Care Quality Commission

University Hospitals Sussex NHS Foundation Trust

Royal Sussex County Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Royal Sussex County Hospital

Inspected but not rated

We carried out an unannounced focused inspection because we received information of concern about the safety and quality of the services.

We inspected the surgery core service, focusing on the upper gastrointestinal service.

We did not rate the service at this inspection. The previous rating of inadequate remains.

Following the inspection, we took enforcement action because the safety of the upper gastrointestinal service required significant improvement. Further detail can be found in the areas for improvement section of this report.

How we carried out the inspection

We carried out this focused inspection on 11 August 2022. During the inspection we spoke with 25 members of staff. This included managers, nursing staff, theatre staff, medical staff of all grades and senior leaders. We reviewed ten patient records and reviewed documents and information provided by the trust as part of the inspection process.

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

Surgery

Inspected but not rated

- The service did not have enough staff with the right skills and experience to care for patients and keep them safe. Safety incidents were not always managed well, and there were limited opportunities to learn from incidents and adverse events.
- Managers did not always monitor the effectiveness of the service and did not make sure all staff were competent. Outcomes for patients who underwent oesphagectomy resection surgery did not always meet national expectations. The service did not comply with NHSE national commissioning guidance. Staff did not always work well together for the benefit of patients.
- Leaders did not operate an effective governance process for the upper gastrointestinal cancer service. Risks to the service were not always identified and acted on. There was a lack of reliable data to inform the performance monitoring of the service. Not all staff felt respected, supported and valued. Consultants did not always demonstrate respectful behaviours or demonstrate they were focused on meeting the needs of patients.

However:

- Nursing staff assessed risks to patients, acted on them and kept good care records.
- Nursing and support staff were focused on meeting the needs of patients receiving care.

Is the service safe?

Inspected but not rated

Assessing and responding to patient risk

Medical staff did not always act quickly upon patients at risk of deterioration. Staff completed and updated risk assessments for each patient and removed or minimised risks.

Staff used the nationally recognised National Early Warning Score (NEWS2) to monitor and identify patients at risk of deterioration. Nurses escalated patients to medical staff in accordance with the NEWS2 guidelines. However, due to shortage of medical staff and their associated workload, the escalation of deteriorating patients was not always responded to in a timely manner. Incident reports involving escalation calls to medical staff who were covering out of hours, showed that patients were not always reviewed in a timely manner. One incident report for February 2022 showed that nurses escalated a patient’s condition to medical staff at 8.30pm, but the patient was not reviewed by medical staff until 5am the following day. A second showed that in June 2022 there were delays in medical staff responding to a deteriorating patient in the emergency department who was under the care of the upper gastrointestinal service.

Shift changes and handovers did not always ensure the continuity of care and treatment for patients or confidentiality of patient information. The upper gastrointestinal consultants rotated, with a different consultant looking after the patients each week. There was a structure for consultants to hand over patient care and treatment plans. However, information received by CQC from some staff indicated that patients' care and treatment plans were sometimes changed to meet individual consultant's preferences rather than considering the continuity of treatment plans to meet patient needs.

Handovers at the beginning of nurse staff shifts included all needed information to ensure staff had relevant details about each patient to provide safe care and treatment. However, patient handover sheets were left on the desk surface in one of the ward managers offices which was unlocked. This increased the risk of unauthorised persons accessed patients' details.

Nursing staff completed risk assessments for each patient on admission, using recognised tools, and reviewed this regularly. Staff completed risk assessments when patients were admitted to the ward. Risk assessments included, but were not exclusive to, moving and handing, risk of malnutrition, risk of falls, skin integrity and risk of venous thromboembolism. Patient records showed staff reviewed patient risks and amended plans of care to reduce the level of risk.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service did not have nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. All nursing staff on both the gastrointestinal surgical ward and the gastrology ward commented that the wards were short staffed. Although staff were being recruited, shifts were not always fully staffed due to staff absences and recruitment processes had not yet been completed. Staff said there had been an increase in patient falls and medicine errors which they attributed to staff being tired and not having enough time to effectively monitor and support patients. Staff spoke about how staff shortages made them feel they were letting their patients down.

