East Sussex Healthcare NHS Trust

Conquest Hospital

Quality Report

The Ridge, St Leonards-on-sea
Hastings, East Sussex TN37 7RD
Tel:01424 755255
Website:http://www.esht.nhs.uk/hospitals/conquest/

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

Ratings

Overall rating for this hospital	Inadequate
Urgent and emergency services	Requires improvement
Surgery	Inadequate
Maternity and gynaecology	Inadequate
Outpatients and diagnostic imaging	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected Conquest Hospital as part of a follow up inspection of the acute hospitals provided by East Sussex Healthcare NHS Trust on 24, 25, 26 March 2015.

In a comprehensive trust wide inspection, carried out in September 2014, we identified serious shortcomings across both acute hospital sites. This inspection was focussed on the four core services that we had the most concern about to determine whether improvements had been made. We reviewed how services were being provided in the outpatients department, maternity, surgery and the accident and emergency department.

We met with the trust and representatives from the Trust Development Agency (TDA) on 23 March 2015. The trust talked to us about the draft action plan created following our September 2014 inspection. We were provided with a copy of the draft action plan on 27 March 2015 but have since received a final action plan which appeared more robust and focussed.

The trust serves a population of around 525,000 patients from across the East Sussex area. There are approximately 700 beds and almost 7,000 staff. The hospital provides a full range of DGH services to its local population although some services are only available on one site. Consultant led obstetric services, acute services for children and young people and trauma and emergency surgery are only available at the Conquest Hospital. The trust has links to larger hospitals in Brighton, Tunbridge Wells and London for some tertiary services.

We found some early improvements had been made by individual teams and departments but these were not sufficient to provide assurance that the trust was providing an acceptable level of care in the four core services we inspected. The trust had failed to effectively address the issue of staffing that failed to meet the national recommendations and this had a real impact on staff morale and wellbeing, patient choice and safety. We were told of several incidents of unacceptable behaviour by senior staff and saw several incident reports where senior staff had prioritised targets over patient and staff welfare.

We also identified serious concerns about the culture and leadership within the trust. This permeated throughout both sites with staff feeling unable to raise concerns and a perception that they were not listened to. We also saw the response to the chair of an external stakeholder group when they raised concerns; the CEO suggested that the chair should consider their position as, "They no longer had the support of East Sussex Healthcare Trust".

We saw overall that safety was inadequate, that the trust was not responsive to the needs of many of its patients, and that leadership was inadequate. We found that effectiveness and responsiveness of many areas required improvement.

We found that caring was largely good across both sites. However, the NHS Staff Survey 2014 demonstrated very low staff morale and we found high staff sickness levels at the trust.

The trust could not demonstrate compliance with the National Specification for Cleanliness in the NHS.

The trust had shared a draft action plan following the publication of the report of the September 2014 inspection but this failed to effectively address all of the issues that we said they must take action on in our previous report.

Our key findings were as follows:

- We saw on-going challenges with staffing in some areas and could identify where this had impacted on patient welfare.
- The quality of the medical notes remained unsatisfactory. Many clinics were running without patient health records and using temporary sets of notes. Health records were in a poor state of repair. Some incidents could not be reviewed satisfactorily because of poor record keeping.

Summary of findings

- We were unable to see evidence of clear strategies to monitor and maintain robust systems to ensure that the trust improved their waiting times and met with these targets..
- Operational staff were stressed, unhappy and keen to discuss their experiences throughout our visit. We were contacted by a number of staff who felt unable to raise concerns within the organisation.
- The trust board continues to say they recognise that staff engagement is an area of concern but the evidence we found suggests there is a void between the Board perception and the reality of working at the trust. At senior management and executive level the trust managers spoke entirely positively and said the majority of staff were 'on board', blaming just a few dissenters for the negative comments that we received.
- We found the widespread disconnect between the trust board and its staff persisted. This did not appear to be acknowledged by the senior management team.
- The NHS staff survey shows the trust below average for 23 of the 29 staff engagement measures and in the worst 20% for 18 of these.
- We saw a culture where staff remained afraid to speak out or to share their concerns openly. We heard about detriment staff had suffered when they raised concerns about risks to patient safety.
- Staff remained unconvinced of the benefit of incident reporting, and were therefore not reporting incidents or near misses to the trust. the trust was not able to benefit from any learning from these. this position had not improved.
- We found that management of outpatients' reconfiguration has led to service deterioration with long delays in the referral to treatment time in some specialities. We did, however that local managers had taken some steps that had resulted in an improved patient experience.
- In surgery and OPD there was clear evidence of significant underreporting of incidents through the correct system. This related to high tolerance or thresholds in the surgical clinical unit and a management decision to prevent staff reporting OPD reception incidents through the proper channels.
- We saw low staffing levels that impacted on the trusts ability to deliver efficient and effective care.
- The poor quality of health records and frequent lack of availability continued to pose a risk.
- Storage and operational arrangements did not ensure that people's personal information remained confidential.
- The referral to treatment times in a number of specialities continued to be significantly worse than expected when compared nationally.
- Short notice cancellations of outpatient clinics continued to be a problem. Large numbers of appointments were cancelled at very short notice. In some cases, people arrived for the appointment unaware it had been cancelled.

We saw one area of outstanding practice :

In maternity the telephone triage system allowed women to access information and advice without necessarily attending the unit.

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

Importantly, the trust must:

- Give full consideration to whether there have been any breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5 (3)(d) Fit and proper persons: directors
- Review the tracking of records. The outpatient department were not tracking patient health records because this job had not been considered during the redesigning of the service. The location of medical records were often unknown and resulted in delays or temporary notes being used. Trusts have a responsibility to track all patients' health records (Records Management: NHS Code of Practice Part 2, 2nd Edition, January 2009).
- Comply with the Data Protection Act 1998. The outpatient department was not protecting patients' confidential data. Patient records were left in public, accessible areas without staff present.
- The trust must make sure the privacy and dignity of patients is upheld by avoiding same sex breaches in the clinical decision unit (CDU).

Summary of findings

- Ensure that there are adequate staff, including managers, consultant midwives and labour ward coordinators employed to meet the recommended minimum standards detailed in Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Royal College of Anaesthetists (RCA), Royal College of Paediatrics and Child Health (RCPCH), 2007.
- Review staffing arrangements for the community midwifery service to ensure they are compliant with the Working Time Regulations (1998), which implement the European Working Time Directive into British law.
- Ensure that all women in established labour receive one-to-one care from a registered midwife.

In addition the trust should:

- Make sure the privacy and dignity of patients is upheld by reviewing the arrangements and facilities for patients awaiting radiological investigations.
- Ensure that the room in the ED designated for the interview of patients presenting with mental health needs has a suitable design and layout to minimise the risk of avoidable harm and promote the safety of people using it.
- Review the number and skill mix of nurses on duty in the ED department to reflect NICE guidelines to ensure patients' welfare and safety are promoted and their individual needs are met.
- Review the number of consultant EM doctors in the ED and how they are deployed to reflect the College of Emergency Medicine (CEM) recommendations.
- Improve the uptake of mandatory training amongst staff working in Urgent Care.
- Make sure there are enough competent staff working in Urgent Care to respond to a major incident.
- Review the arrangements for monitoring pain experienced by patients in the ED to make sure people have effective pain relief.
- Review their arrangements for assessing and recording the mental capacity of patients in the ED to demonstrate that care and treatment is delivered in patients' best interests.
- Make arrangements to ensure contracted security staff have appropriate knowledge and skills to safely work with vulnerable patients with a range of physical and mental ill health needs.
- Review some areas of the environment in the ED with regard to the lack of visibility of patients in the children's waiting area; the arrangements for supporting people's privacy at the reception and triage bay and the suitability of the relatives' room
- Review the provision of written information to other languages and formats so that it is accessible to people with language or other communication difficulties.
- Ensure fridges used for the storage of medicines are kept locked and are not accessible to people and that medicines are secured in lockable units. This is something that is required as part of Regulation 13 in relation to the management of medicines but it was considered that it would not be proportionate for that one finding to result in a judgement of a breach of the Regulation overall at the location.
- Consider how it may improve the experiences of women with regard to their pain management.
- Consider ways of updating policies and procedural guidance so staff have access to relevant information.
- Consider how it enables staff to attend required training and supports staff to gain additional qualifications to support the service.
- Consider how it can improve the checking of all technical equipment across each department.
- Consider how it can improve the completion of care records, so that all risks are assessed and recorded.
- Consider ways of improving the bereavement facilities.
- Improve breastfeeding support to new mothers.
- Consider ways of improving peoples experiences related to food, inappropriate discharge times, antenatal and parent craft provision and partner facilities.

Summary of findings

- Consider the particular needs of vulnerable groups of women and babies within their catchment and provide adequate resources to meet those needs.
- Consider ways of improving the sharing of information and improving engagement with midwifery staff, so they are aware of and involved in future developments.
- Provide resources to accommodate the needs of women in early labour where repeated journeys between their home and the hospital may be inadvisable.
- Communicate more effectively with the local population to ensure they understand the services available and the reasons for decisions being made.

Subsequent to this inspection visit a warning notice served under Section 29a of the Health and Social Care Act 2008. This warning notice informed the trust that the Care Quality Commission had formed the view that the quality of health care provided by East Sussex Healthcare NHS Trust requires significant improvement:

On the basis of this inspection, I have recommended that the trust be placed into special measures.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	The Emergency Department required improvement to ensure that patients are protected from avoidable harm. The trust did not meet The College of Emergency Medicine (CEM) recommendation that an Emergency Department (ED) should have enough consultants to provide cover 16 hours a day, 7 days a week. This compromised senior clinical decision making which could negatively impact on the patient's pathway of care. High levels of absence due to sickness meant there was not always enough nurses on duty in the ED to care for patients safely given the acuity of patients and the extended geographical layout of the department. The number of paediatric nurses working in the ED was inadequate and compromised the safety of sick or injured children attending the unit. Safeguarding was not given a sufficiently high priority with only one nurse having completed level 3 child safeguarding training since our inspection in September 2013. The numbers of staff who had completed level 2 training was below the trust target. Medicine management had improved since our last inspection which minimised the risk of medicine misuse. Information about safety was not always comprehensive or timely. Safety concerns were not consistently identified or fully responded to. When things went wrong, reviews and investigations were not always sufficiently thorough or did not include all relevant people. Necessary improvements were not always made when things go wrong. Opportunities to identify and disseminate learning following untoward incidents was insufficiently developed. The ED provided effective care and treatment. Staff followed accepted national and local guidelines for clinical practice. The department had developed a number of pathways to ensure that patients received treatment focused on their medical needs. The pathways were revised annually

Summary of findings

to ensure current practice. The trust participated in national College of Emergency Medicine audits so that they could benchmark their practice and performance against best practice and other EDs.
There was a multidisciplinary, collaborative approach to care and treatment that involved a range of health and social care professionals.
Patients were given timely pain relief although pain scoring tools were not consistently used. There were insufficient paediatric nurses employed to provide 24 hour presence in the department, but this was mitigated by additional training for staff.
The ED provided a compassionate and caring service.
Patients felt that they were listened to by health professionals, and were involved in their treatment and care. Staff treated patients with respect.
Patients and their relatives and carers told us that they felt well-informed and involved in the decisions and plans of care. Staff respected patients' choices and preferences and were supportive of their cultures, faith and background.
The ED required improvements in the way services are organised and delivered so people's individual needs are met.
The facilities and premises did not always promote people's privacy, dignity and confidentiality. It was accepted practice for male and female patients to share toilets and overnight sleeping accommodation in the Clinical Decisions Unit (CDU). The trust was not following the guidance from the Department of Health in respect of single sex accommodation; this had been pointed out following our September 2014 inspection but the situation persisted.
Facilities for children in the ED were not meeting the standards set by the Royal College of Paediatricians and Child Health. There were insufficient treatment areas for the number of children seen and those that were available were not reserved for use by children.
Facilities for bereaved relatives or those with a critically ill relative in the department required improvements.
There was good support for people with mental health needs from a specialist mental health trust

Summary of findings

working in partnership with staff at Conquest Hospital but the facilities for caring for people who were very agitated or distressed were not appropriate or secure.
Staff in the ED were using relatives for interpreting despite the trust having access to professional interpreting services.
Complaints about the ED were responded to in a timely manner.
The ED required improvements to leadership and culture so the delivery of high quality, person centred care is supported.
The management of risks in the ED need to be strengthened to support the delivery of safe and effective care. The ED has not responded to the breaches of regulation identified at the inspection of September 2014 which means patient experience has not been improved. Staff satisfaction was mixed. Not all staff felt actively engaged. There was a limited approach to obtaining the views of people using the service and no evidence that changes were made as a consequence of patient feedback.
The management of risks in the ED need to be strengthened to support the delivery of safe and effective care. The ED has not responded to the breaches of regulation identified at the inspection of September 2014 which means patient experience has not been improved.
The arrangements for governance and performance management do not always operate effectively. There has been no recent review of the governance arrangements, the strategy, plans or the information used to monitor performance. Risks, issues and poor performance are not always dealt with appropriately or in a timely way. The risks and issues described by staff do not correspond to those reported to and understood by leaders. The governance group is ineffective and fails to bring about dissemination and monitoring of learning from identified shortfalls. Clinical Governance meetings are inadequate and concerns appear over a period of time with no evidence of improvement.
The approach to service delivery and improvement is reactive and focused on short term issues. Improvements are not always identified or action not always taken. Where changes are made, the impact on the quality of care is not fully understood

in advance or it is not monitored. Governance and other meetings were cancelled due to operational issues. Risk identified by the governance group did not get added to the risk register. The risk register was used as a record of identified risk but not as a live tool to drive improvement within the service. There was no sense of ownership of the risk register and problems were seen as 'Trust problems'

Surgery **Inadequate**

Our inspection identified that the processes and frequency of emergency equipment and controlled drugs checks required further attention to improve patient safety in surgical ward areas. We found evidence that some of the concerns raised by CQC's last inspection report were beginning to be addressed; however, the inspectors found an inconsistent approach to implementing progress made and the progress needed to drive the necessary improvements in the department. For instance, we found the theatre and recovery areas had taken the necessary steps to address the concerns, but the same level of improvement was not evident on the surgical ward areas. Safety thermometer data was being collected; however, the most up to date and relevant information was not always available for patients to view on the ward information boards. The hospital policies on emergency equipment and CD medication checks were found to reflect best practice, but were not being followed in practice.

There was continued confusion regarding the display of C.Diff and MRSA spells on boards. Staff appeared to have a lack of clarity about whether the infection control data related to their wards, or the hospital in general. Our review of trust level of compliance with Venous Thromboembolism (VTE) guidelines and policy have remained unchanged. The trust had a VTE policy in place which reflected national guidance from the Royal College of Surgeons. However, we did find that the VTE protocol was not always followed. This suggested that patients may not have received appropriate VTE prophylaxis and that national guidance was not always followed. The trust was not meeting Referral to Treatment Times (RTT) in surgery. We were aware the board, with the assistance of the Trust

Summary of findings

Development Authority (TDA) had put an action plan in place to reduce the waiting times. However, we are remain concerned about the sustainability of the progress made.
Staffing levels throughout the department were found to be insufficient to meet people's needs. This was also identified at the last inspection. The trust has given assurances to CQC that it is actively recruiting staff to fill the vacancies, however, the trust remained heavily reliant on agency and bank staff in the interim to ease the pressures. Staff told us the crisis on the 'shop floor' remained unchanged. We remain concerned that the department is failing to capture all incidents on the electronic reporting system. We acknowledge that the trust has taken steps to incorporate incident reporting into the formal hospital induction for new staff in an attempt to strengthen the reporting process and empower staff at all levels to report. However, we remain concerned that the clinical unit is a low reporter of incidents. Staff continued to tell us that a lack of feedback and low staffing levels was a likely contributor to under reporting.Cleanliness data for the surgical unit was reviewed as part of the inspection process. Our observations identified the areas we visited as being clean and tidy, however, when we reviewed the cleanliness data it highlighted a significant failing in achieving the national standards of cleanliness, and major shortfalls in the audit processes used to measure compliance.
The surgical clinical unit was consistently found to be not meeting the national standards of cleanliness, or of meeting the audit frequency as laid out in national guidance. There is continued concern that the surgical clinical unit was not learning from, or improving quality, from complaints and comments made. Staff remained unaware of complaints which had influenced change, with the exception of the ones made directly to them regarding noise and lights at night, or communication problems. The financial position of the trust and recent service reconfiguration has impacted on the vision and strategy for the service. Staff morale had been left in a poor state as a result of ineffective engagement and consultation processes when surgical services were

Summary of findings

reconfigured. The results of the most recent staff survey continued to raise concerns about staff welfare, morale and organisational culture at the trust.

Maternity and gynaecology — **Inadequate** 

We remained concerned about the overall leadership and considered that the service was inadequate with regard to being well-led and safe. The maternity services being provided had made some fledgling progress but still required improvements for effectiveness and responsiveness.

There was a disconnection and disaffection between the senior leaders and other staff, with staff not being aware of the services strategy, vision or developments. Information from the last inspection had not been shared with staff and they were not aware of the areas which they needed to address. Staff felt they lacked autonomy and were disempowered to make decisions and take forward their ideas. Staff did not feel encouraged or enabled to consider better ways of working and to develop the service, despite having beneficial insight and expertise.

An action plan had been created following publication of our report from the September 2014 inspection but some of the issues raised were not addressed and the action plan was insufficiently robust to bring about sustained change. There was a lack of acceptance of the serious nature of the concerns we identified by the leadership of the maternity services. A letter dated 5 April 2015 sent to all midwifery staff by the Head of Midwifery says explicitly that they, "Did not recognise this report as our unit". Midwifery staff generally considered their direct line leadership to be good, with supportive leaders who understood and shared their aims to deliver quality care.

Staffing arrangements did not always ensure sufficient numbers of skilled and knowledgeable staff were on duty to maintain safety and to ensure people's individual needs were met. This caused considerable pressure on staff, many of whom worked excessive hours and without breaks and increased the risk of incidents occurring. The current staffing arrangements did not allow for a labour ward shift co-ordinator that was

Summary of findings

supernumerary to the staffing numbers. Women did not receive one to one care in labour. The staffing on the labour ward frequently fell below the planned levels set by the trust.

There was not a learning culture and incidents were not reviewed in sufficient depth to enable lessons to be learned and disseminated. Learning opportunities were missed and mistakes continued to occur around previously identified concerns such as CTG interpretation and mothers who had suffered pregnancy loss being contacted about antenatal care or delivery plans. There was no challenge to the process for investigation of incidents and dissemination of learning such that the risk of repetition of similar mistakes and incidents was effectively mitigated.

There was a significant difference between the mandatory training senior midwives spoke to us about and the records supplied by the trust. The records provided by the trust showed poor compliance with training requirements and very little essential specialist training.

The was a lack of specialist midwives to meet the needs of the very young mothers, women who misused drugs or alcohol or traveller families.

The experiences of women's pain management were variable with negative and positive comments made in this regard.

The closure of the midwifery led units to provide staff to the Conquest hospital meant women were not assured that the unit where they had chosen to have their baby would be open when they needed it. It limited choice and discouraged the normalisation of birth.

Women reported positively on midwifery and medical staff's level of information provision and their involvement in decision making and choices. Individual care needs of women using the services were fully considered by staff and respected as far as they could. Nutritional needs were met and people's religious, cultural and medical dietary needs were met.

Consent was sought from individuals prior to treatment and care delivery. Choices were available to women for Midwifery or Consultant-led care. Staff had the support of specialist staff for advice and guidance. Procedures were in place to

Summary of findings

continuously monitor patient safety and recommended guidance was followed by staff. There were effective arrangements in place for reporting adverse events and for learning from these. Maternity outcomes were monitored and information was communicated through the governance arrangements to the trust board.

Outpatients and diagnostic imaging

Inadequate

During our last inspection we found that the condition and availability of patient's health records was inadequate. At this inspection we found that no progress had been made and staff were still managing high levels of health records not being available for clinics, poor tracking of health records and health records which were oversized and in poor condition.

When we met with trust executive representatives they told us about plans for improvements in the management of records across the organisation. The Private Trust Board Minutes dated November 2014 showed that the board had approved the business case for an Electronic Document Management/Clinical portal and medical record scanning system that required TDA approval due to the scale of the financial commitment involved. The trust was aware that there were current problems in the safe and effective management of records and felt that the proposed system would improve the situation significantly.

At our last inspection we had concerns that staff were not consistently reporting incidents. Although at this inspection we found a raised awareness among nursing staff regarding incident reporting. We still found incidents that had been unreported these included an inadequate reporting mechanism for health records that could not be obtained for clinics.

At our last inspection the trust was not able to evidence that they were meeting with RTT NHS standard operating procedures across all specialities for either 2 week or 18 week targets. At this inspection the trust was still not able to evidence that they were meeting with these targets consistently across all specialities.

Summary of findings

The call centre was not fit for purpose with a shortage of skilled staff and operating systems that were not working to advantage patients. As a result of these issues patients and staff were often unable to contact the call centre when they needed to.
We found that the OPD was not being cleaned or audited in line with the National Specifications of Cleanliness and Trust policy.
We found that medicines management had improved since our last inspection. However, we found some medicines that were being stored in the department had past their expiry date, and the keys to the medication cupboards was not stored securely. This meant that there was scope for improvement with the management and storage of medications.
During our last inspection we found that the condition and availability of patient's health records was inadequate. At this inspection we found that no progress had been made. Health records were not available for clinics, there was poor tracking of health records and health records which were oversized and in poor condition.
We also found that in some instances patient's confidential information was not stored securely.
There were four vacancies across the Consultant Radiologist workforce. Locum consultant Radiologists have been in post for over two years to support the service. Radiology registrars are part of the medical workforce. However there is a shortage of trainees, with the Trust having only two registrars instead of five. The outcome of below establishment Consultant Radiologist posts and training registrar posts was that the trust's out of hours reporting service was outsourced and the capacity of the department was diminished resulting in extended reporting times which was identified on the Trusts risk register.
We saw very caring and compassionate care delivered by all grades and disciplines of staff working in OPD.
At this inspection we found that patient's experiences upon entering the department had improved. Systems had been put in place to ensure that patients were directed to the correct areas, and IT systems now informed staff when patients had arrived in the hospital. This meant that if a patient

Summary of findings

did go to the wrong department staff would be aware of this. The queue at reception had reduced and the area was calm and ordered throughout our inspection.

At our last inspection GP letters were not being sent consistently within the five days allocated for this task. This was because of a lack of staff, and issues with the quality of the letters being translated abroad. This had not improved since our last inspection and medical secretaries were still experiencing the same difficulties in performing their roles.

The team responsible for informing patients when clinics were cancelled had a backlog of work and were struggling to meet with the demands of the role. Many patients were being informed at short notice when appointments were cancelled even when clinics were cancelled with the required six weeks' notice. Many patients had not been notified when their clinic appointments had been cancelled and were arriving at the department to be sent away. There was no clinical triage where clinics were cancelled.

Nursing staff had made great improvements in service delivery since our last inspection. However, administration staff were still unsettled and unhappy about the changes that had been made to their department. They had experienced changes in management since our last inspection but felt that the service had not improved as a result.

Conquest Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Maternity and gynaecology; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Conquest Hospital

Conquest Hospital is located in the town of Hastings. It is part of East Sussex Healthcare NHS Trust which provides a range of acute and community services to the population of East Sussex

The health of people in East Sussex is generally better than the England average. Deprivation is lower than average, however about 18.1% (16,000) children live in poverty. Life expectancy for both men and women is higher than the England average. Life expectancy is 8.2 years lower for men and 5.4 years lower for women in the most deprived areas of East Sussex than in the least deprived areas.

The In 2012, 22.0% of adults are classified as obese. The rate of alcohol related harm hospital stays was 543*, better than the average for England. This represents 3,007 stays per year. The rate of self-harm hospital stays was 145.2*, better than the average for England. This represents 719 stays per year. The rate of smoking related deaths was 263*, better than the average for England. This represents 1,037 deaths per year. Estimated levels of adult physical activity are better than the England average. The rate of people killed and seriously injured on roads is worse than average. Rates of sexually transmitted infections and TB are better than average. The rate of new cases of malignant melanoma is worse than average. Rates of statutory homelessness, violent crime, long term unemployment, drug misuse and early deaths from cardiovascular diseases are better than average.

