for the Blind to improve patient’s knowledge and engagement with their treatment plans. The project included the development of patient held records.