Theatres did not have enough nursing and support staff. All staff in theatres spoke of poor staffing levels and exhaustion. This was the same as our last inspection. Staff told us there was a heavy reliance on agency staff and that there were insufficient numbers of experienced staff to support junior staff.

There were not enough cancer nurse specialists. Although there were 3.3 whole time equivalent upper gastrointestinal cancer specialist nurses working across the whole trust, there were only 1.7 whole time equivalent upper gastrointestinal cancer specialist nurses working at the Royal Sussex County Hospital. The cancer specialist nurses provided care and support to patients with a diagnosis of cancer. The number of upper gastrointestinal cancer specialist nurses at the Royal Sussex County Hospital did not enable them to fulfil their job plan. This included not being able to carry out patient reviews, attend clinics and an inability to complete all inpatient reviews. They were not able to fulfil all aspects of their role, for example deliver training, complete audits and develop a rehabilitation service. The shortage of cancer nurse specialists meant that not all patients were supported by a cancer nurse specialist when they were given a diagnosis of cancer at outpatient clinics. Data showed that from August 2019 to March 2022 only 81% of cancer patients had a documented contact with a cancer nurse specialist. The cancer nurse specialist team said there were no dedicated appointments for them to support patients with their diagnosis of cancer. Staff told us this was due to capacity issues, lack of staff and the availability of consulting rooms.

Medical staffing

The upper gastrointestinal service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Surgery

The upper gastrointestinal service did not have enough medical staff to keep patients safe. The number of upper gastrointestinal surgical consultants did not meet the NHS standard contract specifications for cancer: oesophageal and gastric (adult). To support a safe service, the service specifications sets out that a centre carrying out oesphagectomy resection surgery should have between four to six upper gastrointestinal surgical consultants. At the time of the inspection, although there were four upper gastrointestinal consultant surgeons with training in oesphagectomy resection surgery, only two carried out this type of surgery. Of the other two consultants, one acted as an assistant to the surgeon carrying out oesphagectomy resection surgery and the other did not carry out any resection surgery.

There were insufficient numbers of junior doctors. There were four filled senior house officer posts, which left vacancies for this grade of medical staff. This left newly qualified doctors with little support. Registrars at times, needed to cover senior house officer shifts, but staff recognised this practice was not sustainable.

Newly qualified doctors did not feel fully supported to carry out their role effectively and safely. They described their induction was not what they expected. They had a one-week induction programme followed by one day of shadowing a colleague. They felt that working outside the core hours felt unsafe because there was very little support. They described that after 5pm there was one senior house officer and one registrar plus the newly qualified doctor looking after all the gastrointestinal patients in the wards, the rest of the hospital and the emergency department A summary of incidents reported by the upper gastrointestinal service from 1 August 2021 to 11 July 2022 showed two incidents where newly qualified doctors worked night shifts with little or no support from more senior medical staff which resulted in delayed care for patients.

The upper gastrointestinal service did not have experienced medical staff. To ensure they maintained their skills in Oesophagogastric surgery, the NHS service specifications recommend an individual consultant should undertake a minimum of 15 to 20 resections per year. Records showed that for the years 2019 - 2020, 2020 – 2021, 2021 – 2022 only one of the current surgical consultants had carried out between 15 to 20 oesophagealgastro resection operations in one year (2021 – 2022). Senior leaders said that, following recommended best practice, where possible oesophagectomy resection surgery was carried out by two surgeons. However, records provided by the trust showed this did not often happen. Their records detailed that from 1 April 2020 to 30 March 2021, 16 oesophagectomy resection operations were carried out and only three were carried out by two consultants. From 1 April 2021 to 31 March 2022, 29 oesophagectomy resections were carried out and only two were carried out by two consultants.