Priorities in East Sussex include circulatory diseases, cancers and respiratory diseases to address the life expectancy gap between the most and least deprived areas.

The trust has revenue of £364 million with current costs set at £387 million giving an annual deficit budget of £23 million. A turnaround team had been appointed to address this ongoing deficit.

The trust serves a population of 525,000 people across east Sussex. It provides a total of 706 beds with 661 beds provided in general and acute services at the two district general hospital and community hospitals. In addition there are 49 Maternity beds at Conquest Hospital, and the two midwifery led units and

19 Critical care beds (11 at Conquest Hospital, 8 at Eastbourne District General Hospital).

At the time of the inspection there was a stable trust board which included a Chairman, five Non-Executive Directors, a Chief Executive and Executive Directors. The Chair was appointed in July 2011 for a period of four years. The Chief Executive Officer joined the trust in April 2010 and his appointment was made substantive in July 2010.

We carried out this comprehensive inspection in September 2014. We held two public listening events in the week preceding the inspection visit, met with individuals and groups of local people and analysed date we already held about the Trust to inform our inspection planning. Teams, which included CQC inspectors and

Detailed findings

clinical experts, visited the two acute hospitals, community hospitals and midwifery led centres and teams working in the community. We spoke with staff of all grades, individually and in groups, who worked in acute and community settings. We also carried out two unannounced inspection visits after the announced visit.

* rate per 100,000 population

Our inspection team

Our inspection team was led by:

Head of Hospital Inspection: Tim Cooper, Care Quality Commission.

The team of 29 that visited across the Trust on 23,24,25 March 2015 and 10 April 2015 included senior CQC managers, inspectors, senior registered general nurses, consultant midwives and an obstetrician, theatre specialist, consultants in surgery and emergency medicine, a pharmacist, experts by experience, data analysts and inspection planners.

How we carried out this inspection

To get to the heart of patients experiences of care, we always ask the following five questions of every service provider

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

The inspection teams inspected the following four core services across East Sussex Healthcare NHS Trust acute hospitals.

- Accident and emergency services
- Surgery
- Maternity services
- Outpatient services

Before this unannounced inspection we reviewed the information we held about the Trust.

We made an unannounced inspection of the Trust services on 24, 25, 26 March 2015 2015 and an additional unannounced inspection visit to both acute hospitals on 10 April 2015. We interviewed clinical and non-clinical staff of all grades, talked with patients and staff across all areas of the hospitals . We observed staff interactions with each other and with patients and visitors. We reviewed records including staffing records and records of individual patient's care and treatment. We observed how care was being delivered. We held drop in sessions on both sites to listen to staff working in different areas of the Trust.

During and following the unannounced inspection visits we requested current data from the trust about all of the core services we inspected and about the trust wide culture, strategy and governance systems.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Maternity and gynaecology	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Outpatients and diagnostic imaging	Inadequate	N/A	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Urgent and emergency services

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

Information about the service

The emergency department (ED) at the Conquest Hospital is also known as the accident and emergency (A&E) department. The ED saw 40,635 adult patients and 10,782 children between 1 April 2013 and 31 March 2014.

The trust's paediatric inpatient, general surgery, emergency and high-risk services, along with orthopaedic emergency and high-risk services are centralised at Conquest Hospital in Hastings. The Conquest Hospital in Hastings is a designated Trauma Unit and therefore receives only those trauma patients deemed suitable for this level of provision.

The ED is divided into areas depending on the acuity of patients. The resuscitation area has three adult bays and one paediatric bay with facilities for neonates. There are 16 trolley spaces for treating major and minor cases, this includes three rooms for isolation or privacy, a paediatric bay and a two-bed bay for treating ear, nose and throat (ENT) or eyes. In addition, there is a seven-bed clinical decision unit. There is a curtained bay in the waiting room area for the assessment and triage of non-ambulance patients.

We visited the ED on a weekday, during our unannounced inspection. We observed care and treatment and looked at 10 treatment records. During our inspection, we spoke with 23 members of staff, including nurses, consultants, doctors, receptionists, managers, support staff and ambulance crews. We spoke with 11 patients and their relatives. We received comments from people who contacted us to tell us about their experiences. We also used information provided by the organisation and information we requested.

Urgent and emergency services

Summary of findings

The Emergency Department required improvement to ensure that patients are protected from avoidable harm.

The trust did not meet The College of Emergency Medicine (CEM) recommendation that an Emergency Department (ED) should have enough consultants to provide cover 16 hours a day, 7 days a week. This compromised senior clinical decision making which could negatively impact the patient's pathway of care.

High levels of absence due to sickness meant there was not always enough nurses on duty in the ED to care for patients safely given the acuity of patients and the extended geographical layout of the department. The number of paediatric nurses working in the ED was inadequate and compromised the safety of sick or injured children attending the unit.

Safeguarding was not given a sufficiently high priority with only one nurse having completed level 3 child safeguarding training since our inspection in September 2013. The numbers of staff who had completed level 2 training was below the trust target.

Medicine management had improved since our last inspection which minimised the risk of medicine misuse.

Information about safety was not always comprehensive or timely. Safety concerns were not consistently identified or fully responded to. When things went wrong, reviews and investigations were not always sufficiently thorough or did not include all relevant people. Necessary improvements were not always made when things go wrong. Opportunities to identify and disseminate learning following untoward incidents was insufficiently developed.

The ED provided effective care and treatment.

Staff followed accepted national and local guidelines for clinical practice. The department had developed a number of pathways to ensure that patients received treatment focused on their medical needs. The pathways were revised annually to ensure current practice. The trust participated in national College of Emergency Medicine audits so that they could benchmark their practice and performance against best practice and other EDs. There was a multidisciplinary, collaborative approach to care and treatment that involved a range of health and social care professionals. Patients were given timely pain relief although pain scoring tools were not consistently used. There were insufficient paediatric nurses employed to provide 24 hour presence in the department, but this was mitigated by additional training for staff.

The ED provided a compassionate and caring service.

Patients felt that they were listened to by health professionals, and were involved in their treatment and care. Staff treated patients with respect. Patients and their relatives and carers told us that they felt well-informed and involved in the decisions and plans of care. Staff respected patients' choices and preferences and were supportive of their cultures, faith and background.

The ED required improvements in the way services are organised and delivered so people's individual needs are met.

The facilities and premises did not always promote people's privacy, dignity and confidentiality. It was accepted practice for male and female patients to share toilets and overnight sleeping accommodation in the Clinical Decisions Unit (CDU). The trust was not following the guidance from the Department of Health in respect of single sex accommodation; this had been pointed out following our September 2014 inspection but the situation persisted.

Facilities for children in the ED were not meeting the standards set by the Royal College of Paediatricians and Child Health. There were insufficient treatment areas for the number of children seen and those that were available were not reserved for use by children.

Facilities for bereaved relatives or those with a critically ill relative in the department required improvements.

There was good support for people with mental health needs from a specialist mental health trust working in partnership with staff at Conquest Hospital but the facilities for caring for people who were very agitated or distressed were not appropriate or secure.

Urgent and emergency services

Staff in the ED were using relatives for interpreting despite the trust having access to professional interpreting services.

Complaints about the ED were responded to in a timely manner.

The ED required improvements to leadership and culture so the delivery of high quality, person centred care is supported.

The management of risks in the ED need to be strengthened to support the delivery of safe and effective care. The ED has not responded to the breaches of regulation identified at the inspection of September 2014 which means patient experience has not been improved. Staff satisfaction was mixed. Not all staff felt actively engaged. There was a limited approach to obtaining the views of people using the service and no evidence that changes were made as a consequence of patient feedback.

The management of risks in the ED need to be strengthened to support the delivery of safe and effective care. The ED has not responded to the breaches of regulation identified at the inspection of September 2014 which means patient experience has not been improved.

The arrangements for governance and performance management do not always operate effectively. There has been no recent review of the governance arrangements, the strategy, plans or the information used to monitor performance. Risks, issues and poor performance are not always dealt with appropriately or in a timely way. The risks and issues described by staff do not correspond to those reported to and understood by leaders. The governance group is ineffective and fails to bring about dissemination and monitoring of learning from identified shortfalls. Clinical Governance meetings are inadequate and concerns appear over a period of time with no evidence of improvement.

The approach to service delivery and improvement is reactive and focused on short term issues. Improvements are not always identified or action not always taken. Where changes are made, the impact on the quality of care is not fully understood in advance or it is not monitored. Governance and other meetings were cancelled due to operational issues. Risk identified by the governance group did not get added to the risk register. The risk register was used as a record of identified risk but not as a live tool to drive improvement within the service. There was no sense of ownership of the risk register and problems were seen as 'Trust problems'

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

The ED required improvement to ensure that patients are protected from avoidable harm. When things go wrong, reviews and investigations were not always sufficiently thorough or completed in a timely manner. Necessary improvements are not always made when things went wrong and some incidents were not acted on to improve the service provided.

Safeguarding is not given sufficient priority at all times. Staff training in safeguarding children and adults was not sufficient to provide assurance that people who were at risk would be protected from harm.

The trust did not meet The Royal College of Emergency Medicine (RCEM) recommendation that an ED should have enough consultants to provide cover 16 hours a day, 7 days a week. This compromised senior clinical decision making which could negatively impact the patient's pathway of care.

High levels of absence coupled with on-going vacancies meant there was not always enough nurses on duty in the ED to care for patients safely given the acuity of patients and the extended geographical layout of the department.

The facilities and lack of paediatric nurses in the department compromised the safe care of children attending the department.

Mortality and Morbidity was not reviewed in such a way that any incorrect management or lapses in care would be identified.

Where risks had been identified by the trust or by CQC in the report published following our inspection in September 2014 these had not always been acted upon.

Medicine management had improved since our last inspection which minimised the risk of medicine misuse.

Incidents

- There were no Never Events reported relating to the ED at this hospital in the last 12 months. (A Never Event is a serious, largely preventable patient safety incident that should not occur if the available, preventative measures have been implemented by healthcare providers.)
- Information requested from the trust showed the ED reported no serious incidents to the Strategic Executive Information System (STEIS) since 1 October 2014.
- The trust had recorded 299 incidents relating to the Urgent Care Directorate at the Conquest Hospital between 1 October 2014 and 1 March 2015. Of these, 37 were categorised as level three severity and two as level four severity.
- Overall the trust had reported 658 incidents through the NRLS which is a different number to the total shown for both sites on the incident logs which was 556.
- We requested a list of incidents in the emergency department which were reported using the electronic reporting system between since 1 October 2014, broken down by type. There were a number of incidents relating to delays in treatment or transfers due to staffing or bed shortages, a significant number of incidents where duplicate records were created. There were several safeguarding concerns recorded and a number where pressure damage or falls had occurred. There was no evidence that the emergency department staff were reviewing incidents by category to establish patterns of concern.
- We spoke with medical, nursing and allied health professionals who told us they knew how to report incidents and they were given feedback about the outcome verbally at team meetings. Staff we spoke with could not tell us where they had seen a specific example of learning from an incident.
- Senior staff responsible for categorising incidents were not always clear about what constituted a serious incident. The incident log showed that the Patient Safety Lead had considered an incident where a patient sustained a fractured neck of femur following a fall as, "Not a serious Incident". NHS England Serious Incident Framework 2015 guidance on what defines a serious incident includes, "Any unexpected or avoidable injury that requires further treatment by a healthcare professional in order to prevent serious harm.
- Another level 4 severity incident had been downgraded from a 'Major' to a 'Moderate' by the Reportable Incident Facilitator but then regarded to a 'Major' by the Serious

Incident Review Group. NHS England guidance states, "Grading causes debate and disagreement and can lead to incidents being managed in an inconsistent and disproportionate manner'..

- We requested root cause analyses for any of these incidents that were investigated. We were provided with four RCA reports two relating to falls and two relating to pressure damage in the emergency department. We could not see evidence of any learning action in response to pressure damage sustained in the department. For example, there was no evidence of changes made to practice despite there being acknowledgement that the skin damage was exacerbated by delayed acquisition of a pressure relieving mattress for a patient.
- Another RCA we were supplied with showed that trust policy was not followed in some aspects of this incident in relation to risk assessment. No high-low bed was in use at the time of the patient's fall although the patient's bed was recorded as being at its lowest setting. There was learning actions recorded but they did not mention the use of a high low bed. The transfer of this patient between ward areas was recorded as 10.00pm and acknowledged as a contributory factor but no suggested future mitigation to reduce the risk posed to the frail elderly who are transferred at night was mentioned.
- The RCA reports for incidents other than these four level one severity incidents were not supplied when requested. We were not provided with the RCA for the higher severity incidents shown on the incident log. The incident log showed that some additional RCAs were either completed or in draft format but these were not supplied to us.
- We looked at the incident log and saw that there were several quite serious incidents that were not investigated in a timely manner. The log showed a person admitted with ischaemic changes on their Electrocardiograph (ECG) being refused a bay in the resuscitation area when requested by the reviewing doctor. This person was unstable and developed ventricular fibrillation. Only then were they moved to the resuscitation area. The incident happened on 16 December but the action recorded on the log simply says that the shift co-ordinator had been asked for an update on the 12 March 2015. No update was shown when we requested the information on 24 March 2015.
- In January 2015 a woman attended with a clinical presentation and history suggestive of an ectopic pregnancy but the referral by the ED medical staff was not accepted by gynaecologists. On initial presentation ED staff had discharged the women with a potentially life threatening condition, advising her that she should see her GP. There were no updates or actions recorded on the incident log regarding this incident. We were not supplied with the RCA.
- One incident showed a patient with chest pain had not been reviewed by a doctor for 18 hours after admission. We asked for but were not provided with a report of this incident.
- None of the incidents relating to staffing appeared to have been addressed. We saw one report where the site manager insisted on moving two patients before the ward was ready and this placed the patients at risk because one had a history of diarrhoea and one required oxygen but could not have it as they were held in the corridor until the bay they were going to had been deep cleaned.
- We were told that Mortality and morbidity (M&M) meetings were held monthly to review the care of patients who had had complications or an unexpected outcome, to share learning and inform future practice. Recent examples included the death of a patient in the ED who was receiving end of life care in a hospice. The department's response included discussions with the hospice and the junior doctor involved in the decision.
- The minutes of the Urgent Care Clinical Governance Group showed a different picture. There was a lack of clarity about where responsibility for M&M sat with the clinical governance representative saying it was not their job and acknowledgement that the M&M reviews were not being entered onto the database.
- There was also concern identified that the consultants reviewed deaths from their own patients and acknowledgement that this would not stand up to external scrutiny.
- There were several incident reports on the electronic incident reporting system that related to incidents of staffing shortfalls. The trust was unable to tell us how many shifts had been worked with below the planned staffing levels so was not effectively mitigating against this risk and was not taking effective measures to minimise recurrence.
- There were several incidents on the incident log that demonstrated a significant impact of low staffing levels.

For example one incident related to low staffing levels was recorded in February 2015 stated that this resulted in a patient falling in one cubicle and a patient collapsing in another cubicle. There was no recorded action or investigation of this incident.

- Breaches of compliance with the guidance on mixed sex accommodation for patients were not recorded as incidents because the staff did not recognise them as such. Locally staff tried to minimise the impact but this was based on intuition rather than a planned, central response to the incidents.

Cleanliness, infection control and hygiene

- The department was clean and tidy. A labelling system was in use to indicate that an item had been cleaned and was ready for use. The equipment we looked at was clean.
- The treatment areas had adequate hand-washing facilities. We observed staff washing their hands between seeing each patient and using hand sanitising gel. The 'bare below the elbows' policy was observed by all staff.
- We observed that staff complied with the trust policies for infection prevention and control. This included wearing the correct personal protective equipment, such as gloves and aprons.
- Side rooms were available for patients presenting with a possible cross-infection risk.
- The trust's integrated performance report for December 2014 showed 75.1% of staff working in urgent care had attended infection control training against the trust's target of 85%.
- Information requested from the trust showed monthly hand hygiene audits for A&E demonstrated 100% compliance between September 2014 and March 2015.
- We requested hospital acquired infection rate data for the ED (C.Diff, MRSA) broken down by month. The trust told us that there had been no cases of trust attributable C.Diff or MRSA Bacteraemia during the period between the two inspections.
- We requested infection control audits including environmental assessment, undertaken since 1 October 2014. The trust provided us with information that showed poor compliance with the National Specification for Cleanliness in the NHS. At Conquest Hospital the auditing was not carried out at the correct frequency for a very high risk area with 5 completed audits against a target of 36 in January 2015. The scores for the key indicators were low, particularly in areas where nursing staff had responsibility rather than housekeeping staff. The audits continued to show poor compliance across the period the audits that were provided covered with no evidence of improvement.

Environment and equipment

- We found improvements in the environment of the ED since our last inspection. The capacity of the department was increased recently when the existing clinical decisions unit moved to a newly created area adjacent to the ED. This created a further seven bays to accommodate patients. The main treatment area within the ED had five spaces for treating major cases and seven spaces for treating minor cases, which include two rooms for isolation or privacy and a two-bed bay for treating ear, nose and throat (ENT) or eyes.
- There was a designated paediatric bay which could be accessed via the waiting room but no designated paediatric triage.
- There was sufficient seating in the waiting room and reception staff had a direct line of sight of most of the area.
- The triage area was a curtained bay in the waiting room.
- There was an emergency nurse practitioner's room off the waiting area.
- The resuscitation area had three adult bays and a bay designated for the resuscitation of children. This contained a wide range of equipment so that patients of all ages could be immediately resuscitated. We checked a range of equipment, including resuscitation equipment, which was accessible and fit for purpose. Equipment was clean, regularly checked and ready for use.
- There was a small x-ray department within the department. Facilities for CT scanning were easily accessible along an adjoining corridor.
- A room identified for accommodating patients presenting with mental health needs was not fit for purpose. We identified ligature points and loose objects, including furniture, which could be thrown and therefore posed a risk to staff and others in the immediate vicinity. The room had one door and was adjacent to the relatives' room. Nursing staff told us this was used for interviewing patients only and patients would not be left alone in the room.

- There was a dedicated ambulance entrance and an area to accommodate a handover of patients arriving by ambulance.

Medicines

- Medicine safety had improved since our last inspection in September 2014.
- The department used an automated system to store medicines securely and at recommended temperatures throughout the ED. Staff dispensing medication were identified by their fingerprint. Fingerprint ID of two staff was required to dispense controlled drugs. Stock levels were monitored electronically and managed centrally by the hospital's pharmacy.
- Medicine administration records were completed accurately in the patient records we looked at.
- On one occasion we observed the door to the storeroom containing intravenous fluids was left ajar which increases the risk of IV fluids being tampered with or contaminated. A member of staff noticed it open and locked it.

Records

- The department had a computer system that showed how long patients had been waiting, their location in the department and what treatment they had received.
- A paper record (referred to by departmental staff as a 'CAS card') was generated by reception staff registering the patient's arrival in the department to record the patients' initial assessment and treatment. All healthcare professionals recorded care and treatment using the same document.
- An 'integrated patient care' document was implemented for patients in the CDU, or where admission to the hospital was anticipated. The document was clear and easy to follow. There was space to record appropriate assessments, including an assessment of risks, investigations, observations, advice and treatment and a discharge plan.
- We looked at the care records of ten patients and found they were completed.
- The trust's integrated performance report for December 2014 showed 62.6% of staff working in urgent care had completed information governance training against a trust target of 85%.

Safeguarding

- Information requested from the trust showed 82.9% of medical and nursing staff working in the ED had completed training in safeguarding children at level 2.
- Information provided by the trust subsequent to the inspection showed that 11 registered nurses had completed level 3 safeguarding children training and a further 33 registered nurses had not. None of the staff recorded as 'additional clinical services' had completed the training. The recommendation made in the intercollegiate document, Safeguarding Children and Young People; roles and competencies for healthcare staff is that all clinical staff who are working with children, young people or their families should have completed level 3 training.
- There was no system in place to ensure that children attending the department were always cared for by a registered nurse with level 3 safeguarding children training.
- 45.5% of senior ED medical staff (speciality registrar and above) had undertaken training in safeguarding children training at level 3, which means the trust cannot demonstrate they meet the recommendation that all senior emergency medicine (EM) doctors (ST4 and above) are trained in safeguarding children at level 3 as a minimum.
- Staff had access to patients' previous attendance history and to the child risk register**.** Electronic flags identified children 'at risk' when they booked in.
- The ED had a further paper system to support child safeguarding which consisted of giving parents a safeguarding sheet to complete. We found these forms were missing when we checked children's notes.
- ED staff were represented at a weekly multidisciplinary child safeguarding meeting.
- The ED had a nominated lead consultant and nurse responsible for safeguarding children.
- Information requested from the trust showed 69% registered nurses working in the ED had completed training in safeguarding vulnerable adults at level 2.
- Nursing, medical and ancillary staff spoken with were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns.

Mandatory training

- At our last inspection in September 2014 we found the ED's compliance with mandatory training required improvement. There was limited evidence that this had

been achieved. For example, the trust's integrated performance report for December 2014 showed 66.4% compliance with manual handling training, 54.5% compliance with health and safety training and 74.9% compliance with fire safety training for staff working in urgent care. These figures were slightly better than in September 2014, but were still short of the trust's own rolling target of 85%.

- Information from the trust demonstrated 72.4% nursing staff had current BLS, APLS or PILS training. This was not separated into adult and child life support training rates, nor was it separated by hospital site; it showed overall compliance levels that fall short of the trust target and national recommendations that all staff complete basic life support training.
- The trust did not provide us with data separated by location, as requested. This limited the opportunity for effective governance and monitoring that could identify specifically where the service was falling short of the target.
- Since September 2014 11 staff had completed PILS training including several healthcare assistants. PILS is a level 3 course designed to allow staff to understand roles and responsibilities in the management of paediatric peri-arrest, cardiac arrest and post arrest situations and not appropriate for healthcare assistants, according to Resuscitation Council Guidance.
- The trust provided us with data that showed that mandatory training completion rates by junior doctors was good.

Assessing and responding to patient risk

- Patients arriving by ambulance as a priority (blue light) call were transferred immediately through to the resuscitation area, or to an allocated cubicle space. Such calls were phoned through in advance, so that an appropriate team could be alerted and prepared for their arrival.
- Other patients arriving in an ambulance were brought into an area adjacent to the workstation in majors where the designated nurse in charge took a 'handover' from the ambulance crew. Based on the information received, a decision was made regarding which part of the department the patient should be treated. Once transferred to a treatment bay, baseline observations were carried out and a triage category was calculated.
- Babies under a year old who were brought to the hospital by ambulance were taken immediately to the ward to be seen by paediatricians.
- In the training records provided by the trust, there was no evidence that any staff were provided with any training in managing a deteriorating child.
- Where ambulance staff had alerted the department that they were arriving with a child needing resuscitation, staff from the children's ward attended where possible.
- We observed National early warning score (NEWS) and paediatric early warning score (PEWS) were used appropriately for in the department.
- However, The minutes of the November governance meeting reported a patients death where failure to escalate a deterioration in the patients condition was identified as contributory to the death.
- There was also a recorded claim in the February governance minutes which showed that a diabetic patient had received a substantial sum as compensation because their condition had not been monitored effectively.
- The trust consistently met the target to receive and assess ambulance patients within 15 minutes of arrival in the 12 months leading up to October 2014.
- The first point of contact for self-presenting patients was the receptionist who recorded their details and a brief description of their reason for attending the department.
- Patients were called into the triage room for assessment by a nurse. The A&E used the Manchester triage guidelines which helped to determine the severity of the patient's injury or illness. This was reflected on the department's electronic system ('Symphony'), but triage priority was not recorded on the patients' ('cas card') notes. Subsequent nursing intervention may not have access to this important information.
- The time to treatment time for all attendances was consistently better than the national target of 60 minutes.