Consultant on call rotas did not support safe management of patients with oesophagastric conditions. The on-call rota was not in line with the guidance published by the association of upper gastrointestinal surgeons of Great Britain and Ireland: The provision of service for upper gastrointestinal surgery (2016). This guidance set out that centres carrying out major resectionional surgery for oesophagastric conditions must provide robust 24 hours a day subspecialty cover. However, on call rotas were shared with the lower gastrointestinal surgical consultants and upper gastrointestinal surgical consultants. This meant that an upper gastrointestinal and a lower gastrointestinal surgical consultant were on call on alternate days with the agreement that if clinically needed the upper gastrointestinal consultants would attend the hospital to treat patients. This meant there were periods of time when no upper gastrointestinal specialist was immediately available to provide care and treatment. Trust incident reports showed occasions when upper gastrointestinal surgical consultants either refused to come to the hospital to treat patients or could not be contacted when patients’ conditions were potentially deteriorating. This included a consultant refusing to attend the hospital to carry out urgent surgery.

Staff said that feedback they received from patients was that decisions about treatment plans were constantly changed. This was because the 'on call' surgical consultant changed every day. Detail in incident reports, patient complaints and a review of patient records showed some patients experienced changes in decisions and treatment plans when a different surgical consultant took over their care.

The senior leadership team had identified concerns with the on-call rota. They said the upper gastrointestinal surgical consultants were committed to managing the rota with the right cover of upper gastrointestinal surgical consultants.

Endoscopy medical staff said there were insufficient numbers of endoscopist medical staff to effectively support the gastrointestinal service. However, the trust said there was an established out of hours emergency endoscopy service.

Records

Staff kept detailed records of patients' care and treatment. Records were not always clear and were not always easily available to all staff providing care.

Patient notes were comprehensive. Patient records showed their care and treatment was reviewed and records were kept of all treatment plans, treatment carried out, and the patient's condition. Records were signed and dated by the person making the entry. However, some entries in patient medical records were not easily legible.

Records were mostly stored securely. Patient records were held in lockable trolleys on the wards. However, on ward 9a east these were not always locked. This increased the risk of patient's notes being access by unauthorised people. Patient records were not always easily available. On the day of our inspection a member of staff was having difficulties locating the records for a patient who was being prepared for surgery. A second member of staff was not able to locate the medical records for a patient that the CQC inspection team wanted to review. The patient records were later located in one of the consultant's offices. The ward staff had not been informed about the removal of the notes from the ward.

Incidents

The service did not manage patient safety incidents well. Staff recognised but did not always report incidents and near misses. There were no effective processes to learn and make improvements in response to incidents and adverse events.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff reported incidents and near misses using the trust's electronic incident reporting process. However, staff said they did not always get feedback about incidents and some staff were unsure whether incidents reported were investigated.

Some staff said that not all incidents were reported. Reasons for this included lack of time due to staff shortages causing pressure on their time, and the feeling that there was no point as nothing would change as a result of reporting. Examples of incidents that sometimes did not get reported, was the practice of 'boarding.' This was where a patient was allocated from the emergency department to a ward when there was not a bed space available. This was only supposed to occur when there was a confirmed discharge from the ward and the patient due for discharge could vacate their bed space. The trust policy detailed that only one patient should board on a ward at any time. However, staff said, patients were frequently sent to the ward, having been told they would have a bed. Instead, patients would have to sit and wait for a patient to be discharged. Staff said it was not uncommon for patients to be brought up to the ward when there were no confirmed discharges from the ward. Staff said it was not uncommon for more than one patient to be boarded on the ward at the same time.