Nursing staffing

- High levels of absence due to sickness coupled with on-going vacancies meant there was not always enough nurses on duty in the ED to care for patients safely given the acuity of patients and the extended geographical layout of the department.
- We requested information about the ED's bank and agency use for nursing staff in the year to date and were

provided with information that showed the annual spend on bank and agency staff was 10.7% of the department nursing budget. We were not provided with information about the frequency with which shifts were covered by bank and agency nurses.

- The nursing establishment for the ED trust wide was: 86.6 WTE at Band 5 and above. The vacancy rate for ED nursing staff at Band 5 and above was 5.6%
- On a typical 24 hours in the department, the general manager for urgent care told us the trust planned for the following number of nurses on duty:
  - 10 registered nurses (RN), one emergency nurse practitioner (ENP) and six health care assistants (HCA) between 7am and 7pm.
  - 8 RN and 4 HCA between 7pm and 7.30am
  - An additional ENP between midday and half past midnight.
  - The skill mix for each shift included band 7 sister/ charge nurse grades, who were in charge of the shift, with band 6 and band 5 nurses and healthcare assistants (HCA). Staff were allocated to specific areas of the department for their shift, but could be moved around if one area became busier than another. The department had been extended since our last inspection in September 2014 to include seven extra bays in what used to be the CDU. This area was adjacent to the existing minors/majors area, but senior nursing staff told us they used it 'flexibly' because it diluted the numbers of nursing staff when in use.
- We observed a (pre-alert) patient with a reduced conscious level in resus with a student nurse and ED consultant and no trained nurses until another self-presenting patient with chest pain was brought into the area 10 minutes later accompanied by two trained nurses.
- Although the trust reviewed hospital nurse staffing levels in December 2014, A&E and CDU were not included in the exercise but awaiting National Institute of Clinical Excellence (NICE) guidance, which was published in February 2015.
- Nursing staff said the department often worked short of nursing staff in the event of short notice absence, for example, due to nurses 'phoning in sick'. We were told it was not always possible to get replacement bank or agency staff at short notice. We asked the trust for specific information about how frequently the department worked 'short' of nurses; they told us that they were unable to provide this information.
- We asked for copies of the rota for the month preceding the inspection visit and for the percentages of ban and agency staff being used. The rotas for nursing staff were not supplied and the percentages were shared as a percentage of the budget rather than related to the staffing levels.
- The trust's integrated performance report for December 2014 demonstrated an annual sickness rate of 5.1% for staff working in Urgent Care. This compared unfavourably to the trust's overall annual sickness rate of 4.8%.
- Between September 2014 and February 2015 the sickness rate (trust wide) amongst registered nurses in ED varied between 2.0% and 5.9% with a six month average of 4.4%. Unqualified nursing staff had a higher sickness rate with a six month average of 10.4% for the same period and a peak in January 2015 of 12.2%.The combined average for all nursing staff is 6.1% which was higher than the annual rate for the Urgent Care Directorate and 2.7% higher than the trust average.
- The staffing data provided by the trust were not split such that we could see the site level figures, as requested. This limited the opportunity for managers to effectively monitor the levels by location and so identify any areas of particular concern.
- The rate of turnover for nursing staff amongst registered nurses in the ED trust wide in the last 6 months was 5.5%. This compared favourably to the trust wide annual turnover of 13.5% for nursing and midwifery staff.
- Three paediatric nurses were employed in the department at Conquest Hospital; however one nurse was on maternity leave and another had been seconded to a post at Eastbourne Hospital. This meant Conquest Hospital did not meet the Standards for Children and Young People in Emergency Care settings standard for at least one paediatric trained nurse to be on duty over 24 hours. This was included as a moderate risk on the Urgent Care Risk Register and partially mitigated by staff attending the paediatric module in either emergency care or assessment (continued on a rolling programme) and having the fully functioning paediatric unit at the Conquest providing support where needed.

Medical staffing

Urgent and emergency services

- We were told whilst on site that consultant cover was provided daily from 8am until 7pm on weekdays and for six hours on Saturday and Sunday with an on-call rota for outside of these hours but it was not clear from the rotas provided by the trust that this was the case.
- The trust provided us with copies of the rota when requested to provide evidence of the actual medical cover for the month preceding our visit in March 2015. For the weeks beginning 16 march 2015, 9 March 2015 and 2 March 2015, there was no consultant rostered to work over the weekend. There was a single on call consultant for the entire period.
- The rotas also showed that there was consultant presence in the unit from 9:00am until 5:00pm which was less hours than we were told and only half the recommended time there should be consultant presence within the ED.
- At times there was only one consultant in the ED during the day.
- The trust did not meet The College of Emergency Medicine (CEM) recommendation to provide cover 16 hours of consultant presence a day, 7 days a week. The trust had not improved the provision of consultant cover since our inspection in September 2014.
- In September 2014 the trust's risk register identified there were insufficient consultants to provide staffing levels and extended hours cover in line with the College of Emergency Medicine recommendations. The trust recognised this would compromise senior decision making which could negatively impact the patient's pathway of care. At this inspection we found the trust continued to identify this as a high risk, but has made no progress against the objectives to recruit more consultants.
- 15% of the 39 WTE medical staff employed by the trust were consultant grade compared to the England average of 23%. This equated to a consultant establishment of 5 WTE, of which 3.5 WTE consultants were in post.
- We discussed medical shift patterns with a middle grade doctor, FY2 doctor and a consultant. They told us two consultants worked 8am to 7pm, although they often stayed longer; sometimes until 10pm. One consultant was 'on call' overnight. Weekend consultant 'on call' was for 48 hours, with a 'shop floor presence' of six or more hours each day.
- The rotas that we were provided with by the trust did not support the consultant presence we were told about by the medical staff we spoke with. The rota showed three consultants worked from 9am to 5pm.
- The rotas showed gaps in the medical staff cover. On Monday 2 March there were three consultants rostered to provide cover from 9am-5pm but the were gaps in the staff grade and SHO cover. From 8am-9am, for example, the rota showed a single staff grade doctor and 1 SHO on duty in the ED. On 4 March 2015 there was only one consultant on duty during the day.
- At the weekend the rota provided by the trust showed no consultant presence but an on call consultant. On Saturday 7 March the rota showed one staff grade doctor from 8am - 2pm and 2 locum SHOs as the staff in the department during the morning.
- The registrar rota was four 8-hour shifts during the day (with staggered starting times at 8am, 10am, 2pm, 4pm) plus one 10pm to 8am shift. On the weekends there were three 12 hour shifts 8am, 11am and 8pm.
- The SHO rota covered 24 hours a day with shifts: 8am to 5pm, 10am to 7pm, 6pm to 4am and 10pm to 8am.
- We asked the trust for specific information to confirm the establishment for medical staff in the department (which grades of staff for how many hours in each 24hr period. The rotas provided were unclear, with numerous changes which made it difficult to determine exactly who was working when.
- We asked the trust to provide information about how frequently the department worked with less than the planned complement of doctors and we asked for a copy of the actual duty rota worked in the last full calendar month before this inspection. We were provided with copies of rotas that showed that the department frequently operated with less than the planned medical staffing levels. We saw shifts where the department was staffed entirely by locum doctors and with no consultant cover. Locum doctors included staff, middle and junior grade doctors.
- In the week beginning 16 March 2015 the rotas showed that there were three days when there was less than the planned consultant cover for the ED and four days where the other medical staffing fell short of the planned levels.
- In the week beginning 2 March 2015 there were three days when there was less than the planned consultant cover and three days when the other grades of doctors were below the planned levels.

- There was no evidence on the rota that the consultants worked in the ED at weekends.
- We asked the trust for details of locum usage in the ED in the year to date. The trust told us that 13.6% was spent on locum staff but did not provide us with figures about the actual number of shifts covered by locum medical staff.
- The trust did have a generic Induction Planner Tool to support the local induction of locum staff. Information from the trust said, "The induction process for locums follows the trust induction policy and procedure which is available on the Trust extranet guided by the Locum Induction Planner. We aim to use locums that are known to us and are hence familiar with the working environment and clinical systems. New locums in the daytime are met by the consultant and then given a tour of the unit and made aware of the key areas by a middle grade. The workings of the bleep and emergency systems are also highlighted as well as the location of guidelines on the intranet. We try to avoid having a new locum for the first time at night . If this is necessary they are asked to attend prior to the shift and meet with the consultant or registrar for a similar induction."

Major incident awareness and training

- We looked at the trust's Major incident plan which was reviewed and revised since our last inspection in September 2014.
- The trust's annual business plan December 2014 update indicated major incident training would be planned for staff. Information requested from the trust showed 32.7% staff working in the ED (including administration staff) had completed the training.
- Decontamination equipment was available to deal with casualties contaminated with chemical, biological or radiological material, or hazardous materials and items (HazMat).
- We requested information about numbers staff working in the ED who have attended HAZMAT training and the frequency of training updates. We were provided with this and saw that the more nursing staff than medical staff had completed training.
- SIA licensed security staff were contracted by the trust. They patrolled the A&E department regularly.
- The department was secure. An electronic 'swipe' card was needed to enter the locked doors of the treatment area. The door adjacent to the reception desk did not have an electronic lock but we found it was manually locked by staff. There was no facility to electronically lock down the department to isolate it in the event of an untoward incident as some doors had manual locks.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

The ED provided effective care and treatment.

Staff followed accepted national and local guidelines for clinical practice. The department had developed a number of pathways to ensure that patients received treatment focused on their medical needs. The pathways were revised annually to ensure current practice.

The trust participated in National College of Emergency Medicine audits so that they could benchmark their practice and performance against best practice and other A&E departments.

There was a multidisciplinary, collaborative approach to care and treatment that involved a range of health and social care professionals.

Patients were given timely pain relief although pain scoring tools were not consistently used.

Evidence-based care and treatment

- The department used a combination of the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment they provided and a range of clinical care pathways had been developed in accordance with this guidance. Relevant guidance was collated in the trust's local ED handbook.
- We spoke with the joint clinical lead for Acute and Emergency medicine who showed us the trust's junior doctors' handbook (a separate document to the ED handbook) which described the management of the most common acute medical conditions and the protocols and guidelines endorsed by the medical director. We did not see the book in use.

- We observed clinical pathway diagrams showing the decision points and routes of care for the most common conditions such as acute headache and Chronic Obstructive Pulmonary Disease (COPD)
- Specialities had access to care bundle/pathway documentation for some conditions, such as fractured neck of femur and sepsis.
- We saw guidelines for admitting patients to the clinical decisions unit.
- Comprehensive antimicrobial guidelines were available.
- We saw current ALS guidelines clearly displayed in resus along with criteria for a trauma call.

Pain relief

- The trust performed about the same as other trusts in the CQC A&E survey responses to effective pain management.
- We observed that an assessment of pain undertaken on a patients' arrival in the department. All of the patients we spoke with told us that they were offered and/or provided with appropriate pain relief. Patients' records confirmed this.
- Age appropriate pain scoring tools were used in the department; a score was recorded in 50% of the records we looked at. We found no improvement in the inconsistent use of pain scoring tools evidenced during our inspection in September 2014.
- We did not see any patient displaying verbal or non-verbal signs of pain during our inspection that was not being addressed by the staff.

Nutrition and hydration

- We observed staff providing drinks and snacks to patients during our inspection.
- The integrated patient care documentation booklet provided staff with a prompt to carry out a nutritional risk assessment using the malnutrition universal screening tool (MUST).
- Following the assessment of a patient, intravenous fluids were prescribed and recorded, as appropriate.

Patient outcomes

- The mortality rates for the trust shown in CQC intelligence monitoring did not raise any cause for concern during the national monitoring process in December 2014.
- Conquest Hospital participated in the RCEM 2014/15 National Audits of the Initial Management of the Fitting Child , Mental Health in the ED and Assessing for Cognitive Impairment in Older People.
- Results for the audits showed that the department did not meet the RCEM targets in the majority of the audits participated in and fell below the median for all participants for many standards.
- It did perform better than other departments nationally in the management of paracetemol overdose audit 2014-2014.
- In the Assessing for Cognitive Impairment in Older People Clinical Audit 204- 2015 the department missed the fundamental target that required all elderly people to have an Early Warning Score recorded at least once. The ED scored 77% against a target of 100% and a national median of 82%. For standard 3 of this audit (relating to communicating findings with relevant services) the trust scored 8% against a national median of 83% and a target of 100%.
- In the Mental Health in the ED Clinical Audit 2014 - 2015 Conquest Hospital scored above the national median but below the target for each standard.
- In the Asthma in Children Clinical Audit 2013 - 2014, Conquest Hospital scored particularly poorly on standards which were time critical. It was just below the median for patients who had their respiratory rate measured in the ED (89% compared to benchmark of 98%) but was in the lowest quartile for targets to record oxygen saturation level and respiratory rate within 15 minutes of arrival in the department.
- Overall the ED performed poorly on the severe sepsis and septic shock audit 2013-2014. Performance against some key standards was poor. The percentage of patients administered high flow oxygen within 1 hour or 2 hours of arrival in the ED was 2%. The number of patients having a serum lactate level recorded at any time was 64% against a RCEM target of 100% and a national average of 84%.
- The department participated in local audits; examples included care and treatment around paracetamol overdose and aneurysmal subarachnoid haemorrhage. We do not have the results of these audits.
- The A&E department did not meet the national standard relating to the rate of unplanned re-attendances (January 2013 to May 2014) and performed worse than the England average.

Urgent and emergency services

- In the 12 months up to September 2014 and the unplanned re-attendance rate to the ED within seven days was consistently between the England average (7% - 7.5%) and the CEM standard (5%).
- In the year to date the attendances resulting in admission (20.7%) were slightly less than the national average (21.9%).

Competent staff

- Children requiring specialist paediatric services were treated by paediatric doctors from the children's ward; this service was always accessible to A&E staff. Children under 1 year old were streamed directly to the paediatric ward unless they required immediate life support.
- Information from the trust demonstrated 60.9% registered nursing staff in the ED had received an appraisal. This was the lowest performance for appraisal amongst directorates within the trust.
- The trust's integrated performance report for December 2014, showed the medical appraisal status for clinical staff in the trust was between 81 and 88%.
- Junior doctors told us they were well supported and had weekly training sessions.

Multidisciplinary working

- Medical and nursing staff worked across A&E with other specialists and therapy staff to provide multidisciplinary care. We observed team working between medical and nursing staff throughout our inspection.
- The trust's Hospital Intervention Team, consisting of a nurse, physiotherapist and occupational therapist provided a seven day service to promote discharge with appropriate support. The team assessed patients who required packages of care or specialist equipment.
- The A&E was well supported by the adjacent radiology department for X-ray and most requested CT scans were performed within one hour.
- Staff had access to the mental health crisis team to assess and treat patients with acute mental health needs, 24 hours a day.

Seven-day services

- All areas of the A&E department were open seven days a week. Support services were also available seven days a week including for example x-ray, scanning and pathology.
- Physiotherapists and occupational therapists offered a seven day service to patients.
- An ED consultant 'on call' rota was available to support out of hours and seven day working.
- Middle grade doctor presence in the department was available all of the time.

Access to information

- The department had a computer system that showed how long patients had been waiting, their location in the department and what treatment they had received.
- A paper record (referred to by departmental staff as a 'cas card') was generated by reception staff registering the patient's arrival in the department to record the patient's personal details, initial assessment and treatment. However, this document was not fully aligned with the electronic records system throughout the patient's pathway. This created potential for information necessary for the care of the patient (such as details of the initial assessment) to be missed and created a risk that an unexpected deterioration in in the patient's condition might be missed.
- All healthcare professionals recorded care and treatment using the same document.
- Staff could access records including test results on the trust's computerised system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed patients being asked for verbal consent to care and treatment. Patients told us that interventions were explained in a way that they could understand before they were carried out.
- The trust's integrated performance report for December 2014 showed 83.6% staff working in Urgent Care had completed Mental Capacity Act (MCA) training against a trust target of 85%.
- We found no improvement in the way patients' capacity and best interest decisions were recorded since our last inspection in September 2015. Staff we spoke with were clear about their responsibilities in relation to gaining consent from people, including those people who lacked capacity to consent to their care and treatment but patients' capacity and any best interest decisions were not recorded in the four patient records we looked at where it was very clear the patient lacked capacity to make some decisions at the time they were in the department.

Urgent and emergency services

- We saw appropriate mental health referral practices.
- The trust used privately contracted security staff. We spoke with security staff about their role in the ED. They described the supervision of patients presenting with challenging behaviours, such as those intoxicated by substance misuse and patients with mental health need.
- Security staff received training in control and restraint under their Security Industry Authority (SIA) licences for 'manned guarding', 'door supervision' or 'security guard' (SIA is the organisation responsible for regulating the private security industry in the UK). We requested information about training for security staff for the patient groups they worked with in A&E (i.e. restraint, conflict resolution, MCA/DoLS and safeguarding outside of their SIA licences to support them to deal with vulnerable patients. The trust had not provided the information at the time of writing the report.
- We requested information about the number of Deprivation of Liberty Safeguards (DoLS)applications and authorisations in the year to date. The trust had not provided the information at the time of writing the report but our records showed that the number of urgent applications for DoLS notified to CQC was below the comparative level when measured against similar sized departments.

Are urgent and emergency services caring?

Good

The ED provided a compassionate and caring service.

Patients felt that they were listened to by health professionals, and were involved in their treatment and care. Staff treated patients with respect. Patients and their relatives and carers told us that they felt well-informed and involved in the decisions and plans of care. Staff respected patients' choices and preferences and were supportive of their cultures, faith and background.

Compassionate care

- The trust's integrated performance report in December 2014 showed the scores from the NHS Friends and Family Test (FFT) in ED were lower than the target of 46 for six out of the nine months, ranging between 37 and 54. The target of 46 was below the England average for the same period.
- Throughout our inspection of the ED, we observed staff treating patients with compassion, dignity and respect. Patients' privacy was respected by curtains being drawn when personal care was given. Staff lowered their voices to prevent personal information being overheard by other patients.
- During our inspection, demand for beds increased it was necessary to declare an internal incident (code black) across both trust sites. It was commendable that despite the extra pressure put on all staff during this period, patients and relatives told us staff continued to be caring and compassionate.
- Patients responding to the CQC A&E survey 2014 said they were treated with respect and dignity while they were in the A&E department, which was about the same as other trusts nationally.
- The patients and relatives we spoke with during our inspection were positive about the way staff treated them. Their comments included:
  - "Nursing staff and consultants are all very helpful."
  - "I've been treated pretty good. Staff are mixed; some extremely good, some not."
  - "The primary problem is the nurses have too much to do."

Understanding and involvement of patients and those close to them

- Patients responding to the CQC A&E survey 2014 said they were given information about their condition or treatment and they felt involved in decisions about their care, which was about the same as other trusts nationally. However, the trust performed worse than other trusts nationally when asked about relatives being given an opportunity to talk to a doctor if they wanted to.
- Patients and relatives told us that their care and treatment options were explained to them in way they could understand.
- Since October 2014, Urgent Care recorded nine complaints about staff attitude and five complaints about communication.

Emotional support

Urgent and emergency services

- We spoke with staff about caring for the relatives or others close to them when patients died in the department. They said family members were taken to the relatives' room to be informed of the death in private. Where possible, relatives were given the opportunity to spend time with the deceased person if they wished to.
- We observed staff giving emotional support to patients and their families. Staff made use of the designated relatives' room so that people had privacy when they were receiving upsetting news about their relatives' condition.
- Staff had access to the hospital's chaplaincy service and could request support when needed.
- Timely assessment and support was generally available for people presenting with mental ill health as mental health practitioners were based on site.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement

The ED required improvements in the way services are organised and delivered so people's individual needs are met.

The facilities and premises did not always promote people's privacy, dignity and confidentiality. It was accepted practice for male and female patients to share toilets and overnight sleeping accommodation in the Clinical Decisions Unit (CDU). The trust was not following the guidance from the Department of Health in respect of single sex accommodation; this had been pointed out following our September 2014 inspection but the situation persisted.

Facilities for children in the ED were not meeting the standards set by the Royal College of Paediatricians and Child Health. There were insufficient treatment areas for the number of children seen and those that were available were not reserved for use by children.

Facilities for bereaved relatives or those with a critically ill relative in the department required improvements.

There was good support for people with mental health needs from a specialist mental health trust working in partnership with staff at Conquest Hospital but the facilities for caring for people who were very agitated or distressed were not appropriate or secure.

Staff in the ED were using relatives for interpreting despite the trust having access to professional interpreting services.

The flow of patients from the department into other parts of the hospital was generally good which meant patients were transferred to areas treating their speciality and were not accommodated in the A&E for longer than necessary.

Complaints about the ED were responded to in a timely manner.

Service planning and delivery to meet the needs of local people

- Capacity in the department had increased since our last inspection in September 2014 with the change of use of the existing Clinical Decisions Unit (CDU) to create an additional seven bays in the major/minors area. This relieved some of the capacity issues we found in September 2014. A new seven bedded CDU had been created adjacent to the majors/minors area.
- At our last inspection in September 2014 we were told the trust had a capital bid with the Trust Development Authority (TDA) for expansion by December 2014 with plans for building work to commence before March 2015. The general manager told us the trust continued to wait for planning permission to extend the department buildings.
- An agreement was in place an ambulance trust to cohort patients in a designated area with trust staff providing senior assessment if the delay is greater than 30 minutes. However, NHS England winter pressures daily situation reports (SITREP) data for the trust between 3 November 2014 and 29 March 2014 showed there were zero occurrences when ambulances waited more than 30 minutes to hand over. This was better than other trusts nationally.
- A mental health liaison team provided by another provider who had an office based in the ED at Conquest hospital. They had a presence on site at the hospital between 8 am and 8 pm Monday to Friday. ED staff could refer patients to the mental health crisis team, who were based nearby, during the night. Delays for

patients attending A&E who required specialist input from the Mental Health team was identified as a high risk on the Urgent Care risk register. This was because patients were very often anxious or agitated and may wait long periods of time before they were seen by the mental health team, which may compromise their quality of care and the wellbeing of staff and of other patients in the department.

- The Intercollegiate Standards for Children and Young People in Emergency Care Settings recommend at least one clinical cubicle or trolley space for every 5,000 annual child attendances is dedicated to children. Conquest had 10,872 child attendances in 2013/14. One cubicle in the minors area of the department was allocated for paediatric use. In practice, although the area was prioritised for children, it was sometimes used for adults when capacity was an issue.
- The Intercollegiate Standards for Children and Young People in Emergency Care Settings recommend young people have access to quieter waiting and treatment areas, and age-appropriate games, music or films. The department had a separate children's waiting room within the main waiting area. However, it did not allow staff a direct line of sight to waiting children. This meant that the condition of patients waiting to see a doctor could deteriorate without staff being aware of it. We observed two children waiting in the main waiting area.
- Patients who attended the department spoke many languages. Most went to the hospital with a family member who acted as an interpreter. This is recognised as not good practice. Telephone translation services were available for patients for whom English was not their first language and some staff spoke more than one language. Patient information and advice leaflets were available in English, but were not available in any other language or format. During the inspection visit we did not see any staff offering to provide an interpreter despite this being trust policy.

Meeting people's individual needs

- During our last inspection we identified on-going, daily mixed sex breaches in the Clinical Decisions Unit (CDU) because the trust did not recognise this accommodation as breaching the guidance. It accommodated up to seven patients in seven curtained bays.
- Trust guidelines for the CDU indicated a maximum 24 hour stay. An audit of length of stay in the CDU undertaken by the HIT team showed extended lengths of stays for some patients between October and December 2014. Between 13% and 32% of patients were in the CDU for 24-48 hours; between 2% and 12% patients were in the CDU for 48-72 hours and between 1% and 4% patients were in the CDU for in excess of 96 hours.
- The CDU was divided into two areas; one with three cubicles and a toilet and one with four cubicles and a toilet. We observed male and female patients accommodated together in both areas. We looked at the CDU admission register which recorded patients' admission times to the CDU. The register demonstrated that male and female patients were admitted to the areas before midnight and had shared sleeping accommodation in these areas overnight. This arrangement did not comply with standards set out by the Department of Health's Chief Nursing Officer in 2009.
- There appeared to be an acceptance of mixed sex accommodation in the CDU. Nursing staff told us they, "Do their best" to avoid mixed-sex accommodation by separating male and female patients but said they did not complete an incident report or keep a local record of any breaches. The trust's integrated performance report for December 2014 recorded no breaches of mixed-sex accommodation in the CDU. The general manager for Urgent Care told us mixed sex breaches were identified and reported at midnight by the clinical site manager. We requested information about breaches and were given assorted lists showing nil returns. No breaches were recorded for the CDU.
- We observed male and female patients being cared for together in the CDU. On 24 march 2015 one side of the CDU was accommodating one man and two women. On the other side of the unit a man and a woman were being accommodated.
- The arrangements for consulting with patients did not always maintain their privacy and dignity. For example, confidential conversations between staff and patients could be heard by people sitting on the chairs nearest to the triage bay. Patients who self-presented in the department had to book in with the receptionist who sat behind a glass screen. Patients were required to give details of their symptoms. This area was part of the main waiting room and people could easily be overheard.

Urgent and emergency services

- There were Dementia Friends Champions identified among the nursing staff to offer training support and advice to other staff in the department to support the needs of people living with dementia.
- Staff had not received training in meeting the needs of people with learning difficulties; however, staff spoken with were aware of 'passports' which included details of a patient's health and care needs, so that staff could provide prompt and appropriate care and treatment in an emergency. We observed sensitive and appropriate responses from staff when a patient with learning difficulties arrived in the ED with their carer.
- We looked at the relatives' room where people waited while their seriously ill relatives were being cared for, or where people were informed that a relative had passed away. It was unwelcoming; the walls were scuffed and flooring in the room and toilet area was stained.
- The trust scored about the same as other trusts in the 2014 A&E patient survey about whether patients were given enough privacy during discussions with the receptionist and during examinations and treatment.
- The wall mounted visual display unit informing patients of waiting times was missing. Nursing staff said it had been damaged during an untoward incident in the week before our inspection. We were not made aware of any mitigation to address this.
- The room available for private and quiet discussions with relatives was unwelcoming, with stained flooring in the sitting area and toilet and was adjacent to the interview room for patients with mental health needs.
- There was no designated area for relatives to spend time with their loved one in the event of their death. This took place in bays or a side room if available.
- There were no secure areas where high-risk mental health patients could be accommodated. The interview room was used solely for the purpose of undertaking psychiatric assessment and patients were not left there unsupervised. Patients who were at risk of harm or at risk of absconding were cared for in the majors area where they were supervised closely. Staff told us that additional nursing staff or security staff could be called to assist with patient supervision and to prevent them from absconding.

Access and flow

- The flow of patients from the department into other parts of the hospital was generally good and was facilitated by a number of pathways the trust had put in place to ensure that patients spent as little time as possible in the department or bypassed it altogether. For example, the hospital had both surgical and acute assessment units and patients could be referred directly to one of those without needing to go to A&E.
- Information from the trust demonstrated the month on month average patient 'time to treatment' was usually less than 60 minutes since October 2014.
- The trust was not consistently meeting the four hour target for admission with some months being well below the target. Despite this, the trust performed better than the England average for patients waiting less than four hours to be admitted, transferred or discharged Between October 2014 and December 2014 (Q3) 92.9% patients waited less than four hours to be admitted, transferred or discharged against the England average of 92.6%. Between January and March 2015 (Q4) 92% patients waited less than four hours to be admitted, transferred or discharged against the England average of 91.2%.
- The trust consistently performed worse than the England average for the total time (average per patient) spent in A&E.
- The percentage of patients leaving the department before being seen is recognised by the Department of Health as potentially being an indicator that patients are dissatisfied with the length of time they are having to wait. The number of patients leaving before being seen in the 12 months up to February 2015 ranged between 0.5 and 2.5%. The trust consistently performed better than the England average.
- The percentage of emergency admissions via A&E who waited between four and 12 hours from the decision to admit until being admitted was consistently better the national average (month by month for the year ending January 2015).
- The trust had an escalation plan needed to be followed if the demand for beds increased. This covered the normal steady state (green) and escalated to the declaration of critical status (black) when the trust is unable to provide a safe level of care due to lack of capacity. A critical (black) status was declared during our inspection due to a lack of capacity in the trust.

Learning from complaints and concerns

- Information about how to complain was displayed in the department. Information leaflets were available to

all patients. They contained helpful information about how to access the Patient Advice and Liaison Service (PALS) and how to make a complaint. The department followed the trusts complaints policy.
- Informal complaints could be received by any member of the team. These were dealt with by the most appropriate person. Staff were aware that if they could not resolve an issue they should advise the patient/ relative how to use the formal complaints policy.
- Information received from the trust showed 52 complaints were received by the Acute and Emergency Medicine division across both sites since October 2014. The top areas of complaint were care (27), attitude (9), pathways (8) and communication (5). The ED at Conquest hospital had received 27 complaints during this period.
- The trust's complaints report for 2013/14 complaints showed the trust responded to complaints in a timely manner, with 86% responded to in time.

Are urgent and emergency services well-led?

Requires improvement

The ED required improvements to leadership and culture so the delivery of high quality, person centred care is supported.

The management of risks in the ED need to be strengthened to support the delivery of safe and effective care. The ED has not responded to the breaches of regulation identified at the inspection of September 2014 which means patient experience has not been improved.

The arrangements for governance and performance management do not always operate effectively. There has been no recent review of the governance arrangements, the strategy, plans or the information used to monitor performance. Risks, issues and poor performance are not always dealt with appropriately or in a timely way. The risks and issues described by staff do not correspond to those reported to and understood by leaders. The governance group was ineffective and failed to bring about dissemination and monitoring of learning from identified shortfalls. Clinical Governance meetings were inadequate and concerns appeared over a period of time with no evidence of improvement.

The approach to service delivery and improvement is reactive and focused on short term issues. Improvements are not always identified or action not always taken. Where changes are made, the impact on the quality of care is not fully understood in advance or it is not monitored. Governance and other meetings were cancelled due to operational issues. Risk identified by the governance group did not get added to the risk register. The risk register was used as a record of identified risk but not as a live tool to drive improvement within the service. There was no sense of ownership of the risk register and problems were seen as 'Trust problems'.

Staff satisfaction was mixed and not all staff felt actively engaged.

There was a limited approach to obtaining the views of people using the service and no evidence that changes were made as a consequence of patient feedback.

Vision and strategy for this service

- The trust defined their mission was to: "Deliver better health outcomes and an excellent experience for everyone we provider with healthcare services." The trust's defined objectives are to:
  - "Improve quality and clinical outcomes by ensuring safe patient care is our highest priority.
  - Play a leading role in local partnerships to meet the needs of our local population and enhance patients' experiences."
  - Use our resources efficiently and effectively for the benefit of our patients and their care to ensure our services are clinically, operationally and financially sustainable."
- Staff we spoke with during the course of our inspection were not aware of the mission or objectives of the trust when we asked them about vision and strategy.
- Staff were aware of the trust's values (Working together; Engagement and Involvement, Respect and Compassion and Improvement and Development) which were displayed publically throughout the hospital. We found an improvement in the number of staff who were able to tell us about or sign post us to the trust's values compared to our inspection in September 2014.
- The ED did not have an individual vision or values nor anything that translated trust values into a local plan.

Urgent and emergency services

Governance, risk management and quality measurement

- The trust maintained a system of scorecards for monitoring targets; for example, national performance targets, patient experience and clinical quality
- Minutes from the Urgent Care Directorate Governance meetings for the past three months showed that the meetings were held monthly (although there appeared to be no meeting in December 2014). They were attended by the general manager, the Head of Nursing along with consultants and matrons from the wards within the Urgent Care Directorate and a representative from the clinical governance team.
- The minutes showed us that the meetings lacked clarity about how learning was going to be disseminated and embedded. They also showed some anomalies in the data between different reporting systems such that the reporting systems could not be relied on to provide an accurate picture and so were of limited use in providing assurance to the Board.
- The meeting that took place in January 2015 showed very little action about anything and was focussed exclusively on NICE guidelines and NCEPOD. There was no Health and Safety report, no discussion of FFT, no discussion of complaints, no report or discussion around patient safety and risk and the Quality and Performance Review was cancelled.
- There was a lack of effective action against identified risks and shortcomings identified at the Urgent Care Directorate Governance meetings. For example, low levels of completion of mandatory training levels had been mentioned several months running but there was no clear plan to address this other than to, "Remind staff".
- There was a lack of understanding of the importance of mandatory training and the improvements to patient safety and care that high levels of completion brought. The minutes showed that the groups were concerned because of what a CQC inspection would show not because of the impact on patient safety.
- The Urgent Care Directorate Governance meetings showed that the management team were aware of the persistent low scores for the FFT within the directorate. There was little analysis of the reasons for this and action was limited to reminding staff.
- The minutes from the February Governance meeting showed that there were six open serious incidents from the directorate. The minutes suggested one was to be downgraded but that five remained. These were not showing on either the incident log provided by the trust or through the national reporting systems.
- There was a comment in the November Governance Meeting minutes about the death of a patient that had not had an elevated clinical risk score escalated to more senior staff and who had subsequently died. The action was , "Staff to be reminded to escalate raised NEWS". There was no comment about how this was to be done nor who was responsible for ensuring the action was completed. There was no timescale and no suggested indicator for monitoring that the action was complete.
- The Trust Audit Committee Report for the February Board meeting stated the Urgent Care Clinical Unit had 13 risks open, of which six were identified as inadequate controls and related to medical staffing, mental health assessments, lack of integrated IT services and ambulance offloads. The Urgent Care risk register provided by the trust at our request showed five risks: delays for patients with mental health needs, consultant vacancies, middle grade vacancies, lack of integrated IT services and shortage of paediatric nurses resulting in non-compliance with the Standards for Children and Young People in Emergency Care Settings.
- With the exception of an increased capacity which helped minimise ambulance off loading, there was no evidence of action in the Urgent Care Clinical Unit to address the risks since our inspection in September 2014. For example, the ED continues not to meet The College of Emergency Medicine (CEM) recommendations for consultant cover to provide and continues to have mixed sex breaches in the CDU.
- The minutes of the Urgent Care Directorate Governance Meeting in February 2015 acknowledged that there were insufficient geriatricians to support wards with the recommendations of the National Confidential Enquiry into Patient Outcome and Death and should go on the risk register. It was not on the risk register provided by the trust.
- The trust has failed to comply with the breaches of regulation related to mixed sex accommodation which were identified within the ED during the inspection in September 2014. The trust received the draft report in

January 2015, although it was not published until March 27 2015. We expect providers to address breaches of the regulations when they are raised rather than waiting for the final report to be published.
- There was consistency between what frontline staff and senior staff said were the key challenges faced by the service. The risk register reflected what individuals raised as their key concerns for the service. Staff were clear on the risks and areas in the department that needed improvements.
- For several months in a row there was no Health and Safety report to the governance group.

Leadership and culture within the service

- A general manager had oversight for management of acute and emergency medicine for both trust sites at Eastbourne District General Hospital and Conquest Hospital, which included ED, medical assessment units.
- Cross-site nursing leadership in the ED was provided by a senior (band 8b) Head Nurse. Two nurse service managers) were accountable to the head of nursing. At our last inspection in September 2014, the nurse service managers were allocated service-specific rather than site-specific responsibilities. This had been reorganised since September 2014 so each nurse service manager was responsible for a site; one at Conquest Hospital and one at Eastbourne District General Hospital. Nursing staff we spoke with were clear as to their lines of supervision.
- The general manager and head nurse of the urgent care directorate had been in post for several years and understood the current and future needs of the service, including the number of leaders, qualities and skills required.
- The clinical lead for the Urgent Care Directorate across the trust's sites was job shared by two consultant acute physicians. Senior clinical ED staff expressed concern that there was no longer an Emergency Care Consultant lead in the department as this post was lost in the recent restructure. From speaking with medical staff, there appeared to be resistance from some consultants cross-covering both sites, which would allow for a less frequent requirement to provide on-call cover. This separation of consultant rotas also meant there were inconsistencies between sites; for example, the A&E handbook, much trumpeted at Conquest, was not used in Eastbourne.
- There was positive feedback from trainee doctors who had been on placement in the department. They said they had been made to feel part of the team and staff ensured that they were fully involved in all aspects of patient care and treatment.
- Staff within the department spoke positively about the care they provided for patients. Quality and patient experience were seen as everyone's responsibility.
- All the staff we spoke with said that they enjoyed the work they did. Most staff spoke with a sense of pride about their local team and department. The way staff felt about their involvement in recent changes and future plans for the department was variable; some said they had been consulted or told about changes, while others felt their opinion had not been sought for proposed changes to their areas of speciality within the department.
- Staff morale in the department was variable, but was said by some to be a little better than at our last inspection in September 2014.
- The trust's quality and performance report for December 2014 showed high staff sickness levels amongst staff working in Urgent Care with 5.9% sickness for the month and 5.1% annually compared to trust wide sickness rates of 5.7% monthly and 4.8% annually.

Public and staff engagement

- The trust's integrated performance report in December 2014 showed the response rate from the NHS Friends and Family Test (FFT) in A&E met the trust's target of 20% for six out of the nine months between April and December 2014, with a range of between 13.6% and 35%.
- There was no evidence displayed in the department of changes made as a result of patient feedback such as 'You said we did', NHS Friends and Family Tests or patient-led assessments of the care environment (PLACE).
- A quality board was not displayed in the department to show staff how they were performing or to celebrate their achievements. These boards were available in other areas of the hospital. When we asked staff why they did not have a board, they suggested the ED had been overlooked.

Innovation, improvement and sustainability

- Services at the trust were restructured between December 2013 and May 2014 so that general surgery,

emergency and high-risk services, along with orthopaedic emergency and high-risk services were centralised at Conquest Hospital. The trust's inpatient paediatric ward is also at Conquest Hospital so ambulances conveying sick children are received at Conquest. A capital bid was secured by the trust development authority for expansion of the ED. Phase 1 was completed with the creation of the CDU. Phase 2 and 3 were dependent on the approval of planning consent to extend the building of the ED into an existing car park.

- We did not identify any examples where staff were encouraged to innovate.

Surgery

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

Information about the service

East Sussex Healthcare NHS Trust provides care to a population of 525,000 people and is one of the largest healthcare organisations in the country. The recent service reconfiguration saw some of the acute hospital services moved from the Eastbourne District General Hospital to the Conquest Hospital site in Hastings. We visited the surgical wards and theatre departments at the Conquest Hospital site. The Care Quality Commission (CQC) undertook an unannounced inspection at the Conquest Hospital on 24th and 25th of March 2015. In preparation for this inspection, CQC reviewed information from a wide range of sources to get a balanced and proportionate view of the surgical services. We also reviewed data supplied by the trust and other external stakeholders and reviewed feedback from members of the public who shared their experiences with CQC. We visited the surgical wards, discharge lounge, theatres, recovery areas, and observed care being delivered by staff.

We reviewed patient feedback from a range of sources and took the information we received from members of the public into consideration before, during and after the inspection process. The Commission held drop in sessions, where staff could talk to inspectors and share their experiences of working at the trust. For the purpose of this report the surgical department will be referred to as the surgical clinical unit which reflects the renaming of the service post reconfiguration.

Summary of findings

Our inspection identified that the processes and frequency of emergency equipment and controlled drugs checks required further attention to improve patient safety in surgical ward areas. We found evidence that some of the concerns raised by CQC's last inspection report were beginning to be addressed; however, the inspectors found an inconsistent approach to implementing progress made and the progress needed to drive the necessary improvements in the department. For instance, we found the theatre and recovery areas had taken the necessary steps to address the concerns, but the same level of improvement was not evident on the surgical ward areas. Safety thermometer data was being collected; however, the most up to date and relevant information was not always available for patients to view on the ward information boards. The hospital policies on emergency equipment and CD medication checks were found to reflect best practice, but were not being followed in practice. There was continued confusion regarding the display of C.Diff and MRSA spells on boards. Staff appeared to have a lack of clarity about whether the infection control data related to their wards, or the hospital in general. Our review of trust level of compliance with Venous Thromboembolism (VTE) guidelines and policy have remained unchanged. The trust had a VTE policy in place which reflected national guidance from the Royal College of Surgeons. However, we did find that the VTE protocol was not always followed. This suggested that patients may not have

received appropriate VTE prophylaxis and that national guidance was not always followed. The trust was not meeting Referral to Treatment Times (RTT) in surgery. We were aware the board, with the assistance of the Trust Development Authority (TDA) had put an action plan in place to reduce the waiting times. However, we are remain concerned about the sustainability of the progress made.

Staffing levels throughout the department were found to be insufficient to meet people's needs. This was also identified at the last inspection. The trust has given assurances to CQC that it is actively recruiting staff to fill the vacancies, however, the trust remained heavily reliant on agency and bank staff in the interim to ease the pressures. Staff told us the crisis on the 'shop floor' remained unchanged. We remain concerned that the department is failing to capture all incidents on the electronic reporting system. We acknowledge that the trust has taken steps to incorporate incident reporting into the formal hospital induction for new staff in an attempt to strengthen the reporting process and empower staff at all levels to report. However, we remain concerned that the clinical unit is a low reporter of incidents. Staff continued to tell us that a lack of feedback and low staffing levels was a likely contributor to under reporting. Cleanliness data for the surgical unit was reviewed as part of the inspection process. Our observations identified the areas we visited as being clean and tidy, however, when we reviewed the cleanliness data it highlighted a significant failing in achieving the national standards of cleanliness, and major shortfalls in the audit processes used to measure compliance. The surgical clinical unit was consistently found to be not meeting the national standards of cleanliness, or of meeting the audit frequency as laid out in national guidance. There is continued concern that the surgical clinical unit was not learning from, or improving quality, from complaints and comments made. Staff remained unaware of complaints which had influenced change, with the exception of the ones made directly to them regarding noise and lights at night, or communication problems. The financial position of the trust and recent service reconfiguration has impacted on the vision and strategy for the service. Staff morale had been left in a poor state as a result of ineffective engagement and consultation processes when surgical services were reconfigured. The results of the most recent staff survey continued to raise concerns about staff welfare, morale and organisational culture at the trust.

Surgery

Are surgery services safe?

Inadequate

Our last inspection highlighted some serious safety concerns in the surgical department at the Conquest Hospital. We found that some steps had been taken to address the concerns raised by CQC at the last inspection. We did note improvements in the identified checks in the theatre and recovery areas. However, we continued to identify the same concerns in ward areas that related to the frequency of emergency equipment and controlled drugs checks. The ward areas required further management support to ensure that the standard of safety was improved. Staff were aware that the emergency checks were to be undertaken daily. Staff were asked to explain why the checks were not always undertaken and told us that in their view, the current 'staffing crisis' had a knock-on effect on staff ability to carry out these tasks.

CQC raised concerns regarding the lack of Mortality and Morbidity meetings in general surgery. We were told by the trust that these meetings were reinstated, held regularly and well attended. We requested the minutes of these meetings to evidence this process. However, we only received the minutes from the September 2014 meeting. This was insufficient to evidence the improvements we were told about.We found further improvement was needed in theatres to ensure that the malignant hyperthermia trolley reflected AAGBI (Association of Anaesthetists of Great Britain and Ireland) guidance.We also identified a lack of pharmacy auditing across the surgical clinical unit. Regular audit processes would help monitor improved compliance following the noncompliance we identified with the controlled drugs checks, medication errors, missed medications and prescription errors. We identified gaps in the CD registers in ward areas which demonstrated a lack of compliance with trust policy. Our inspection identified episodes of missed medication where the reason for the omittance was not recorded and reviewed charts that demonstrated that medication administration was frequently delayed. Staff told is that this was due to the availability of medications from the pharmacy department.

Safety Thermometer boards were available in ward areas; however, we found that data was either outdated or boards were left blank.Staffing levels throughout the department were found to be insufficient to meet people's individual care needs. Staff told us that they were unable to deliver the standard of care which they would like to due to staffing shortages. Our inspection identified incidents that, had hospital policy been followed, should have been reported through the electronic incident reporting system. We acknowledge that the trust has taken steps to incorporate incident reporting into the formal hospital induction for new staff in an attempt to strengthen the reporting process and empower staff at all levels to report. However, staff continued to tell us that they rarely received feedback from reported incidents and were unable to give inspectors examples of learning from these events. They told us that the constraints on them in relation to continuous staffing shortages. The most recent staff survey raised a concerning theme where staff reported feeling unable to raise concerns. This meant that there was limited measurement, monitoring of safety performance which impacted the organisations ability to learn and improve standards.

The clinical areas we visited appeared to be clean and tidy, however we reviewed the hand hygiene and environmental audits for the surgical clinical unit and found the reported monthly scores and frequency of the audit cycles to be inconsistent and inadequate to meet national standards for a high risk clinical area. This was also the case for the environmental audit processes and results. The data demonstrated that the National Standards for Cleanliness (NSC) were consistently not being achieved, audited or improved upon in surgery. This meat that patients were receiving care in an environment that was not meeting standards to manage to patients of acquiring a health acquired infection.

We saw improvement in theatres in the handling of contaminated waste. The trust had acted upon the feedback given at the last inspection and had put measure in place to minimise the risk of cross infection. On the day of inspection the trust was interviewing candidates that it hoped to employ, whose sole role in the department was to manage and oversee the safe management and removal of contaminated waste form the theatre area. We were told that this was an interim measure until the trust had secured finance to carryout building works to provide a permanent "dirty area" (an area where contaminated waste can be stored to reduce the risk of spreading a health acquired diseases).Staff working in ward areas were unable

to demonstrate that their temporary workforce had received an induction to their work environment or hospital policy and procedures. This suggests the risk to people who use the service was not being managed appropriately given the increased risk transient staff pose to the service. We requested a copy of the surgical risk register to review as part of the inspection process. A whistle-blower who came forward to CQC raised a concern in relation to the way risk was managed at this trust. This person informed us that the risk registers were reviewed and risks were removed from the register without careful consideration or consultation with clinical line mangers. The surgical risk register submitted to CQC had a total of 11 risks documented, 10 of which related to surgical services across both hospital sites. We have a concern that a total of 10 risks in a service rated by CQC as inadequate may not be a true reflection of the risks in service. The entry's did not reflect the findings at our last inspection. This demonstrates that risk is being inappropriately identified and managed at the trust.

Whilst the medical records we viewed during the inspection demonstrated that consent was obtained and respected. The patients we spoke to told us that they were given adequate time to discuss their care and treatment before consent was obtained. CQC have been provided with information where consent was obtained for one procedure and another has been undertaken. This meant that patients were not given a chance to change any decisions about the care, treatment and support that has previously been agreed.

Incidents

- Our last inspection identified concerns with the under reporting of incidents in the surgical department. During this inspection, we continued to identify incidents that should have been reported.
- We identified incidents which should have been reported if the trust policy had been followed. For example, the non-availability of profile mattresses for patients identified as being at high risk of acquiring a pressure sore, and the inadequate staffing levels in ward areas. We identified four patients who were assessed as being high risk of acquiring a score who did not have access to a profile mattress. We also found ward areas that were subject to reduced staffing levels on a continuous basis was also not reported.
- Staff we talked with gave us two different perspectives on incident reporting of staff shortages: some were encouraged to formally report such episodes, while others said that they had been told by senior staff not to bother. This demonstrated clear inconsistency in the reporting of staff shortages although staff were aware that they needed to report shortages as incidents.
- Staff were aware that they needed to report these episodes as incidents, but they also told us that they continuously worked over and above their hours to ensure that nursing documentation was completed at the end of a shift. We observed this during our inspection.
- Staff told us that they rarely received any feedback from the incidents which they had reported, and were therefore less likely to, "spend time reporting when nothing changes".
- The trust board told us they were taking steps to improve staff awareness of incident reporting and had incorporated incident reporting into the hospital induction programme to ensure that all new staff, regardless of position, were clear on their duty to report, and of the mechanisms in place in the trust to report incidents. However, we did not find evidence that the board's strategy to strengthen the reporting process had an impact on the shop floor at the time of our inspection.
- It is worth noting that two out of the five key findings in the NHS staff survey for which East Sussex Healthcare NHS Trust compared least favourably with other acute trusts in England related to the percentage of staff agreeing that they would feel secure raising concerns about unsafe clinical practice, and fairness and effectiveness of incident reporting procedures.
- Under reporting of incidents poses a significant risk to the trusts ability to ensure the safe delivery of services and the organisational learning required to improve patients' outcomes and experience.
- Trust data indicated no 'never events' over the last twelve months. A 'never event' is defined as a serious, largely preventable patient safety incident which should not occur if the available preventative measures were implemented. However, data received from the trust indicated a clinical incident where a retained swab was left in a patient. Data from the patient safety drill down Jan – Dec 2014 indicated that an 'instrument was retained post operation'. Neither incident was reported through as a never event.