Surgery

Staff did not meet to discuss feedback from incidents and look at improvements in patient care. Although morbidity and mortality meetings were held, these were not effective at learning from events and making improvements to the service. Morbidity and mortality meetings are a recognised and recommended process to support a systemic approach to the review of patient deaths or care complications in order to improve patient care. From February to October 2020 and March to September 2021 morbidity and mortality meetings were not held. The trust said this was initially because elective surgery had stopped to protect public health at the beginning of the Covid-19 pandemic and in 2021 when a second 'lockdown' happened after which restoration and recovery was prioritised. However, when morbidity and mortality meetings were reinstated, these did not result in a responsive and effective forum to reflect and learn from patient outcomes. Trust data showed morbidity and mortality minutes and associated presentations were not presented in a standard format and the learning from the cases presented was not clear. There was insufficient evidence to demonstrate how these reviews were used to improve quality and safety standards through learning. There were no formal processes to identify how cases were chosen for discussion. There was a lack of evidence to demonstrate the service had taken account of the Royal College of Surgeon's Morbidity and Mortality meetings guide to good practice.

On the wards, staff did not have formal staff meetings to discuss feedback and learning from incidents. Staff said this was due to lack of capacity to hold meetings.

Is the service effective?

Inspected but not rated

Patient outcomes

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

The service participated in relevant national clinical audits. The national standards for clinical outcome data from the National Oesophago-Gastric Cancer Audit showed that in a cohort of 83 patients from 2017 to 2020, the Royal Sussex County hospital had a 4.7% 30-day mortality rate, compared to the national average of 1.6%. In the same cohort of patients the hospital had a 6.9% 90-day mortality rate, compared to the national average of 3.2%. However, both of these values sat within the standard deviation confidence limits despite being twice the national average.

Records provided by the service showed there was an increasing number of emergency readmissions for patients who had undergone upper gastrointestinal surgical treatments. This had risen from 8% in the year 2019 to 2022, to 12% in 2021 to 2022. The figure for emergency readmission for 2022/23 was currently 11%.

Patients did not always have a cancer nurse specialist to give support when a diagnosis of cancer was given to them. Patient experience is reported in the National Cancer Patient Survey. In this survey patients with a clinical nurse specialist (CNS) reported more favourably than those without on a range of items related to information, choice and care.

Surgical consultants and senior leaders knew about the results and had some plans to improve the service. This included the recruitment of an additional upper gastrointestinal surgical consultant to increase the number of procedures carried out and increased capacity with the planned opening of a new building in February 2023.

Competent staff

Surgery

The service did not make sure all staff were competent for their roles.

Managers did not fully support medical staff to develop through regular, constructive clinical supervision of their work. There was lack of evidence of formal supervision of medical staff. Supervision was carried out on an informal basis and there was no evidence that medical staff skills and competencies were checked formally, other than through the revalidation process with the general medical council register. We requested assurance from the trust about how the skills and competencies of medical staff were assured but received no feedback.

The clinical educators supported the learning and development needs of some staff. Nurse clinical educators supported the development and training of nursing and health care assistant staff. All nursing and health care assistant staff we spoke with commented positively about the support and training received. However, there was little evidence to demonstrate medical staff were supported in their learning and development.

Multidisciplinary working

Doctors, nurses and other healthcare professionals did not always work together as a team to benefit patients.

Staff did not hold effective multidisciplinary meetings to discuss patients and improve their care. Multidisciplinary meetings to plan treatment and care for patients were held weekly. However, the approach to multidisciplinary (MDT) care and treatment exposed patients to risk of harm. There were insufficient numbers and mixes of health care professionals at the meetings to ensure effective discussions and challenges about the care and treatment of patients with complex healthcare needs took place. Data provided by the trust showed they did not take account of standard contract and service specification for oesophageal gastric cancer services. Attendance records showed that from 1 April 2021 to 30 March 2022 only 84% of MDT meetings had the required number and mix of professionals at them. From 1 April 202 to 31 July 2022 only 41% of MDT meetings had the required number and mix of professionals at them. There was not always an upper gastrointestinal surgical consultant present at these meetings.

The NHS contract and service specification details that there should be two or more upper gastrointestinal consultants attending the MDT meetings. Trust records showed that there was more than one upper gastrointestinal consultant attendance for only 20 of the weekly MDT meetings for the 12 months prior to this inspection.