- The minutes of the general surgical M&M meeting dated September 2014 was reviewed and evidenced the M&M meeting activity in general surgery had been reinstated. We requested copies of the minutes for meetings after September 2014, which were not submitted for review. The last inspection identified a concern with Mortality and Morbidity (M&M) meetings in general surgery. M&M meetings were established across the NHS to review deaths as part of professional learning, and to provide the hospital board with the assurance that patients were not dying as a consequence of unsafe clinical practices. We found M&M meetings for all surgical disciplines were in place at the trust. We received evidence that the trust continuously monitors mortality and morbidity across the clinical unit.
- We requested the Root Cause Analysis (RCA) data for eight Serious Incidents Requiring Investigation (SIRI) relating to the surgical clinical unit reported between December 2014 to March 2015. Not all of the investigations had been completed in a timely manner, however the RCA reports we viewed had documented organisational learning and had an action plan in place. We did not received documentation that evidenced the on-going monitoring or progress of individual actions plans.

Safety thermometer

- All the areas we visited participated in the collection of safety thermometer data.
- Safety thermometer data was available for public view on the information boards in each ward. We saw evidence that safety data was being collected regularly. However, we noted that the majority of the information boards in ward areas displayed information that was significantly out of date (by several months) or were blank spaces. In the ward areas where we noted these discrepancies we asked staff when the data was last updated and the reasons why the most current data was not displayed. Staff told us that the continued staffing shortages meant that the information boards did not take priority over delivering care. We also noted that the boards that did display information in the "you said we did section" appeared to be very similar to the information viewed at the first inspection.
- CQC received concerns from a member of the public who wished to express disappointment regarding the information displayed on a ward safety board. Their relative had acquired two pressure ulcers during their admission, which was never reflected on the information board despite the patients extended admission.
- Data was clearly displayed in main theatres and appeared to be up to date and accurate.
- There was a continued lack of clarity amongst staff about whether the safety thermometer board should display the infection rates, such as Clostridium difficile (C. difficile) and MRSA data for the whole hospital or just the individual ward areas. It is usual for safety thermometer information to relate to individual ward and departments, in order that local trends can be identified and comparison can be made.

Cleanliness, infection control and hygiene

- Hand hygiene audits were undertaken by each clinical area. We reviewed the hand hygiene audit data from September 2014 to March 2015 and found that it depicted a varying and concerning trend. Surgical areas are considered to be high risk clinical areas and there is an expectation that hand hygiene scores should achieve a consistently high standard. However, the data demonstrated that some areas were achieving 100% month on month compliance with hand hygiene requirements, and several areas were not audited at all.
- CQC identified a discrepancy's in the scrub technique in the theatre department at our last inspection. The department has since carried out an audit that demonstrated that there was a variance in scrub quality. We reviewed meeting minute's labelled 'highlights from audit day 26.01.2015' which "implored all staff to revisit their scrub technique". There was no information provided for staff regarding the support, training or surveillance of scrub technique to ensure the highest standard of sterility was upheld. Hand washing data received form the trust also identifies a worrying trend with the achieved scores and frequency of audit. We looked at data from September 2014 to March 2015 and found the theatre department only achieved the expected score of 95% for two of the seven months reviewed. There was no audit data for February or March 2015. The trauma ward did not have a hand washing audit in place for three of the seven months we viewed, and only achieved the recommended score of 95% for three of the months audited. The elective surgical ward was not audited for five out of the seven months and only achieved the recommended score once in that

period. However, we did find 100% compliance with hand hygiene in the surgical short stay, SAU and Jubilee Eye Suit. This demonstrates an ineffective approach to monitoring of an identified health care risk.

- There is a significant concern that the minimalistic infection control audits that were undertaken highlighted poor performance in several areas and there was no action taken by management to address the concerns, increase the frequency of audit to improve the standards. This demonstrates there was an awareness of a substantial risk that was not actually addressed in the surgical clinical unit.
- Infection control data reported to the Centres for Disease Control and prevention (CDC) between April 2014 and April 2015 showed that the trust reported three cases of MRSA (Methicillin-resistant Staphylococcus aureus), 51 cases of C. difficile and 20 cases of MSSA bacteremia (methicillin-sensitive staphylococcus aureus).
- We noted from the Trust Board Minutes dated March 2015 that there was an increase in Clostridium Difficile (C.Diff) cases over the preceding three months. In the ten month period April 2014 - January 2015 there had been six months where the levels were above the trajectory. The year to date figure was 44 cases compared to a target of 33 for the same period. Analysis of cause had shown that in 18 cases the infection was attributable to a lapse in care.
- We found a note in a ward diary telling staff to ask patients to record their own fluid intake and output and wash their own fluid collection jugs in the sluice. Whilst we accept that patients who have capacity and are willing to complete their own fluid charts is acceptable, washing their collection jugs in the sluice poses an infection control risk.
- All the areas we visited appeared clean and we noted that an ample supply of hand gel was available, and was being appropriately used by staff.
- We saw that cleaning rotas were in place and curtains changed and dated in line with trust policy. We requested the environmental hygiene audits for all areas in the surgical clinical unit in order to check the overall quality and standards being achieved.
- However, the data we reviewed raised a significant concern that high risk surgical areas were not meeting the target of 95% against the National Schedule for Cleanliness in the NHS. Twelve areas were included in the regular audit, but only six of the twelve were audited in December, two of the twelve were audited in January, six of the twelve were audited in February and March. The results of these audits month on month showed that the national standard was not being achieved across both sites. The data also showed an inconsistent approach to vital audit monitoring of standards in surgery that did not comply with the guidance on frequency of audit.
- There were a number of side rooms available on each ward which were utilised appropriately for the purpose of barrier nursing and infection control management.
- The Surveillance of Surgical Site Infections in NHS Hospitals in England 2013/14 report showed that the trust's rate of inpatient surgical site infections for total hip replacements (0.15%) was within expected limits during 2013/14, and they recorded no surgical site infections for total knee replacements over the same time period.
- No data was available via the Health Protection Agency Surveillance of Surgical Site Infections in England 2012 report relating to infections following repair of fractured neck of femur or reduction of long bone fractures.
- Our last inspection identified a variance in the scrub technique used by staff to prepare for surgery. A recent scrub technique audit undertaken at the Conquest site also identified a difference in scrub quality. Minutes from the theatre departments January governance meeting cascaded this information to staff. However, the minutes did not discuss the steps put in place by the department to improve quality and minimised the risk of a health acquired infection, it instead, "implored staff to re visit their scrub technique". The hand hygiene data we viewed showed poor compliance with hand hygiene in the theatre department. Between September 2014 and March 2015 the department had only achieved 100% twice in the six month period. Scores for other months ranged between 80% and 90%, there was no audits data for February and March 2015. This evidence suggests an inappropriate approach to the management health care associated infections in a very high risk clinical area.
- Our last inspection identified concerns with the storage of contaminated instruments in the main theatre areas. The department has embraced the concerns raised and put in place an action plan to maximise the attention to detail on minimising risk of cross infection in the interim

period until funding has been approved for an extensive re-design of the department. The trust have employed two band 1 staff whose sole job is to monitor and maintain the cleanliness of the waste areas.
- We saw that an adequate supply of personal protective equipment was available and being used appropriately by staff when delivering care.

Environment and equipment

- A supply of Dantrolene (a medicine used for the treatment of malignant hyperthermia) was in date and available in the department. We noted the trolley was being assembled in line with AAGBI (Association of Anaesthetists of Great Britain and Ireland) guidance since 09/2014 and the task had not been completed at the time of our inspection in March 2015. We were told that no progress was made since the member of staff initially responsible for the task had left the trust. We found all the necessary items of equipment were available and in date, but were not laid out in any specific order which may pose a problem in an emergency situation.
- However, we noted that the trolley did not have a complete check list. We asked staff why this was and were told that Malignant Hyperthermia trolley had remained incomplete since the member of staff responsible for the task had left the trust in September 2014. This meant that the trolley not reflect AAGBI (Association of Anaesthetists of Great Britain and Ireland) guidance for seven months.
- We carried out checks on the emergency and resuscitation equipment in all the clinical areas we visited. We continued to find discrepancies with the checking of emergency equipment on the surgical ward areas. For example we viewed records between 1st of January and the 24th of March 2015. These records demonstrated that checks had been missed on seventeen occasions in that period. Records reviewed in another ward area between 14th of Feb to the 24th of March demonstrated that twenty five checks out of a possible 38 were undertaken.
- We found evidence in the theatre and recovery areas that the feedback from our September inspection and been embraced, and that emergency checks were now being carried out in line with trust policy.
- We are concerned with the availability of profile mattresses for patients who were identified as being high risk of acquiring pressure ulcers. The staff we raised this concern with seemed to be aware of the problem; however, it appeared that no action had been taken to address it.
- The recovery area was found to be cluttered with patients' beds such that it was noticeably crowded and limited the space around patients whilst staff provided care.
- One member of staff raised a concern with us about working in a clinical area with a very high patient turnover that did not have enough drinking cups to give people drinks.

Medicines

- The surgical ward areas we visited were unable to demonstrate adherence with the trust policy in relation to the checking of CD's. Between 1st and the 24th of March checks were missed on six occasions, and 10 occasions in February 2015. Another ward we had carried out 12 checks for January, 11 for February, and 12 checks were carried out up until the 24th of March. This meant that daily controlled drug checks were not routinely being carried out. Staff we talked with told us that the current staffing levels and pressure to meeting patients care needs meant the these checks were missed.
- We carried out spot checks on the controlled drug (CD) registers in theatres. We found drugs were signed out and checked in line with trust policy and national guidance. The theatre and recovery department demonstrated noticeable improvement in adhering to trust medicine policy.
- Our inspection identified concerns regarding the storage of medication on Benson ward. We found that TTA's (Tablets to Take Away) medicine was not stored securely but left on a shelf behind the nurses' station which could be easily accessed. We also noted normal saline ampoules and water for injections and 100ml bags of normal saline were stored alongside the nurses' station. These items were not being stored in line with the guidelines outlined in the Royal Pharmaceutical Society Duthie Report (1988), updated March 2005.
- The theatre and recovery areas were able to demonstrate that medication fridges were being checked in line with trust policy. Checks on wards varied in demonstrating completeness with some wards rarely recording that fridge temperatures were being monitored.

- We continued to identify a lack of pharmacy auditing within the surgical clinical unit. Regular pharmacy audit would have identified that daily controlled drug checks were not being carried out and the inadequate storage of TTA's. Medication audit is an important tool for measuring safety and quality in a service and the organisation is missing a valuable opportunity to improve and ensure compliance.

Records

- We identified some room for improvement in the nursing documentation we viewed. For example, times, dates, staff designation was not always recorded. Care records were not always complete or able to demonstrate continuity of care. Staff told us that" the recording of care was not always up to date due to the staffing levels. For example observations chart, fluid charts, evidence of appropriate referrals when a risk was identified. We also looked a selection of patient records on each ward that we visited which demonstrated that relevant risk assessments were in place and care needs were risk assessed. There was a variance in the quality of the records we viewed on different wards.
- Our concern regarding the overall quality of patients' medical notes kept at East Sussex Healthcare NHS Trust still exists. The majority of clinical notes we reviewed were in very poor condition and wrapped in elastic bands to prevent pages being lost. This meant that there was a high risk that patient sensitive data and important clinical records could easily be lost or filed out of sequence, thereby affecting patient care.
- There were also problems with the availability of patients' notes, and thus a frequent use of temporary notes being generated.
- If a patient had been seen and treated in the hospital previously, staff could access medical secretary letters which provide recent and relevant patient information. However, we were aware that some consultants were not happy to treat patients using temporary notes given the risk it posed.
- The trust acknowledged concerns with the availability of notes and had an action plan for the implementation of an Radio Frequency Identification Device (RFID) system. This system should reduce the incidence of lost notes, and will aid note-traceability throughout the trust.
- We also found examples of good practice in the records we viewed. This included staff recording that they had introduced themselves to the patients and made them aware that they were the designated person in charge of their care and of recording that consent was obtained before any care or intervention was carried out.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- CQC have received two significant concerns relating to the consent process at East Sussex Healthcare Trust. The themes identified from these contacts relate to consent being obtained for specific surgical procedures and another being carried out without discussion or further consent from the patient. This raises a significant concern regarding how consent is obtained and upheld.
- A sample of medical records we reviewed demonstrated that formal consent was obtained, and that appropriate discussions had taken place with patients prior to surgery. Documents also evidenced that patients were made aware of the likely hood of surgical complications as a result of having a surgical procedure. The patients we talked with during the inspection told us they were given a suitable amount of information to be able to give informed consent for a surgical intervention. The also confirmed that they were given enough time to make their decision to proceed and to ask any outstanding questions of their surgeons.
- As with our previous inspection we did not see completed mental capacity documentation during the inspection process. However, staff were able to tell us the steps they would take to raise any concerns identified relating to a patient's mental capacity.
- Though staff we talked with during the inspection went on to demonstrated an understanding of mental capacity and could describe the safeguarding escalation process. However, it is worth noting that one of the patient records we viewed on the SAU noted a diagnosis of dementia. The patient did not have a mental capacity assessment in place and had "consent to care" documented in their nursing notes. This demonstrates a lack of understanding of the processes and procedures required to safeguard patients who lack capacity.
- Staff continue to experience a lack of clarity regarding Deprivation of Liberty Safeguards.

Safeguarding

- Staff were able to describe what constituted a safeguarding concern and the process in place to report such issues. However, it is worth noting that staff told us

they did not always received feedback on the safeguarding alerts they reported. Staff were unable to a varied examples of learning from safeguarding incidents or examples of trend and themes from the surgical clinical unit. All the examples we received related to falls and the implementation of senor mats. This did not promote confidence at the department was learning from trends and themes identified through the safeguarding process.

- The trust worked closely with safeguarding organisations to investigate and learn from safeguarding incidents. CQC has identified a trend and theme regarding the alters generated from the surgical unit as falls, pressure ulcers, poorly planned discharges and medication concerns and communication.
- We noted that some concerns regarding poorly planned discharges and pressure ulcers were identified in the community once the patient had been discharged.
- The trust had a dedicated safeguarding team and relevant safeguarding policy in place which reflected national guidance.

Mandatory training

- Theatres and recovery were able to demonstrate a noticeable improvement in the quality and accuracy of training records kept in the department.
- The ward areas from which we chose to review training records were able to demonstrate complete records.
- Staff reported receiving their mandatory training annually. Data available in the Knowledge Management Report to the trust Board dated January 2015 showed variable compliance with mandatory training requirements. Whilst most new staff had completed induction training, participation rates for other training did not meet the target of 85%. Theatres performed marginally better than the Surgical Clinical Unit being below target in Manual Handling (82.9%) and Health and Safety Training (68.33%). The Surgical unit was below target in all subjects with completion rates varying between 60.09% for Health and Safety training to 82.26% for Fire Safety training. Both areas had met the target for Mental Capacity Act 2005 training.

Management of deteriorating patients

- The surgical department used a national early warning score (NEWS) system to help identify and monitor deteriorating patients.
- VitalPAC (an electronic vital signs system) for monitoring deteriorating patients was also in use.
- When the NEWS indicated a concern about a patient's condition this was escalated using the escalation protocol so that the patient was reviewed by a doctor and/or a member of the critical care outreach team. This team is available on site from eight am to until two am and provides specialist nursing support and advice for patients and ward staff.
- We were aware that the VitalPAC system had failed in January 2015 and that the trust went back to using paper documentation while the system was being repaired. Whilst this provided staff with some challenges, we could not identify any major impact on patient safety and wellbeing. This incident was reported via the appropriate notification system to CQC.
- We saw some problems with the VitalPAC hand terminals not synchronising with the terminals onwards and causing unnecessary delays to observation rounds.
- The staff relied heavily on the use of agency staff. However, we noted that these staff did not have password access to the VitalPAC or blood monitoring technology. Permanent staff told us they got round this problem by allowing agency/bank staff to use their passwords to record observations. This practice was a breach of trust policy and potentially of the Data Protection Act 1998 but staff felt they had no alternative but to allow temporary staff access to maintain patient care at a safe level.
- Compliance with the WHO safety checklist was audited regularly and the records demonstrated good compliance. The last audit data for the department suggested an 81% compliance rate in January and 100% in February. We found the final element of check list of the records we viewed was not consistently completed which may have an effect on learning and safety in the department.

Nursing staffing

- The staffing levels across the surgical department continued to be insufficient to deliver individualised patient care.
- Staffing levels within the surgical department have been identified as a major risk to the organisation and, in particular, within the surgical assessment unit. We saw this risk included on the surgical trust risk register. The entry documented the risk identified, the steps taken in an attempt to resolve the issue and a record and stating

the risk be removed from the risk register, the entry was dated 27/01/2015. Whilst steps had been taken by management to resolve the situation the impact of the measures in place had not had an impact on the ward area, and unit continued to struggle with its staffing numbers and skill mix.

- At our previous inspections we identified staffing levels were below those we expected, and raised this as a concern. At this inspection, we failed to identify improvements to the staffing levels in this area and we consider this to be one of the most significant risks identified at both inspections. Removing this risk register without the risk being appropriately managed does not demonstrate effective management of clinical risk. This clinical area has been identified as requiring five trained nurses on the morning and afternoon shifts, we did not see the agreed staffing levels being met consistently on the off duty we viewed. On the day of our unannounced inspection we found the ward with four trained nurses to twenty eight patients and one patient in an assessment area. Given the acuity of this area and the nature of the direct access to services which it provides for GP referrals and SECAMB, staffing in this area is of the utmost importance to ensure patient safety and providing good quality care.
- Staff told us that on the very rare occasions when wards had their approved quota of staff, staff were instantly moved to relieve the pressures in other areas.
- Staff continued to tell CQC that they were continuously affected by staffing shortages and "there isn't enough staff to work safely".
- The patients we talked with told us that they had their care needs met, but were concerned for the welfare of the staff.
- Staff were seen to be working at exceptionally busy and unsustainable levels. We observed staff remaining in their clinical areas long after their twelve hour shift had finished in an attempt to catch up on essential paperwork. This was sometimes hours over their planned work time rather than minutes.
- We were told that the trust used an acuity tool to measure and monitor staffing levels across the trust but did not see this in use during our inspection visit. The staff we asked about how the staffing review was being carried out did not have access to the computer system or have knowledge of how the review was being undertaken.
- Inspectors attended handovers on a selection of surgical wards and found the handovers to vary in quality. It was evident that the wards with the greatest staffing pressure were the wards where there was little time for staff to update nursing records or the electronic handover sheets which affected overall efficiency and quality.
- The theatre and recovery department reported 25 WTE (whole time equivalents) vacancies. The department reported relying on 15 WTE agency staff per week to deliver a service but this left the department consistently 10 WTE short of the planned staffing complement.
- Agency usage data demonstrated that general surgery, trauma and orthopaedics and theatres relied heavily on agency staff deliver a service.
- The trust reported its agency usage at 7.9%, which is higher than that national average of 6.1%.
- We observed nursing staff delivering acceptable care in this area, but it was at a cost to their own welfare by skipping breaks, working late and delivering task-orientated nursing care.
- We noted that the skills mix in some areas was not ideal, as newly qualified nurses were relied upon to support services. Processes had been put in place by the trust to support these staff members. However, newly qualified staff told us that did not always received an appropriate level of support they required as it was heavily reliant on staffing numbers, skills mix and ward acuity.
- We were told that the trust was in the process of formally assessing the staffing levels in the department by using a staffing acuity tool. The result of this analysis was not available to CQC as the process was to continue beyond the inspection period.
- Theatres and recovery areas were able to demonstrate improvements to the management and oversight of temporary staff working in the department. This was evident from the information we reviewed and the staff with whom we talked during the inspection.
- However, ward areas had little or no oversight of their temporary workforce. There was no documentary evidence that staff received any induction, or were familiarised with their work environments.
- Staff raising concerns told us that temporary staff did not always know the ward areas or the patients, despite attending a handover.

Medical staffing

Surgery

- The trust reported its medical staffing skills mix as 222 WTE (Whole Time Equivalents). This comprised of 38% consultants, 22% middle grade doctors, 29% registrars and 12% junior doctors.
- Consultant presence had increased during the week and at weekends.
- We attended a medical handover and found it to be of a suitable standard with effective communication.
- The trust continued to be heavily reliant on locum doctors to deliver its services. Locum use was running at 7.9%, which was above the national average of 6.9%.
- Middle and junior grade doctors were on duty 24 hours a day in the department. We did not identify any concerns with this cover during the inspection. However, it's worth noting that some ward staff mentioned that their availability sometimes had an effect on the timeliness of discharges.
- Data we viewed demonstrated that maxillofacial, general surgery and ophthalmology relied on the use of agency staff to deliver a service.

Major incident awareness and training

- Staffing records revealed that major incident training had been provided to staff. The last training was delivered before the service reconfiguration in July 2013. With recent changes to work environments, medical specialities and mobility of staff, this posed a potential risk to the organisation.
- Staff we spoke to were aware of the policy to defer elective surgical activity in order to prioritise unscheduled emergency procedures during a major incident.

Are surgery services effective?

Requires improvement

CQC remains concerned about trust compliance with venous thromboembolism (VTE) guidance. Data received from the trust called 'surgical checks' provided data that suggested the trust was performing at the lower end of the peer average markers for the prevention of Deep Vein Thrombosis (DVT) blood clot typically in the legs and Pulmonary Embolism (PE), clots in the lungs that can prevent berating.We found that Nil by Mouth (NBM) best practice was not always being followed, which meant that patients were without food and drink for prolonged periods. The current configuration and resourcing available to the pain team remains a significant concern, given that service is expected to be delivered across two hospital sites. The team is currently staffed by two part time band six trained nurses and one locum anaesthetist.Whilst the patient notes we viewed during the inspection demonstrated that people had their health risks assessed, we found inconsistencies in the recording in fluid, nutritional diary's and elimination charts.The mortality and patient safety data we reviewed demonstrated improvements in performance with post-operative pulmonary embolism (from .14% to .05%) between January and December 2014. However, it showed the trust performance to be double the peer average, which suggests more action is needed for the prevention of post-operative pulmonary embolism at ESHT.

The level of post-operative acute respiratory failure was also higher than expected with the trust significantly worse than other trusts in England according to information supplied by the trust on the Patient Safety drill down dated March 2015. The trust participated in the national laparotomy audit which demonstrated a mixed performance. It showed the trust carried out between 101 and 150 emergency general (EGS) Surgery cases a year, and had 1.2 general GI (Gastrointestinal) critical care beds per 100 patients. The trust reported not being able to provide a fully staffed operating theatre, and a reserved theatre for EGS patients, an emergency surgical unit, critical care outreach, minimum four tier EGS rota twenty four hours a day.

The trust had a hip fracture surgical pathway which appeared to be working well throughout the clinical unit. However, we noted that it was only commenced once the patient reached the ward area and is not utilised at the first point of contact in A&E. The National Institute for Health and Care Excellence (NICE) recommends that from admission, patients should be provided with a formal, acute, orthogeriatric or orthopaedic ward-based Hip Fracture Programme.

Participation in the annual national lung concern audit also demonstrated a mix performance. Whilst 99% of patients diagnosed were discussed at an Multi-disciplinary meeting)(MDT), 78% were seen by a specialist nurse and only 55% had a specialist nurse present for their at diagnosis. Specialist nurses are a valuable resource to reduce unnecessary hospital admissions and admission

times. They also free up consultant time and provide specialist advice and additional support to patients and their families.The trust shared an audit plan with us to demonstrate the activity within the department. We did not receive any completed audit reports for review. Audit activity within the department could be significantly improved upon, and expanded to incorporate more nurse led audit activity. For example CQC received concerns from patients about the waiting times on the SAU unit. We found that admission and discharge times were intermittently documented for these patients on a list by the desk and occasionally in patients notes. There was no formal process of monitoring the length of stay or outcomes for this patient group. We talked to staff about complaints regarding this area and they told us that if a patient did complain it was about the waiting times. We found the service was missing a valuable opportunity to monitor the service and improve patient experience in this area. This was identified at out last inspection and no improvements have been noted. CQC also received concerns regarding discharge processes in surgery. The themes identified from this contact were discharge delays, poor community support arrangements, poor communication and medication errors. The discharge process was not audited therefore another chance to improve the quality and standard of discharges was being missed. This was also noted at our last inspection and no notable improvements during our March review.

Staff had received their mandatory training and appraisals. However, there was a lack of clinical supervision available in the clinical unit. Newly qualified nurses commented that they did not always get the support they needed as this was very dependent on the staffing numbers, skill mix on each shift which was ever changing due to the staffing shortages. Clinical areas were very reliant on transient staff which also posed a risk to the service in term of having the right skills, knowledge and experience to do their jobs. We found suitable arrangements in place which reflect the Royal College of Surgeons (RCS) standards for unscheduled surgical care and emergency surgery.

The ten records we viewed demonstrated that the trust adhered to best practice guidance, such as NICE CG50 (Acutely ill patients in hospital). We found records demonstrated co-morbidities were documented, there was an MDT approached to care and staff escalated concerns when NEWS scores triggered. An outreach service was also available in the department. An outreach services was also available in the department. We noted an improvement with consultant cover at the trust. However, significant improvement was needed to ensure the delivery of robust and effective multidisciplinary care seven days a week.

Evidence-based care and treatment

- Our review of trust compliance with venous thromboembolism (VTE) guidelines and policy have remained unchanged. The trust had a VTE policy in place which reflected national guidance from the Royal College. However, we found that the VTE protocol was not always followed. Some wards were able to demonstrate 100% compliance and others were not. In a random review of medical records, we identified five patients who did not have completed VTE assessment in place during the inspection. Data received from the trust called 'surgical checks' provided data that suggested the trust was performing at the bottom of peer average measurement for the prevention of DVT Deep Vein Thrombosis – blood clot typically in the legs) and PE (pulmonary Embolism – clots in the lungs that can prevent berating). This suggests that patients may not have received appropriate VTE prophylaxis and that national guidance was not being followed. We found that patients on specific care pathways (such as the fractured neck of femur pathway) were more likely to be compliant with VTE guidance.
- We requested audit data from surgical VTE audits carried out to form part of the inspection review. We were provided with a document listing eight VTE audits, three of the eight related to the surgical unit and one of the relevant three was recorded as complete. We received only one audit from the trust. It did not state which site it related to, or the sample size of the review undertaken. It was called 'Snap-shot' Audit of VTE prophylaxis amongst General
Surgery (Emergency & High Risk) inpatients and suggested that the trust was achieving compliance rates of 96% for the selected patient group. The trust did not submit any other data to evidence compliance for admissions outside of the chosen reference group, and there was no evidence that the action plan from this audit was reviewed, recommendations monitored or a plan to re-audit was in place.
- Data received form the trust labelled 'patient safety drill down' indicated that the trust had a higher number of DVT's and PE that the peer average. This suggested that

patients may not have received appropriate VTE prophylaxis and that national guidance was not being followed. This data was submitted as an image rather than a spread sheet that would have assisted CQC in data interpretation.

- The trust compliance with referral to treatment (RTT) for non-admitted pathways showed poor compliance against targets agreed with the TDA and local commissioners. The ratings for February 2015 showed the following services (General surgery, Trauma and Orthopedics, Ophthalmology, gastroenterology) rated as red with waiting lists and backlogs significantly higher than agreed. The overall waiting list showed at total waiting list of 8936 patients for the four specialties identified. (General surgery as 2378, Trauma and Orthopedics 2014, Ophthalmology 2450 and Gastroenterology as 2094). We noted that urology was meeting its targets.
- The level of post-operative acute respiratory failure was also higher than expected with the trust significantly worse than other trusts in England according to information supplied by the trust on the Patient Safety drill down dated March 2015.
- The trust participated in the annual national laparotomy audit which demonstrated a mixed performance. It showed the trust carried out between 101 and 150 emergency general surgery (EGS) cases a year, and had 1.2 general GI (Gastrointestinal) critical care beds per 100 patients. The trust reported being unable to provide a fully staffed operating theatre, and a reserved theatre for EGS patients, an emergency surgical unit, critical care outreach and a minimum four tier EGS rota twenty four hours a day. It also reported being unable to provide a formal on site interventional radiology and onsite diagnostic endoscopic services twenty four hours a day, as well as pre and peri-operative elderly medicine input for this patient group. However, it did report being able to provide contemporaneous CT reporting, consultant pathology advice and critical care consultant cover twenty four hours a day. Data also suggested the trust had an enhanced recovery and sepsis pathways, bi-monthly reviews of all EGS deaths and formal consultant handover procedures for surgeons and anaesthetics.
- The trust also submitted data to the annual national lung cancer audit. Data suggested that 268 patients were treated with 99% of patients being discussed at an MDT (multidisciplinary team meeting for cancer patients to decide on the best individual treatment plans for patients.) 83 % of patients received a CT before bronchoscopy and 78% were seen by a nurse specialist. However, only 55% of these patients had a nurse specialist present at diagnosis. Data suggested that 74% of patients had a histological diagnosis and 55% of those diagnosed were having active treatment. 12% of patients received surgery and 28% received radiotherapy.
- We saw the hip fracture surgical pathway was working well throughout the department. However, we noted that it was only commenced once the patient reached the ward area and is not utilised at the first point of contact in A&E. The National Institute for Health and Care Excellence (NICE) recommends that from admission, patients should be provided with a formal, acute, orthogeriatric or orthopaedic ward-based Hip Fracture Programme.
- The records we viewed demonstrated that the Trust adhered to best practice guidance, such as NICE CG50 (Acutely ill patients in hospital). We reviewed a total of 10 records and found they demonstrated compliance with the guidance.
- The care plans we reviewed demonstrated that patients had their care needs adequately identified and risk assessed during their admissions.
- VitalPAC electronic monitoring played an important role in monitoring patient conditions but we identified delays on occasions of up to four hours in data being synchronised between hand-held and main terminals. The delays identified with VitalPAC was identified as a trend across the clinical unit.

Pain relief

- The trust had a dedicated pain team which provided a service across both hospital sites. However, we continued to have concerns relating to current configuration, sustainability and quality of the service which can be provided given the staffing resources available.
- Pain services at East Sussex Healthcare Trust continued to be delivered by two part time band 6 staff nurses and a locum anaesthetist. There was no clinical lead for the service. Given the recent reconfiguration and the increase in surgical procedures on the Conquest site alone, there is a concern that the service is unable to

deliver a quality and robust pain service to meet the needs of patients and provide support to nursing staff across two hospital sites, with minimal staffing resources.

- We spoke to patients during the inspection, the majority of whom told us their pain had been adequately managed. However, we also talked with patients who experienced delays in receiving their analgesia (pain killers) and had to request it several times. They did not wish to raise a concern about this as they recognised the nurses were "doing their best".
- We reviewed a selection of pain charts in the ward areas during the inspection and found them to be incomplete, on some there was no recording of a pain assessment. The charts we viewed in the theatre department were fully completed.
- We requested pain audit data from the trust and received a list of audits. There were none relating specifically to the Conquest Hospital but we saw that there was an audit of analgesia for elective laparotomies in adults with a commencement date of December 2014. The expected end date had not been confirmed. We were not provided with details of the actual audit results, as requested but rather a short list of the audit plan related to analgesia.

Nutrition and hydration

- As with our previous findings, the trust was not following national guidance for patients who are required not to eat or drink prior to surgery. We found a blanket approach to nil by mouth status being used within the department. This meant that patients were without food and fluids for unnecessary and extended lengths of time, which did not reflect national guidance or demonstrate individualised patient care.
- We found an inconsistent approach to the completeness of fluid monitoring charts in ward areas. Ten records were viewed and all were found to be incomplete.
- The selection of notes we viewed demonstrated that patients had their nutrition and hydration needs risk assessed using the MUST (Malnutrition Universal Scoring Tool).
- Appropriate measures were put in place to monitor any identified risks: for example referral to dietician, nutritional supplements, weight monitoring, food diaries and hydration charts.
- Patients mostly told us they were happy with the quality of the food and support they received. Some of the patients we talked with told us the food was "not very good".
- The trust provided a range of meal choices which meant that individual or religious needs could be met.
- Patients on the surgical wards were being kept nil by mouth for extended periods of time, which is not in line with best practice guidance.

Patient outcomes

- Data reviewed from the mortality and patient safety submission showed the crude mortality for urology to be 0.5% which is double the peer average of 0.2% for the same period.
- The Conquest hospital performed better than the England average for most measures in the 2014 Hip Fracture audit. This included higher than average scores for the number of patients having surgery within 36 hours of admission (84% for trust against a national average of 71%) and cementing of arthroplasties (93% for trust against a national average of 77.2%).
- However, we noted that performance with the target to ensure that patients were admitted to a bed within four hours of admission via the ED had reduced to 28%, the England average was 48%.
- We requested data from the trust to assess the time taken from clinical decision to operate to actual operate times. We were provided with the following statement in a word document, "The average duration from arrival time to surgical start for all CEPOD emergency admissions over the date range; 15th September 2014 to 22nd March 2015 was 37 minutes". There was no explanation of how these times was calculated, nor was there any data that CQC could review to identify trends, themes in the service.
- We attended a selection of nursing handovers during the inspection. As our previous findings highlighted, we found the quality and structure varied with some teams providing a more comprehensive and structured handover. We found that nursing staff had little time to prepare or update the electronic information sheets which were heavily relied upon for communicating continuity of patient care.
- We observed a medical handover and found the communication of patients' needs to be satisfactory.
- Where medical patients received care on surgical wards, due to a shortage of medical beds the trust operated a

'buddy' system. This meant that the surgical ward was paired with a medical ward for support and continuity in terms of medical reviews for these patients. The nursing staff with whom we talked informed us that the system generally worked well, but expressed frustrations in recent weeks with its efficiency. They described having to repeatedly remind medical teams that the outliers on surgical wards required a medical review.

- It is also worth noting the marked improvement in the percentage of patients who received a pre-operative assessment from a geriatrician. In 2013 the trust reported only 2% of patients compared to 30% of patients in 2014 who received reviews. 30% is lower than the England average of 51% but the data does demonstrate a marked improvement.
- The trust performed well in the national Bowel Cancer audit compared to the England average.
- The trust contributed to national audits such as the NCPOD (National Confidential Enquiry into Patient Outcome and Death), the National Emergency Laparotomy audit and the National Bowel Cancer audit and we noted the results were in line with the national averages.
- The most recent CQC Intelligence Monitoring report has not identified any concern with any surgical procedures.
- The surgery data obtained from the trust demonstrated a reduction in day surgical activity in the last six months of 2014 when compared to same six months in 2013. The data we viewed demonstrated the trust was meeting the national targets for unscheduled care.
- The trust contributed to national audits such as the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and the National Emergency Laparotomy Audit, and the results were found to be in line with the national averages.
- We saw evidence of trust involvement in national audit programmes. There was also evidence of departmental audit activity to monitor compliance with national guidance, and some activity driven by clinical interest. Audit activity within the department could be significantly improved upon, and expanded to incorporate more nurse-led audit activity. However, staff told us that the staffing shortages meant that meaningful engagement with audit was difficult. We were not provided with the outcomes nor shown improvements made following local audits.
- The average length of stay across the trust for elective procedures is slightly better than the England average and for non-elective it is slightly worse.
- Readmission rates for other surgical disciplines were found to be within the England average.
- The rates of death within thirty days of surgery had been reduced from 0.04% from 0.03%, the peer average is currently 0.02%.
- As per our previous findings there were appropriate arrangements in place which reflected the Royal College of Surgeons (RCS) standards for unscheduled surgical care and emergency surgery. This included handover of information between medical teams and included access to operating theatres, or diagnostics. The trust also participated in a 'trauma network' with another hospital, and patients admitted with various traumatic problems were managed with combined input and decisions by specialty consultants.

Competent staff

- Junior doctors were very complimentary about the support and quality of teaching provided by the consultant group. The quality of the training junior doctors received was also evidenced in the recent deanery report.
- We viewed records which demonstrated that staff had an annual appraisal, with both the surgical and the theatre teams meeting the 85% target. However, staff told us that the appraisal process had little impact on their development and was seen more of a tick box exercise.
- Staff confirmed that they had received an annual appraisal and an appropriate level of training in order for them to be able to perform their roles. However, we noted that there was little training provided over and above what was stipulated as mandatory due to financial restraints and staffing pressures.
- Clinical supervision was not available in in the clinical unit. Clinical supervision is a formal process of professional support and learning that addresses practitioners' developmental needs in a non-judgemental way. Its aim is to help them increase both their competence and confidence through exchanges with experienced professionals and the use of reflective skills (Butterworth, 1992). The trust was missing an opportunity to support staff to develop and learn from their experiences.

- Newly qualified nurses commented that they did not always get the support they needed as this was very dependent on the staffing numbers, skill mix on each shift which was ever changing due to the staffing shortages. Clinical areas were very reliant on transient staff which also posed a risk to the service in term of having the right skills, knowledge and experience to do their jobs.
- As reflected in our previous findings, the orthopaedic ward that cared for the majority of older patients with fractured hips and/or who were a high risk group for dementia had seven patients and only one nurse who had received dementia training. This was insufficient to meet the needs of patients living with dementia in this particular ward area.
- Annual checks to Nursing and Midwifery Council pin numbers were undertaken to ensure that staff held a valid registration.
- There was an annual re-validation process undertaken by the trust to monitor medical staff skills and learning objectives.

Multidisciplinary working

- There was evidence of a multidisciplinary approach to care on the surgical unit.
- We observed multidisciplinary working during the inspection and found the clinical notes we reviewed had multiple entries to demonstrate a cohesive approach to care delivery.
- We also observed a multidisciplinary team approach to the ward rounds that we attended. This meant that all relevant information was shared between healthcare professionals and others to ensure that patients received safe and coordinated care, treatment and support.
- The pre-assessment team were able to demonstrate a very good working relationship with anaesthetic and work colleagues in theatres.
- The physiotherapists and occupational therapists told us they had recently recruited staff, which would improve multidisciplinary team working within the trust.
- There were arrangements in place for the transfer of patients between the Conquest Hospital, Eastbourne District General Hospital and the other community sites. However, CQC have contacted by members of the public to raise concerns regarding discharge planning and in particular communication with local GP's and community services. We are also aware of a number of safeguarding referrals that have been made by local care homes.

Seven-day services

- We found consultant cover available seven days a week at the Conquest Hospital. This included consultants being onsite during normal working hours Monday to Friday and providing on-call services out of hours. There were also consultant-led ward rounds for surgical patients at weekends.
- The availability of physiotherapist-cover remained unchanged. Physiotherapy services were available five days a week with limited on-call cover provided at weekends.
- There was no weekend or out-of-hours cover for other therapy services, such as occupational therapy, dietician or speech and language therapists (SALT) teams.
- There was limited access to a pharmacist out of hours and at weekends. Cover was proved by an on-call system.
- There was adequate provision of imaging services out of hours.

Are surgery services caring?

Good

We have judged the surgical services at Conquest Hospital to be caring.Patients we talked with during our inspection were very complimentary about the staff in the surgical clinical unit. They told us that staff helped them understand the care, treatment and choices available to them and empowered them to be involved in making decisions about their care. Patients felt confident that they could raise a concern and have their views and experiences taken into account during their hospital stay. We observed staff delivering care that promoted dignity, respect and independence and observed positive interactions in all the areas we visited during the inspection. Comments received during the inspection included "the staff always seem to go that extra mile" and "they really do work hard". However, patients also reflected on their perception of the staffing levels and felt that there was not enough staff in any of the

clinical areas we visited. One relative on told us "You cannot fault the nurses, they are trying to do their best, but my mum didn't have a wash yesterday because they were so busy" and "the staff are just rushed off their feet".

CQC received a number of contacts from the public praising the staff at East Sussex Healthcare Trust. However, we also continued to receive some concerns and complaints regarding staff attitude and poor communication. The majority of the contact we received continued to raise concerns for staff in terms of wellbeing, staff shortages and the impact on the quality of care delivered. Our observations recognised that staff were committed, loyal to their patients and teammates but working at exceptional rates to deliver a service. However, this did not seem to affects their ability to be compassionate, kind to patients. Staff were very proud of their ward areas and their teams ability to be resilient to the daily pressure and continue to put patient care first. We saw several examples of staff going to extreme lengths to be able to meet the care needs of patients and the organisational demands, sometimes at a personal cost. They continued to skip breaks, regularly work late to complete essential documentation and work extra shifts in an attempt to ensure patients and their colleges were not affected by the poor staffing levels.

The friends and family test trust data demonstrated that surgery as a whole scored slightly higher than the England average.

Compassionate care

- We observed staff treating patients in a kind and compassionate way that promoted their dignity and respected their privacy.
- We saw staff meet people's individual needs in a kind and compassionate way during a period of high demand and staff shortages.
- The staff we spoke with told us they were very dedicated to delivering the best patient care they could with the resources they had available to them.
- Curtains were drawn around beds when personal care was delivered.
- We observed staff introducing themselves to patients before any care or intervention was carried out.
- During the inspection we became aware of a high proportion of patients on the surgical assessment unit with complex care needs which required constant input from staff to ensure that their needs were met and their safety was maintained. Despite staffing pressures, the staff efforts, compassion and ability to prioritise was highly commendable. Patients we talked to confirmed our observations by telling us about the extreme lengths to which staff went to ensure that these patients were kept safe.
- Each ward area had a board that displayed "you said we did" information. We noted that much of the feedback related to communication and noise levels. Wards were providing patients with ear plugs and staff told us they were much more aware of the noise levels at night and doing their best to minimise it. Other comments related to poor communication. Staff were aware of this concern and were able to tell CQC the steps put in place to address the concern from a multidisciplinary perspective.
- CQC received positive feedback about the staff working at the Conquest site. However, we also continued to receive a number of contacts wishing to raise concern about staff attitude and what was perceived as a lack of empathy and curt communication.

Patient understanding and involvement

- During the inspection we spoke to patients who praised the staff highly and commended their hard work and dedication.
- The patients we spoke to felt the care they received was respectful and promoted their dignity and independence.
- As with our previous findings, there was a named nurse system in place, however, the patients we talked with were not aware of whom their named individual was. Despite this patients felt they would get the care they needed if they asked any member of staff for assistance.
- We noted that staff encouraged patients to complete the NHS Friends and Family Test feedback prior to discharge.
- The Friends and Family Test (FFT) scores where patients are asked whether they would recommend the service to others were generally high scoring above 90% for most wards. De Chan ward had a mean score of 86.1% and the Surgical Assessment Unit had a mean score of 90.75%.
- The response rates for the FFT were very variable with wards such as De Chan and the Surgical Assessment Unit having response rates of 21% and 20% respectively. Cookson Devas had a response rate of 74%.
- The FFT response rates for this trust overall were slightly higher than the England average

Surgery

- The East Sussex Healthcare NHS Trust website also has the facility for patients to leave feedback
- NHS choice website also had a feedback facility for patients to leave feedback. The trust had a current satisfaction score of 3.5 out of 5 stars.

Emotional support

- As with our previous findings, emotional support was predominately provided by local nursing teams.
- The trust had a range of clinical nurse specialists employed to deliver specialist services to patients and provide specialist support for staff.
- We did not see evidence of support for patients who had anxiety or depression. We were told that staff would refer patients to the mental health team when necessary.
- We were not made aware of any specific counselling services available for patients. We were told that counselling was available via the clinical specialist nurses and the chaplaincy service for patients.
- The trust had a range of specialist nurses to support patients and staff for example, breast care, stoma, learning difficulties, cancer and McMillan specialists.

Are surgery services responsive?

Requires improvement

We remain concerned about the referral to treatment times for patients who require surgery. Whilst the trust has an action plan in place to deal with this with the assistance of the TDA. We continue to have concerns about the sustainability of the progress made so far.Data reviewed demonstrated that the trust was not meeting its referral to treatment targets for surgical patients. The trust had an action plan in place to address this and was working closely with the Trust Development Authority (TDA) to make the necessary improvements. The trust compliance with RTT for non-admitted pathways showed poor compliance against targets agreed with the TDA and local commissioners. The ratings for February 2015 showed the following services (General surgery, Trauma and Orthopaedics, Ophthalmology, gastroenterology) rated as red with waiting lists and backlogs significantly higher than agreed. The overall waiting list showed at total waiting list of 8936 patients for the four specialties identified. (General surgery as 2378, Trauma and Orthopaedics 2014, Ophthalmology 2450 and Gastroenterology as 2094). We noted that urology was meeting its targets.

Contacts from the public highlighted that surgical patients were unable to access services when they needed to. This predominantly related to accessing outpatients clinical for patients who had undergone surgery. People told us that they experience long delays, cancelations that were frequently not communicated and that on some occasions, when their initial appointment was cancelled they “went for months without being reviewed”. During our inspection we saw elective surgery cancelled and escalation beds in use. The trust told the inspectors that the service was seeing an unusually high demand for its services. Three escalation beds were used during this busy period and we noted one mixed sex accommodation breach and a number of medical outliers on surgical wards.

The orthopaedic ward which cared for the majority of older patients with fractured hips had several patients with a dementia diagnosis but only one nurse who had received dementia training. This was insufficient to meet the needs of patients with dementia in this particular ward area. We found a lack of quality monitoring on the surgical assessment unit relating to the length of stay in admissions lounge, time to assessment /treatment, and discharge times. We saw that admission and discharge times were being recorded in individual notes, and intermittently on a list at the ward desk. However, data was not being collected in formal way which would mean it could be used as a service improvement tool. CQC are aware of concerns from the public regarding the waiting times in the admissions lounge. Staff were aware of patients’ complaints but were unable to tell us about service improvement or changes to practice as a result of concerns raised. There is continued concern that the surgical clinical unit is not learning from, or improving quality, from complaints and comments made. Staff remained unaware of complaints which had influenced change, except from the ones made directly to them regarding noise, or lights at nights, or communication problems. CQC continued to have many contacts with members of the public who were engaged with the trust complaints process. Trends and themes identified from this contact reviled frustrations with the length of time taken to respond to their complaints and the quality of the responses. The delays in responding to complaints had left people feeling ignored. The majority of

the contacts we conversed with wanted to ensure that no other patient would experience the same failings. There was a sense that people just wanted the service to learn from these complaints and improve quality.

We continue to have concerns regarding the frequency of bed moves at this site. The data we received from the trust did not provide a time frame for the numbers reported and there was no way to interpret how these figures were calculated or which clinical areas were most effected. The data showed the frequency of bed moves from 1 to 9 and reported that 1648 patients had moved beds during their admission.

Patients we spoke to were very complimentary about how the staff cared for patients who had complex needs. We also received positive feedback about the learning difficulties service which was provided by the trust, which was seen as a great support to patients and staff.