The NHS contract detailed that a core member of the specialist palliative care team should be part of the team. Records showed that no palliative care team member attended the MDT meetings.

Patients had their care pathways reviewed and changed by different consultants. Staff said and records confirmed that patients sometimes had their treatment plans changed on a weekly basis. This was because the consultant in charge of patient care changed on a weekly basis which resulted in a lack of continuity of plan of care for some patients.

Is the service well-led?

Inspected but not rated

Leadership

Surgery

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

The leadership of the perioperative directorate was unchanged since our last inspection. Perioperative care is work in settings where surgical care is being given. This includes preoperative assessment, outpatient clinics, surgical wards, operating departments and post-anaesthetic care/recovery rooms. The directorate was led by a chief of service, divisional director of operations and a divisional lead nurse (current post holder was interim).

Each surgical speciality had a clinical director and a matron who was supported by the ward managers. The upper gastrointestinal service was part of the gastrointestinal surgery speciality. Although there was a clinical director for this speciality there was no identified lead for the upper gastrointestinal service. Staff had differing views about who was the lead consultant for the upper gastrointestinal service.

Staff views remained mixed about the visibility and how approachable trust leaders were. Some staff told us the local senior leadership team were visible and approachable, but as a department they felt there was a disconnect between the executives and frontline staff. They told us they did not see senior leaders such as the board of directors, so they were unsure if their voices or feedback was heard at that level. Staff felt the trust leaders were not aware of the pressures staff worked under and how operational pressures affected their other work. The trust had implemented quality improvement processes that all clinical areas were required to engage in. However, on the wards, this did not happen. Reasons for this included managers not having protected time to complete this work, no training, guidance or support from the trust about the process or methodology.

Ward managers and matrons told us they had no protected time to carry out their managerial roles. This meant they were drawn into operational issues rather than supporting and developing staff.

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

Culture

Not all staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service did not have an open culture where staff could raise concerns without fear.

Not all staff felt respected, supported and valued. Nursing staff felt respected and supported by their immediate leaders and it was evident they were committed to providing the best possible care to their patients. However, the culture amongst the senior medical staff was not respectful or a supportive culture. Theatre staff spoke about the poor behaviours of some surgical consultants. Staff felt action was not taken to manage behaviours, even when escalated to leaders.

Staff and teams did not always work in a way that supported each other. Nursing staff spoke about a lack of communication from some consultants. They did not let nursing staff know when ward rounds would be carried out. This had a potential to adversely impact on patient experience, as nurses could not plan their shift effectively. Medical staff did not always share information from ward rounds with nursing staff. Nursing staff had to review patient records to find out decisions made during ward rounds.

The practices and culture between some medical staff were not fully focused on meeting needs of patients. The practice of large ward rounds lasting from morning until mid-afternoon, restricted the time junior medical staff had to act on decisions made on the ward round. This had the potential to create delays in patients' treatment. Some staff said the practice of lengthy ward rounds did not support effective decision making and did not facilitate the involvement of patients in decisions about treatment plans.

The service still did not have an open culture where staff could raise concerns without fear. Prior to this inspection, we received information from various sources that some staff felt unable to raise concerns about the service for fear of reproach. Similar comments were made by some of the staff we spoke with during the inspection. The trust did not have a substantive freedom to speak up guardian and there were no freedom to speak up champions or ambassadors that staff could approach with their concerns.

Governance

Leaders did not operate effective governance processes.

The current capacity and capability of the divisional governance arrangements exposed patients to the risk of harm. Several staff, of different professions and grades, commented that there was no governance of the upper gastrointestinal service. There was insufficient administration support in the surgical division to ensure key governance functions like morbidity and mortality governance and risk systems functioned.

Other than morbidity and mortality meetings, the service did not review the clinical effectiveness of the service. We requested records of clinical effectiveness meetings but did not receive any. There was no evidence that performance, safety, incidents, infection control, complaints, training or staffing were regularly reviewed in the speciality.