Service planning and delivery to meet the needs of local people

- CQC received multiple concerns from patients who were not receiving outpatient follow up appointments in line with their treatment plans. There was also a theme identified where an appointment would be booked and then cancelled by the trust. This meant that patients were not reviewed for a prolonged length of time. Patients told us this was causing patients additional stress and worry.
- East Sussex Healthcare NHS Trust continued to struggle to meet the referral to treatment times for surgery. RTT (referral to treatment times) times have fallen below both the standard and the England average for surgical patients. The Trust had an action plan in place to address this and was working closely with the Trust Development Authority (TDA) to make the necessary improvements. Data shared in the Trust Quality Account 2013/2014 showed the trust was meeting the RTT for admitted patients of 74.8% against a target of 90%. The data related to the trust wide position rather than being site specific.
- The areas recognised by the trust with the biggest challenge in meeting RTT were general surgery, trauma & orthopaedics, ophthalmology and gastroenterology.
- We found a good quality service of clinical care was provided to patients by the pre-assessment team. However, we noted it was not a one stop shop and the recent relocation of the department had resulted in disrupted the patient flow in this service. Assessments were frequently held at short notice and just days in advance of patients' admission dates. This clearly created pressures on the pre-assessment team to meet the demands of the service. Staff told us that the recent reconfiguration of admin services may be the reason for the short notice admissions.
- Data provided by the trust indicated that only one operation was cancelled where the patient was not seen within 28 days between April 13th and Sept 14th. However, it's worth noting that elective surgery was cancelled on the day we commenced our inspection at the Conquest Hospital.
- Average length of stay across the trust for elective procedures was slightly better than the England average, and slightly worse for non-elective procedures. The average length of stay for non-elective surgery was 6.3 days compared to the national median average provided by the Nuffield Trust of 5.3 days.
- Recovery staff returned patients to their ward areas when they were ready for discharge. We have no doubt that recovery nurses returning patients is an efficient and timely way of avoiding long stays in the theatre department, however, we were concerned that patients were being returned to ward areas without communication with ward staff. This meant that there was little time to prepare for the patients, or to reallocate the already stretched resources to ensure that post-operative safety could be balanced with ward safety and the other demands of patients with complex needs. For example, one area we visited which was very understaffed had a patient admitted from A&E and a patient returned from theatre at the same time, as well as at least three other patients requiring immediate attention due to their complex needs. We saw patients queuing on trolleys whilst waiting to be received by a nurse. There was also a long delay in the ward nurse being able to receive the handovers for both patients. The ward staff we observed prioritised effectively and worked efficiently with great tact and professionalism in this instance.
- We identified a concern with patient flow during the inspection. The number of bed moves may indicate problems with flow throughout the department. Data requested from the trust did not provide a time frame for the numbers reported, and there was no way to interpret how these figures were calculated or which clinical areas were most affected. However, the data

showed the frequency of bed moves between one and nine moves and reported that 1648 patients had moved beds during their admission. For example data suggested that 1174 patients experience one bed move, 326 experienced two moves, 98 experienced three moves, 32 experienced four moves.

- During our inspection we saw elective surgery cancelled and escalation beds in use. Three escalation beds were opened in the surgical assessment unit. Staffing for these beds was not in place at the time the beds were put into use on the 23 March 2015.
- The trust had extended nursing roles which had the potential to make services more effective and responsive to patients' needs. An example of this was the nurse-led admissions in surgical admissions unit (SAU), the nurse-led discharges, and the introduction of advanced practitioners who had specific skills to support the surgical services. However, there was a lack of quality assurance measures in place to monitor these incentives. There was no meaningful data available on the length of time patients spent in the admissions lounge, or the length of time taken to make clinical decisions in relation to formal admission or discharge. This meant that the trust could not be sure that the measures in place had improved the quality of service delivered to patients. CQC received a number of complaints regarding the current systems and processes in the SAU admissions lounge.
- We were informed about the different process in place to communicate with local GP's regarding hospital admissions and discharges. Electronic discharge letters were sent out when patients left the hospital. However, we found an entry in a ward communication book which highlighted that a number of GP letters had been returned to the trust because the patients were no longer registered at the practice to which the letter had been addressed. This suggested that GP contact details were not routinely being checked at the point of admission, and therefore important information regarding patients' hospital admission never reached their GP's. CQC received concerns from patients who wished to make us aware of the delays in letters reaching their GP's.
- The CQC is aware that a number of complaints and safeguarding alerts have been raised as a result of inadequate discharge planning. Nurse-led discharges were in operation, but there was no evidence of audit processes to monitor the quality of the discharges.
- We were aware that a new booking system had been introduced that centralised the booking process for patients who required surgery. The feedback received from staff at all grades relating to the recent changes was entirely negative. Theatre lists were currently being made available one week in advance of the planned surgeries, which gave the department little time for forward planning. Trust policy states that lists should be reviewed 6 week in advance.
- We could see from the theatre lists we viewed and the conversations we had with staff that theatre lists were being under-booked and over-running. This had led to an underutilisation of the theatre department and an increase in spend in terms of staffing resources when lists overran. The trust provided us with a theatre utilisation spread sheet which showed significant underutilisation by speciality. ENT had not met their target utilisation within the twelve month period April 2014 to March 2015, with all months showing as below the target set of 85% with the lowest monthly utilisation being 56%.Breast surgery and general surgery had failed to meet theatre utilisation targets for seven of the twelve months with low scores of 70% and 74% respectively.
- Seeing the clinical areas function in times of high demand and pressure gave inspectors a good opportunity to see how well the service dealt with very busy times and with staff shortages. It also gave us the opportunity to see areas which might require improvement.

Meeting people's individual needs

- We noted a mix-sex breach on a surgical ward during the inspection.
- We also identified one patient who had been waiting on the surgical assessment unit for an MRCP (a special type of magnetic resonance imaging exam that produces detailed images of the hepatobiliary and pancreatic systems, including the liver, gallbladder, bile ducts, pancreas and pancreatic duct) for four days. Staff told us this delay was due to a lack of capacity.
- During the inspection we became aware of the high proportion of patients on the surgical assessment unit with complex needs which required constant input from staff to ensure that their needs were met and their safety was maintained. We were acutely aware that a possible

unforeseen incident could have had a catastrophic effect on the staff's ability to keep the ward safe and to continue to be able to meet patients' complex individual needs.
- Each patient had an information board above their beds with a space for their name, consultant and named nurse. However the boards were not consistency completed in the ward we visited.
- We saw an open approach to visiting hours on the surgical assessment unit, which was much appreciated and valued by relatives.
- Translation services were available in the department. We did not see this in use during the inspection process.
- There was a learning disabilities team who provided support to patients, carers and staff. We received very positive feedback about their support this team provided.

Learning from complaints and concerns

- Our last inspection identified some concerns regarding the complaints-handling process, quality and timeframes of trust responses and learning from these events.
- CQC has continued to receive a high number of complaints from members of the public regarding surgical services at ESHT. Trends and themes identified relating to surgery highlight staffing shortages, particularly at night and weekends, poor patient experience, communication, RTT's, discharge planning and the trust's complaints process.
- The unannounced inspection did not identify a noticeable difference following our September 2014 visit. Staff were asked if they had received feedback, or had input into complaints resolution. Most staff we talked with were unaware of any trends and themes identified at department level. Staff were unable to give examples of, or learning as a result of a complaint at department level.
- Staff were able to tell inspectors about complaints received at ward level. For example, patients complained about the noise at night. Staff showed us that wards had a constant supply of ear plugs for patients to improve their experience. Staff also told us that there were systems in place to improve communication. However, these steps were not being measured and therefore assurance could not be given that communication had improved. CQC have identified a trend in the complaints received where poor communication has been identified as a problem.

Are surgery services well-led?

Inadequate

Our September inspection saw the surgical department rated as inadequate in the well-led domain.The September inspection highlighted a significant disconnect between board and floor and this inspection failed to identify improvements to our previous finding. CQC have been given assurances by the trust board regarding the steps it plans to take to address the concerns identified in our last report to improve and support continuous meaningful consultation with staff and board to floor relationships. We are aware that the current situation will require an on-going commitment and robust approach to future engagement, and that any evident improvement may take a considerable length of time. However, the steps put to date have yet to have any impact on the staff in the surgical clinical unit. Staff expressed being unfamiliar with the vision and strategy for surgical services.

The trust informed CQC of improvements made to the structure and functionality of the trust's governance, risk and quality improvements board. However, staff continued to be unaware of the recent improvements and were unable to give any examples of how the boards worked or influenced changes, or drove improvements in the service.We found that the senior leadership of the service had not yet been firmly embedded and continued to be subject to continuous change. Staff reported feeling disillusioned about raising concerns. This was echoed in the recent staff survey. Staff told us that they have raised clinical concerns only to find their manager then relocated to another role, which meant their concerns remained unaddressed. Staff commented, "If managers stayed in their jobs for longer than three weeks we might see some change". They also expressed feeling exhausted by what they perceived as, "A knee jerk management style" in the trust.Contact with staff had also made CQC aware that one

of the steps taken by management to address the bullying culture identified across the organisation was to send an email to staff asking them to speak to their managers if they wished to address their concerns.

CQC received many contacts from staff pointing out how ineffective this approach to communication was, but also highlighting in some cases, that it was the mangers that were perceived, as being responsible or engaged in for the said culture. Staff felt that they continued to be put in a situation they were unable to address their concerns. It is worth noting that CQC continued to receive correspondence and have contact with staff working at all levels, from a varied range of positions within the department raising concerns about the leadership style and culture of the service.

Feedback from staff and the recent staff survey results identified low levels of staff satisfaction and high levels of stress and work overload. We remain concerned that staff feel they are not treated with respect, openness, transparency or candour when raising concerns. Staff continued to express a fear of retribution if they raised concerns.

The culture in the organisation could be perceived as defensive with an organisational deafness towards staff, patients and members of the public. Staff continued to express We did not find any improvements to the way the trust engaged with members of the public since our last inspection. Feedback has shown that public trust in the leadership of this organisation has severely diminished and causes excessive local anxiety about services as a result.

Vision and strategy for this service

- The financial position of the trust and the service reconfiguration has impacted on the vision and strategy for the service.
- As with our previous findings, there was no evidence of a clear strategy for the delivery of surgical services that was known to staff working in the surgical clinical unit or in theatres. We heard about the trust strategy during the meeting we attended with the TDA and trust representatives prior to the inspection visit. We could not see this strategy had been devolved into a plan for the service that was known and understood by operational staff. Staff were unaware of how their roles supported the vision or values of the trust.

Governance, risk management and quality measurement

- The trust reported a strengthened governance, risk management and quality measurement processes. However, the majority of the staff we talked with were unable to tell us about these processes.
- CQC outlined significant concerns in our previous report which would be expected to be managed under governance, risk management and quality measurement processes. However, there was little evidence that our concerns were being addressed. Some of the areas of concern related to basic safety across the clinical unit. Addressing these safety concerns had a sense of urgency and required little financial support required to address the issues. However, with theatres as the exception, steps were not put in place to address the concerns we raised, which meat that patients were still exposed to the risk of potential unsafe care. This is not indicative of a fully functioning or effective governance, risk and quality measurement processes.
- Theatres and recovery made their departmental governance meeting minutes available to staff on the staff communication board. Staff were more aware of the function, impact and outcomes of these meetings.
- However, there is much more work needed to improve staff awareness regarding the function, impact and of clinical governance and risk management in the surgical clinical unit. It's worth noting that none of the staff we talked working on the shop floor had ever attended, or been invited to a governance meeting, or received feedback from the regular meetings. This demonstrated that the governance function was neither effective nor an inclusive process.
- The trust had appropriate boards in place to monitor and improve care quality from serious incidents. These include the Serious Incident Review Group and the risk and quality management group. However, as with our previous findings the majority of staff we talked with were unfamiliar with the structure, function or learning from these groups.

Leadership of service

Surgery

- We asked several staff what had changed since the last CQC inspection. The majority responded by telling us that "nothing has changed". There was a continued trend where the leadership was referred to as having an ineffective top down directive.
- Further leadership re-organisation had taken place since our last inspection. This had left ward staff feeling frustrated as they felt that they were raising concerns which were not addressed because of the continuous movement of senior managers. The ward staff felt that there was inconsistent support from senior management because of this. Comments received from staff included, "If the managers stayed longer than three weeks we might start getting things resolved".
- Staff continued to tell us that their immediate line managers and team members at clinical level were an invaluable source of support. However, we received feedback that senior/middle management were not as visible in clinical areas as staff felt they should be. One concerning comment we received stated "We haven't seen them since your last inspection".
- Staff continued to tell us that they were tired of the "reactive not proactive" management style. The also continued to tell us they had little faith in the current leadership at board level and had no held little hope for change whilst the current leadership style of middle managers remained unchained.
- Staff told us they have been trying to alert management at senior and board level about the continued staff shortages and the impact it was having on patient care and staff welfare long before our inspection in September 2014. In March we found the trust had started a staffing review to reassess staffing levels. The delay in conducting a review to address the staffing issue is very concerning. It does not promote trust or a responsive culture in the leadership to address concerns that directly affect patients care or staff welfare in a timely manner.
- There was evidence that change was still being carried out with little notice or opportunity for staff engagement. The latest changes affected the pre-assessment team who were given just one week's notice that the department was relocating to a difference area of the hospital. The distance patients had to walk to the new department had significantly increased and was having a real impact particularly on the elderly, infirm and patients with mobility issues.
- The staff survey measured the percentage of staff reporting good communication between senior management at their Trusts. East Sussex Healthcare Trust achieved just 18% for this question compared to the national average of 30%.
- We identified at least three separate occasions where the trust may not have been as responsive as it could have been in planning for consultant retirement. Examples included the replacement of a spinal, anaesthetic (pain lead) and pain service provision post-surgical reconfiguration. These examples are not indicative of a responsive culture which promotes continuity of care for patients.
- There was evidence in theatres and recovery that the most recent changes to the senior management team had had a positive impact on the department. For example, staff reported confidence in the nurse management, and there was ample documentary evidence that the department had taken steps to improve staff knowledge in regards to incident reporting, risk management, clinical governance activity and clinical unit meetings. This area had made progress in addressing the concerns raised by CQC at our initial inspection.

Culture within the service

- Our assessment of the culture within the surgical department at the unannounced inspection remained unchanged. It continues to appear dysfunctional and damaging to the future of the organisation.
- Staff morale had been left in a poor state as a result of ineffective engagement and poor consultation processes when surgical services were reconfigured. Staff commented in particular about what they perceived as a destructive approach adopted by the trusts 'turn around team' to drive change.
- The latest staff survey results (published March 2014) revealed that staff satisfaction at East Sussex Healthcare Trust was at an all-time low. Overall staff engagement, staff ability to contribute towards improvements at work, staff recommendation of the trust as a place to work, or receive treatment, and staff motivation at work results, were rated as being in the lowest 20% in the country when compared to other trusts.
- CQC remained very concerned about the number of staff who felt unable to raise concerns.

- We continued to identify pockets of good clinical practice which was not shared across the departments or hospital sites.

Public and staff engagement

- Engagement with members of the public was found to be stagnant since our last inspection. There was no evidence that meaningful engagement with the public had been improved or even attempted in the six months after our first inspection. Feedback has shown that public trust in the leadership of this organisation has severely diminished and causes excessive local anxiety about services as a result.
- There was a perception amongst local people that communication with trust leadership was ineffective and their concerns about the quality of care or the perceived needs of the public continued to be ignored.
- Upon the publication of our last report, an open letter was provided with an information link to the trust website where patients and visitors could read the reports and review the Trust Action Plan in place to address the concerns and demonstrate the progress made so far.
- Staff continued to tell us that engagement methods were not effective. They also told us they had little confidence or trust in those undertaking the engagement projects. This meant that the processes put in place were ineffective in making a difference or driving change for individual staff or in the organisation.
- The trust held an open meeting with staff on the day the CQC inspection report was published.

Innovation, improvement and sustainability

- The pre assessment team had a very clear vision and strategy for the development of the service which included training nursing staff to read ECGs and to introduce a health screening service for the elderly, which would maximise their health before surgery.
- A staff awards incentive was in place to reward and make staff feel more valued within the organisation.
- LiA – listening in action group - continued to assist the organisation with learning from comments and complaints from patients.
- The trust had introduced the National Campaign for Compassionate Care called, 'Hello my name is'. This campaign encouraged and reminded healthcare staff about the importance of introductions in the delivery of care.

Maternity and gynaecology

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

Information about the service

The East Sussex Healthcare NHS Trust maternity services were reconfigured after a group of consultant obstetricians wrote to the trust board detailing their concerns about patient safety. These arrangements were made permanent in July 2014 with involvement of the clinical commissioning groups and the health overview scrutiny committee of East Sussex County Council. It was not within the remit of the CQC inspection to comment on the commissioning arrangements.

Services are arranged across three sites, with consultant-led care, including a day assessment unit, antenatal and postnatal inpatient wards, a labour ward and special care baby unit at Conquest Hospital, Hastings. There are two midwifery-led units, one at Crowborough War Memorial Hospital and the other at Eastbourne District General Hospital, which was opened as part of the reconfiguration arrangements. Women could also choose to have a home birth and these, along with antenatal and postnatal care, were supported by community midwives.

The minutes of Trust Board meeting on 25 March 2015, provided detailed figures on the number of births per site by year. During 2014 there were a total of 3463 births: 2961 at Conquest, 326 at Eastbourne and 176 at the CBC.

We visited the services on the 24, 25 and 26 March 2015 in order to review progress since our last inspection, which took place in September 2014. We spoke to a range of medical and midwifery staff, including community workers, obstetric theatre staff and students. We spoke with 14 women and the partner of one. Women had received care at either the midwifery-led units and or at the Conquest hospital, partners. We reviewed nine sets of care records and made consideration of other documentary evidence submitted by the trust. We also spoke with other external personnel who had direct involvement with the maternity services.

Maternity and gynaecology

Summary of findings

We remained concerned about the overall leadership and considered that the service was inadequate with regard to being well-led and safe. The maternity services being provided had made some fledgling progress but still required improvements for effectiveness and responsiveness.

There was a disconnection and disaffection between the senior leaders and other staff, with staff not being aware of the services strategy, vision or developments. Information from the last inspection had not been shared with staff and they were not aware of the areas which they needed to address. Staff felt they lacked autonomy and were disempowered to make decisions and take forward their ideas. Staff did not feel encouraged or enabled to consider better ways of working and to develop the service, despite having beneficial insight and expertise.

An action plan had been created following publication of our report from the September 2014 inspection but some of the issues raised were not addressed and the action plan was insufficiently robust to bring about sustained change. There was a lack of acceptance of the serious nature of the concerns we identified by the leadership of the maternity services. A letter dated 5 April 2015 sent to all midwifery staff by the Head of Midwifery says explicitly that they, "Did not recognise this report as our unit". Midwifery staff generally considered their direct line leadership to be good, with supportive leaders who understood and shared their aims to deliver quality care.

Staffing arrangements did not always ensure sufficient numbers of skilled and knowledgeable staff were on duty to maintain safety and to ensure people's individual needs were met. This caused considerable pressure on staff, many of whom worked excessive hours and without breaks and increased the risk of incidents occurring. The current staffing arrangements did not allow for a labour ward shift co-ordinator that was supernumerary to the staffing numbers. Women did not receive one to one care in labour. The staffing on the labour ward frequently fell below the planned levels set by the trust.

There was not a learning culture and incidents were not reviewed in sufficient depth to enable lessons to be learned and disseminated. Learning opportunities were missed and mistakes continued to occur around previously identified concerns such as CTG interpretation and mothers who had suffered pregnancy loss being contacted about antenatal care or delivery plans. There was no challenge to the process for investigation of incidents and dissemination of learning such that the risk of repetition of similar mistakes and incidents was effectively mitigated.

There was a significant difference between the mandatory training senior midwives spoke to us about and the records supplied by the trust. The records provided by the trust showed poor compliance with training requirements and very little essential specialist training.

The was a lack of specialist midwives to meet the needs of the very young mothers, women who misused drugs or alcohol or traveller families.

The experiences of women's pain management were variable with negative and positive comments made in this regard.

The closure of the midwifery led units to provide staff to the Conquest hospital meant women were not assured that the unit where they had chosen to have their baby would be open when they needed it. It limited choice and discouraged the normalisation of birth.

Women reported positively on midwifery and medical staff's level of information provision and their involvement in decision making and choices. Individual care needs of women using the services were fully considered by staff and respected as far as they could. Nutritional needs were met and people's religious, cultural and medical dietary needs were met.

Consent was sought from individuals prior to treatment and care delivery. Choices were available to women for Midwifery or Consultant-led care. Staff had the support of specialist staff for advice and guidance. Procedures were in place to continuously monitor patient safety and recommended guidance was followed by staff. There were effective arrangements in place for reporting

adverse events and for learning from these. Maternity outcomes were monitored and information was communicated through the governance arrangements to the trust board.

Are maternity and gynaecology services safe?

Inadequate

Substantial and frequent staff shortages increased risks to people who used the service. Midwifery staffing levels were not always to the expected levels and staff were moved on occasion from other sites to support the service. This had resulted in the temporary closure of the freestanding midwifery led unit, with excessive travel for women and staff between sites, as well as extended working hours for some staff. It also posed a risk to women as there was no supernumerary labour ward shift co-ordinator, limited one to one care in labour and on one occasion a baby was delivered by a first year student midwife. There were examples where the labour ward was so busy that women in labour were cared for and delivered on the antenatal ward.

The maternity dashboard showed that the unit was never closed during this period but this related to the entire clinical unit on all sites rather than specific midwifery led centres. There were 9 women affected by, "Diversions to other within same organisation". During the period April 2014 to December 2014 there was only one month when there were no diversions.

The staffing escalation plans were not fit for purpose and the impact of escalation was not monitored effectively.

When concerns were raised or things went wrong, the approach to reviewing and investigating causes was insufficient or too slow. There was little evidence of learning from events or action taken to improve safety. There were several incidents that were closed without proper investigation and planning to reduce the risk of recurrence. There had been improvements in the reporting of incidents since our previous inspection but the depth of review and dissemination of learning continued to be ineffective. There was evidence that lessons which were identified as part of the review and monitoring processes did not result in service or organisational learning. Concerns identified were addressed with individual practitioners as part of performance management and supervision rather than seen as an opportunity for development and service improvement.

Maternity and gynaecology

There was good knowledge amongst midwives about safeguarding that was external to the unit (such as risks within families) but much less recognition of the risks from within the service.

There was no visible guidance to indicate the expected level of cleanliness and some of the procedural guidance to staff for infection prevention and control was out of date. Cleaning schedules were not available. There was no evidence provided to demonstrate that the service was compliant with the National Specifications for cleanliness within the NHS. Despite this the maternity areas appeared clean and uncluttered and midwifery staff were following procedures to minimise the risk of cross contamination and possible infection.

Technical equipment was available and had most had been tested prior to use. Medicines were, in the main stored, managed and administered appropriately, although some improvements were required.

Trust guidelines on the use of Syntocinon during were available but some consultants had other preferences for the use of the drug. This lack of consistency and adherence to evidence based practice posed an increased risk of errors.

Records were not always completed in a consistent manner and the storage arrangements did not always ensure confidentiality of information for staff or patients. Notes audits were not completed as per the unit policy and the risk register had not been updated in respect of poor maternity records.

Mandatory training at the trust was provided in addition to other role specific training. Training data given to us on site was very different to the figures provided by the trust. The trust records indicated that midwifery staff had significantly lower levels of completion of mandatory training than we were told about during our visit. Midwives undertook role specific training in respect to infusion devices, anaphylaxis, oxygen therapy and nebulisers. There were also areas of training which significant numbers of staff had not been recently updated.

Processes for safeguarding, assessing and responding to risks to safety were appropriate and there were system and processes to follow for escalation of concerns.