Staff did not keep records of all meetings held on the wards. The ward kept records of safety huddles which were documented, but these were not standardised and varied in their detail. Ward meetings were held, but no records were kept of them which meant there was no record about discussions and learning from the performance of the service.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues.

Processes to identify, escalate and manage risks were not effective. Not all risks to the service were identified. The service had a risk register which identified five risks for the upper gastrointestinal surgery service. Although one of these included the risk to the service (patients' treatment being delayed or patients having to be treated elsewhere) due to the lack of upper gastrointestinal surgical consultants, there was no consideration about the risk to safe practices associated with the small numbers of oesphagectomy resection surgery carried out by consultants. Risk of poor patient experience due to insufficient numbers of cancer nurse specialists were also not recorded as a risk.

Risks that nurses identified were not all included on the risk register. One of the risks to patient safety and experience that all nursing staff spoke about was the practice of 'boarding'. Staff said they had raised this as a risk to patient safety and experience, but this was not included on the risk register.

There was lack of evidence the service effectively used auditing processes to support improvements to the service. We asked the service for an audit over the last six months of recommendations from the multi-disciplinary team meetings

and subsequent treatment undertaken. We were provided with a document titled Audit - Discrepancy Between the Clinical and Final Pathological TNM Findings in OG cancer and a document describing subsequent treatment undertaken. This had an action plan that stated, "our plan is to implement some changes and then re audit our practice." There was no detail about what those changes were, no accountable person for implementing the action plan and no set date for re audit of the actions. This audit was not able to demonstrate whether recommendations from multidisciplinary team meetings were followed and therefore could not demonstrate the effectiveness of the MDT approach. Some staff said there were no audits completed about the upper GI service.

The service was not confident in the data it collected. In response to our request for data about anastomotic leaks for the time period 2019 to 2022, the service responded, "We have no concerns about our anastomotic leak rate and are confident this matches national benchmarks. However, we have commissioned a review of all appropriate patient notes by an experienced consultant oncological surgeon in a different specialty. Due to annual leave this cannot be provided currently; we will confirm a completion date for this work within the next 7 working days." Following receipt of this data, the presentation of the data made it difficult to interpret and it was unclear how the service would be able to have any assurance from the data provided.

Areas for improvement

Enforcement actions: Conditions have been added to the trust's certificate of registration, restricting elective oesophago-gastric resections from being undertaken at Royal Sussex County Hospital.

Action the trust MUST take is necessary to comply with its legal obligations.

Surgery

- The trust must ensure that there is a robust governance and risk arrangements to provide assurance that the upper gastrointestinal service is safe, effective and well led. (Regulation 17)
- The trust must ensure there are enough numbers of appropriately trained and competent upper gastrointestinal consultants working in the service in line with the "NHS standard contract for cancer: oesophageal and gastric (adult) section B Part 1 service specifications." (Regulation 18)
- The trust must ensure there is enough Cancer Nurse Specialist resources to support the upper gastrointestinal service. (Regulation 18)
- The trust must ensure that there are enough numbers of competent staff to provide out of hours emergency cover. (Regulation 18)
- The trust must ensure that all upper gastrointestinal multidisciplinary team (MDT) meetings are held in line with "NHS England and Improvement Streamlining Multi-Disciplinary Team Meetings" guidance. (Regulation 12)
- The trust must ensure that patient records are legible and easily available to all staff providing care and treatment. (Regulation 17)
- The trust must ensure that patient records and details are not accessible to unauthorised persons. (Regulation 17)
- The trust must ensure morbidity and mortality meetings are carried out in accordance with national guidance. (Regulation 17)
- The trust must ensure they consistently use audits to measure quality and improve services. (Regulation 17)

Surgery

- The trust must ensure leaders and managers have protected time to effectively carry out their role. (Regulation 18)

Our inspection team

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