Incidents

- There had not been any never events recorded in the previous 12 months. A never event is a situation which arises usually as a result of failure to follow correct procedures.
- Seven serious incidents (STEIS) had been reported by the maternity division between April 2014 and January 2015. Examples of incidents included; unexpected admissions to Neonatal Intensive Care Unit, two to intrauterine death, one unplanned maternal admission to ITU and one intrapartum death.
- We selected and reviewed the reports on the root cause analysis investigation for two of these supplied and saw detailed information included. In accordance with the duty of candour parents and relatives involved with these two incidents received support and the outcome of the investigation was shared during a debrief with the consultant obstetrician.
- We asked for three specific RCAs subsequent to the inspection visit and used these to review learning from incidents. They showed a lack of clear plans to ensure effective learning and looked to blame individual staff shortcomings rather than organisational failings.
- An incident in September 2014 showed that, "ESHT guideline for Diminished fetal movements was not adhered to". The planned action to address this was, "All staff to be aware of and adhere to clinical guidelines and Trust policies when providing maternity care for women and their babies.". Another incident in March 2015 recorded one contributory factor as, "Staff continue to be unaware of / confused with the clinical guideline for the management of diminished fetal movements after 37 weeks of pregnancy despite multiple reminders and availability of the guideline electronically and in paper format." The recommendation made was, "All staff to be aware of and adhere to clinical guidelines and Trust policies when providing maternity care for women and their babies."
- These incident RCA report from September 2014 said, "Despite shared learning from previous serious incidents of a similar nature, there appears to be evidence of poor rule compliance relating to the adherence to the diminished fetal movement guideline." There was no clear plan that demonstrated that despite knowing it was an on-going problem that resulted in very serious damage to babies that this problem was being adequately addressed.

- A separate incident RCA from April 2015 showed that, "One midwife and one MSW on Murray ward (with high risk women) when other midwife taken to Frank Shaw to help. This demonstrated that low staffing levels had exacerbated the care failings and consequent injury to the baby. The recommendations made in the RCA did not mention staffing.
- An incident RCA from march 2015 showed that, "The midwife facilitating DAU was also acting as Triage midwife answering telephone calls and providing unscheduled care for women in the DAU." The recommendations made in the RCA did not mention staffing.
- There were incidents recorded where it was less clear that the trust supported staff fully in their duty of candour. One incident, for example, showed that the unit at Conquest hospital was so short staffed that women in labour could not be admitted to the delivery suite and were cared for on the antenatal ward. Two women delivered on the antenatal ward with one woman who wanted an epidural not being able to have it. The manager reviewing the incident describe the midwives back injury and time off sick rather than addressing the issue of understaffing. They describe the situation as, "Being managed appropriately given how busy the hospital was". The wording suggested that the midwife didn't want to move from Crowborough to Conquest and so reframed the incident rather than consider fully the causality of the situation. This is not an organisation that encourages candour, openness and honesty at all levels as required by regulation.
- The trust incident log showed that they had reported 362 safety incidents on the incident log between October 2014 and March 2015.
- Data retrieved directly from the NRLS system showed that 492 were recorded for the same period.
- There were several incidents that were closed without proper investigation and planning to reduce the risk of recurrence. We saw one incident in the incident log supplied by the trust where a baby was given an unnecessary Hepatitis vaccination without the mothers informed consent and outside of trust policy. The investigation was closed because the investigator thought the baby might have been born outside the trust and the situation was unclear. The opportunity to learn from this was limited by the insufficiently robust investigation and dissemination of the findings.
- We noted that from an RCA report of an incident supplied by the trust that there was a serious incident related to a pathological CTG identification and resultant action. This had been identified as a theme on the previous inspection and this further incident demonstrated that learning was not fully embedded.
- In the published report following the inspection carried out in September 2014 we identified concerns about communication failings between the obstetric unit at the Conquest Hospital and the community teams that led to women who had suffered pregnancy loss being contacted about antenatal visits and delivery plans. The incident log supplied by the trust showed that three similar incidents had occurred between October 2014 and March 2015. This demonstrated that lessons were not being learned and that any action was not embedded. Although it was acknowledged as a recurrent theme on the log the action was recorded as, "It is because HVs do not have access to Euroking". There was no attempt to find a solution.
- We asked for examples of learning from incidents and staff were able to advise that a change in practice had been put in place with regard to topping up of epidurals, as a result of a reported clinical incident.
- There was full awareness within the staff group about a recent serious incident. This had been subject to initial review and staff involved said they had been provided with “excellent support.” Initial debrief after the event had taken place and there was to be a subsequent debrief later in the week of our visit.
- The service had a Patient Safety Midwife, (PSM) who worked closely with the Head of Midwifery, particularly for reviewing reported incidents. This individual also facilitated lunchtime risk meetings, which took place on Monday, Wednesday and Fridays. A video link could be arranged on request for staff at the Eastbourne site. The PMS said that it was in the main the midwives who reported incidents, although such reports were sometimes inappropriate. For example, a midwife reporting that they could not carry the baby weighing scales.
- It was said to be rare for doctors to complete incident reports but there was no evidence to support this assertion. The incident log could not be filtered to show who had reported the incident by staff group and there was no evidence that any action was taken to improve medical staff incident reporting.

- We joined one of the risk meetings, which was attended by six obstetric and two anaesthetic doctors, a manager and the PSM. A copy of the latest reported incidents since the previous meeting was brought to the meeting by the PSM, as chair. Each incident was discussed; however, we found the teaching discussion to be very basic, with no apparent constructive comment or criticism as to what may have been better or alternative management.
- Where incidents related to the work of an individual healthcare practitioner, we could not see that concerns were identified and the action recorded.
- Examples of incidents discussed in the risk meeting included the disposal arrangements for unused controlled drugs added to infusion bags and a case discussion related to an emergency caesarean section and the use of the drug Syntocinon. The discussion around the second incident highlighted the fact that there was a guideline for the use of Syntocinon but consultants differed on their preferred management. This lack of consistency made it difficult for midwives and junior doctors to deliver the best evidence-based care as they would have to go against trust policy and national guidance to comply with the individual consultants preferences. Failure to follow hospital policy also increased the likelihood of errors occurring
- A third incident discussed related to an elective lower segment caesarean section,(LSCS) which had been reported on the electronic system as being necessary because of previous traumatic delivery. When the notes were reviewed the actual reason for the LSCS was for other medical reasons, and it was agreed that it was the appropriate management. The fact that the reason for the LSCS was reported wrongly was mentioned but not emphasised to the junior doctors and they were not offered support as to helping them to decide what to report. This was a missed opportunity to learn and mistakes such as this would make audit inaccurate.
- The incident log for maternity services showed several incidents that could not be fully reviewed because there was inadequate recording. One incident at the end of September showed that a potentially unjustified caesarean section could not be fully reviewed because, "Documentation almost non-existent". Another incident, dated November 2014, stated that, "Due to staffing levels and skills and busy delivery suite (and pulled midwives). Handover of patients, student not documenting handover, not handing over low temp, not commencing postnatal care booklet".
- The PSM told us the risk meetings were not minuted but a record of attendance was kept and they completed the electronic record with the outcomes and discussion from the meeting. We looked at the log and saw that some limited actions were recorded but it was insufficiently robust to provide assurance that incidents were fully investigated and opportunities for learning were maximised.
- A newsletter was produced, (copies of which we saw) and circulated on at least a monthly basis, via the Clinical Governance Lead. This was displayed in hard-copy in staff rooms and offices, as well as emailed to staff on all sites. The Practice Development Midwife was said to take on board the required learning and a quarterly newsletter about this was disseminated to staff. We viewed a copy of the latter to confirm this.
- The Clinical Director told us they reviewed the weekly incident reports on a Thursday with the Patient Safety Midwife (PSM) but there was no documentary evidence of this.
- Where incidents were escalated as being serious the PSM was responsible for arranging professional review, which involved consultants and senior midwives. All the necessary information, including statements and root cause analysis outcomes was gathered by the PSM.
- A further review took place within the Serious Incident Review Group (SIRG) meeting. This group was attended by representatives from across different departments within the trust and they had a role to critique the investigative process, to make recommendations and actions. These were subsequently communicated to the Clinical Commissioning Group. We were not supplied with the minutes from these meetings.
- Mortality and morbidity meetings were held on a monthly basis. These were attended by Obstetric and Paediatric consultants and had midwifery representation. We noted from the minutes of the meetings held between September 2014 and February 2015 that several cases were carried over for discussion several months after the birth. The suggested learning from these meetings was recorded as action points but there was no evidence of follow up or how the learning would be disseminated. For example, one baby had a low skin temperature on transfer to the special care

baby unit (SCBU) from theatre. The SCBU staff reported this as a frequent occurrence and the action was for the Head of Midwifery and chair to discuss pre-warming. There was no record of this having happened on the following months update from previous meeting. There was no other evidence of this having been done.
- Community midwives were not always made aware of safety alerts. For example, they were not aware of the NHSE Patient Safety Alert (June 2014) concerning standing water when using birthing pools.

Safety thermometer

- We asked to see the maternity dashboards for the period October 2014 to the end of February 2015. We were told a new electronic management system had started to be used but this was not functioning correctly and as a result there was no data for the last two months.
- We were supplied with dashboard data for the unit from April - November 2014 and could see that there were significant concerns about the unit meeting targets. The number of normal deliveries during this period was RAG rated red for every month with an average of 39% against a target of 60%.
- The data showed that there were three instances of hypoxic-ischemic encephalopathy (HIE) during the period against a target of 0.
- The midwife to birth ratio was very variable with a range of 24:1 at best and 33:1 at worst.
- During our observations on the ward areas we looked to see if there were any previous results displayed in respect to the maternity safety dashboard. This would usually monitor outcomes such as number of falls, number of pressure sores and infection rates from urinary catheters. We did not see any dashboard information formally displayed, other than there not having been any Meticillin Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile.

Cleanliness, infection control and hygiene

- There had been no episodes of Meticillin Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile in the maternity service during 2014.
- We found the environment in which women were receiving care on each site appeared clean. Comments made by women who were using the service included: "It feels like a nice clean and safe environment." Another said with reference to the post-natal ward, it was clean and hygienic.
- We did not see any information displayed which would inform the public of the expected standards of cleanliness or the frequency of cleaning. We spoke with a member of domestic staff and they said they did not have any guidance but undertook all the necessary cleaning daily.
- Separate cleaning requirements were in place for clinical staff to follow. We saw for example cleaning checks on incubators and we found other equipment to be clean and ready for use.
- We saw domestic staff had been provided with the recommended separate colour coded cleaning equipment for different areas of the departments. This enabled them to minimise risks arising from cross contamination.
- Environmental checks were said by staff to be carried out and entered onto a database. We requested evidence of these cleaning checks, carried out in accordance with the National Specifications for Cleanliness in the NHS (2007) but these were not provided. The delivery suite is a graded as a very high risk area and cleanliness audits should take place at least weekly until sustained high levels of compliance with the cleaning schedules are achieved.
- We asked for environmental audits and were provided with copies of the Health and Safety checklist but no cleanliness audits.
- Staff on the maternity unit told us that there was no infection prevention and control link midwife at Conquest. Staff in other areas said there were infection control link midwives, although they didn't always know who the individuals were. These staff members were said to attend infection control meetings, although there was no certainty as to the frequency of these. Standards were said to be monitored by infection control link staff. We asked for evidence of this, including the minutes of the infection prevention and control meetings, but these were not provided. We have since been told by the trust that there is an infection prevention and control link midwife in post and had been at the time of the inspection.
- We observed staff to be complying with the trusts dress code, which included having bare arms below the elbow

to facilitate full hand washing. Staff were seen using personal protective equipment, (PPE) such as gloves and aprons appropriately. There was good access to PPE in all areas that we visited.

- There was access to hand washing and drying facilities and we observed staff hand washing during the course of their duties. Hand hygiene monitoring indicated 90% compliance on the midwifery led unit at Eastbourne for February 2015. The last results on display in Crowborough Birth Centre (CBC) indicated 100% compliance with hand hygiene checks in December 2014.
- Training information supplied to us indicated 87% of midwifery staff had completed their infection control training and there were further dates planned for the coming months.
- We saw that staff handled and disposed of clinical and household waste correctly and sharps items were disposed of in safety receptacles. The majority of sharps bins had been correctly labelled and dated.
- We saw staff had access to infection prevention and control policies. These were accessible on the hospital intranet, a sample of which were reviewed by us. We saw out of date policies in respect to the following: 'Managing the risk associated with infection prevention and control' and 'Universal infection prevention and control precautions'. The latter was due to be reviewed October 2014.

Environment - Conquest Hospital

- As far as possible, the areas in which women were receiving their care had been suitably laid out to afford privacy and access to facilities, such as toilets and bathrooms. Staff were seen to ensure that privacy was provided at all times, for example when supporting women with their care. The labour ward at Conquest had ten delivery rooms with ensuite facilities. One delivery room had a birthing pool. In reply to our questions there was a vague response as to the process for removing a woman from the pool in an emergency. We were told there were 'PAT slides' and we saw these present by the pool. A support worker also showed us a net to be used. We were told there was no formal practising of emergency evacuation of the pool but the pool was mainly used for pain management and not very often for delivery. There was no standard evacuation policy for staff to follow.
- There were two operating theatres on the labour ward at Conquest, one of which was only used when the primary theatre was in use, such as in response to an emergency. The primary theatre had associated clean preparation area, anaesthetic equipment, scrub facilities and dirty area for the management of clinical waste and used surgical instrumentation. Appropriate checks had been carried out of equipment and there were safe systems in place for the management of medicines, fluids, surgical instruments and other associated items.
- The postnatal ward was a 19 bedded until with 4 transitional care beds. The day assessment unit located on the antenatal ward had 4 beds. The antenatal ward had 14 beds which included 2 side-rooms.
- On each area a whiteboard was completed by staff to indicate where women were allocated. The boards were not, in all cases, placed in areas where they could not be viewed by the public. Information noted on the boards included each person's initial and surname, plus where relevant an indication of a problem. For example if a woman had a third degree tear.

Environment - Eastbourne District General Hospital

- The Eastbourne maternity unit had two delivery rooms, one of which had a birthing pool. This was adequate provision for the number of deliveries occurring at any one time. Delivery room four contained the emergency equipment.
- The day assessment unit was used for antenatal care and for triage. This area was arranged to facilitate treatment and care and afforded privacy.
- There was sufficient level of privacy afforded in the maternity areas viewed. One new mother spoke with us on the Eastbourne maternity unit and said, "The environment and care is spot on

Environment - Crowborough Birthing Centre (CBC)

- There were two birthing rooms, with access to a birthing pool in one of these. This was adequate provision for the number of deliveries occurring at any one time. Toilet and bathing facilities were easily accessible. Separate dining room and areas for antenatal care were provided.

Equipment

- In each location we found there was access to resuscitation equipment, including equipment for neonates. Regular safety checks had been undertaken and checks were embedded in the daily routines. Drugs required for resuscitation were available and in date.
- Emergency equipment used for responding to pregnancy related complication was accessible to staff. This included pre-eclampsia (a disorder of pregnancy characterised by high blood pressure and large amounts of protein in the urine) and postpartum haemorrhage kits.
- The majority of electrical equipment safety checks had been carried out and items were labelled to indicate this. Sonicaids in the Eastbourne maternity unit were found without up to date checks in two rooms and the ear thermometer was last tested in 2013.
- We saw that Cardiotocography (CTG) equipment used for monitoring fetal well-being was readily available.
- Resuscitaire's, used to support new born babies who may need warming or resuscitation after delivery, were available in each delivery room at the Conquest site and were accessible in the midwifery-led units. These had been checked on a daily routine schedule, with records made to support this.
- Staff working at Conquest said there were insufficient items of some equipment, such as blood glucose monitors for babies and said it was a protracted process to obtain new items. There was a limited number of electric beds and none were specific for women with bariatric needs.
- The WRASH Advisory Group meeting minutes dated 22 December 2014 showed that the unit had a shortage of Sonicaids for monitoring foetal heart rate without the need for a scalp monitor. These were essential for monitoring a normal delivery. It was suggested that a business case be put together and if this failed then to go to the League of Friends. Minutes from the subsequent meeting showed that the money for these had to be obtained from the Friends.
- There was a similar problem when the local policy changed such that all intravenous drugs and fluids had to be administered using a pump. There were insufficient pumps, according to the minutes of the WRASH Advisory Group.
- One woman who spoke with us said she had been disappointed by the lack of equipment to help with labour and the birth when she had to deliver at the Conquest site. She said there were no balance balls or mats available.

Medicines

- The systems and processes for managing medicines, including ordering, storage and administration were reviewed by us. We found there were systems for overseeing the availability of stock, with checks by Pharmacy on a bi-weekly basis confirmed by staff.
- Medicines were generally stored safely, within locked cupboards in designated treatment rooms. The exception to this was Konakion, (a medicine used to correct vitamin K deficiency in babies) at Eastbourne maternity unit, items of which were found in drawers in delivery rooms. Medicines trolleys used for staff to administer prescribed medicines were locked and secured to walls.
- We saw that controlled drugs (CD's) were stored correctly and there were processes in place for undertaking routine counts of stock, with signatures to support such checks.
- A fridge used for storage of medicines on the Midwifery Led Unit (MLU) at Eastbourne did not have a lock. The rationale for this was said by staff so they could access drugs promptly in an emergency.
- Staff had carried out checks on the fridge temperatures used for storing temperature controlled medicines.
- There was access to emergency medicines, such as those used for allergic reactions and treating low blood sugar.
- Prescription records were checked and we noted that there were many of these which were not on the original form, having been photocopied. They did, however contain all the same information as the original but on a less robust form. Staff told us this was because there was lack of stock of card forms.
- We saw in one case a note had been left attached to the records for a midwife to sign for vitamin K injection which had been given but not signed for at the time.
- Staff had access to up to date information on medicines.
- We observed staff undertaking a medicine round on the Conquest site and saw the staff member followed safe procedures.

- Drug errors were reported via the incident reporting system and were reviewed under the normal incident process.

Records

- Women held their own paper maternity record that they brought to appointments and which was used to record information throughout the pregnancy. Parents were given a 'Red Book' once their baby was born to record child health information as the child grew and transferred between services. These patient held records were in addition to the hospital recording system.
- We were told that a new electronic records system (E3) had been introduced at the end of last year and had caused considerable problems in maternity services. For example, the maternity dashboard could not be populated and women who had experienced a still birth had received a 'congratulations on the birth of your baby' letter. Remedial action was said by staff to be being undertaken during the week of our visit but the problems caused significant distress to bereaved parents and had been extremely frustrating and time consuming for staff. Some community staff could not access the system and this had resulted in some information not being communicated effectively between teams.
- We looked at eight sets of treatment and care records. Six of the records we reviewed for women in the maternity areas provided an indication of their initial assessment and individual needs, including options and wishes with regard to the delivery. This included, where relevant, a safeguarding plan.
- Although there was no specific page in the care notes for identifying the preferred birthing plan, there was evidence of discussion about this at 36 and 40 weeks respectively in one set of notes reviewed. Women's wishes during the delivery had been recorded, as had the amount of time that mothers had skin to skin contact with their new baby.
- Gaps in records included absence of preferred names on four records and incomplete signature records in two cases. We noted in one case the fetal heart rate had not been recorded after a vaginal examination and there was no evidence for this same individual that the fetal heart rate had been auscultated in labour between 15:20 and 17:10 hours. The fluid intake for one individual had not been recorded and their output had only been recorded once.
- Information required to support the continuity of care had been documented and we saw care had been reviewed as the labour progressed. We found where a tear had happened staff had recorded the time of commencement of post-delivery suturing.
- We asked staff about record audits and were told there was an on-line notes audit, which was completed on a monthly basis. The involved reviewing 12 sets of notes taken from each area, including the community. Results were said to be discussed at the monthly matrons' Quality Review Meeting. We asked to see audit results but the matron in question did not know how to access these which meant that this matron was not using the audit results to improve recording practice.
- We were not provided with the minutes of the matrons' Quality Review Meeting.
- We have an email from the trust that confirmed there were no records audits had taken place within the preceding six months so the results could not have been discussed at the monthly Quality Review Meetings.
- Risk assessments including those for venous thromboembolism were in place as part of the documentation but were not consistently recorded. For example risk assessments were incomplete for the first postnatal assessment in one case, although they had been completed during labour assessment.
- There was an audit of VTE assessment in antenatal and postnatal patients on maternity wards that had a planned start date of July 2014 but at the time of writing the report the lead for this audit had not completed the report.
- Staff had documented where women had specific wishes outside of the norm.
- Medicines given and any post-delivery interventions required had been recorded.
- Women had their own maternity records, which were brought into the hospital and these were supported by hospital based hard copy records. Staff also completed an electronic record, which detailed the specifics of the delivery and registered the baby's birth.
- We noted detailed assessment of the new born and any required care entered in notes.

- The discharge arrangements for women following the baby's birth included provision of a 'red book', which is used to provide a record of the child's health.
- We identified one set of women's hand-held notes on the labour ward at Conquest, which should have been returned to the mother on discharge. This was brought to the attention of the matron and arrangements were made to deliver them to her.
- We were able to identify confidential information as to the reasons for staff sickness absence contained within a folder, in which the off duty documents were kept on an open shelf in the labour ward at Conquest. Unsecured records were also found in one of the birthing rooms on the midwifery-led unit at Eastbourne.
- We found an unsealed bag of confidential papers in one delivery room, which included referral letters about patients.

Safeguarding

- Midwives demonstrated their knowledge about safeguarding, such as signs and symptoms they may look out for and what they then did if they suspected a safeguarding matter.
- However, the failing of the service to learn from incidents and mistakes such that there were serial repetitions of similar incidents was not recognised as a potential safeguarding risk. Incidents that resulted in actual or potential harm were not recorded or referred as safeguarding concerns (such as the RCA from April 2015 where low staffing levels were recorded as exacerbating the injury to the baby).
- There was good knowledge about safeguarding that was external to the unit (such as risks within families) but much less recognition of the risks from within the service.
- Additional support forms were completed where a safeguarding matter was identified as a concern and the community midwife held a copy of this. Further copies were made available to the ward. Ward staff were alerted by the electronic system when an individual was admitted who was subject to a safeguarding concern.
- The majority of maternity staff had been trained in regard to safeguarding children and young people. Training figures reported to us indicated safeguarding children's training to be at 85% with forthcoming training days identified. The training matrix indicated there were 6 midwives who had not completed level 3 safeguarding children training and this was recorded as n/a.
- We noted however from training data supplied that there were a significant number of staff who had not had safeguarding vulnerable adult training since 2012.
- We saw a good example of staff following best practice guidance in respect to safeguarding of a vulnerable person. Community midwives reported having safeguarding supervision sessions on a quarterly basis with the safeguarding midwife. Regular safeguarding supervision from a safeguarding supervisor is a requirement for community midwives to support them in their care and management of families with safeguarding needs.
- Safeguarding was overseen by a safeguarding midwife, although it was said "Not to be satisfactory" by some midwives. This was linked to poor communication of information from the acute unit to the community staff. Safeguarding was seen as a high risk area for clinical practice by community midwives.
- Midwives working in the Langley team said there was insufficient time to support this aspect of their role. For example, the midwife we spoke with was late going off duty as they were busy writing safeguarding reports.
- We were told that where community midwives could not get to safeguarding meetings, the safe guarding midwife attended and fed back to them. Midwives said when working in the Children's Centres, they either did not have access to a computer or the computer did not interface with the ESHT system, so they could not follow up on cases. The impact was that safeguarding issues may not have been identified and that on-going work may have had to be cancelled or rescheduled in order to attend case conferences.
- Another community midwife explained how safeguarding took a "huge amount of time", to attend meetings and cover clinics.
- Staff reflected positively on the multi-disciplinary team working around safeguarding in Eastbourne. Midwives told us the team was supportive and communication was good between the midwives, health visitors and social services.
- There were arrangements in place for securing the areas in which mothers and babies were receiving treatment and care. We were unable to access any area without

first pressing the buzzer to the ward and identifying ourselves the majority of the time. However, we were able to 'tailgate' individuals who were entering wards in front of us on a couple of occasions.
- We reviewed the policy for 'Security of the new-born, identification of neonates and guidance on suspicion of abduction or a missing baby form maternity'. This contained sufficient information to guide staff accordingly, was in date and due to be reviewed in December 2015.
- Community midwives told us they did not get many cases of Female Genital Mutilation (FGM) but they were aware of their responsibilities for safeguarding in these instances.
- Since September 2014 it has been mandatory for all acute trusts to provide a monthly report to the Department of Health on the number of patients who have had FGM or who have a family history of FGM. In addition, where FGM is identified in NHS patients, it is now mandatory to record this in the patient's health record. Since September 2014, all acute trusts are required to provide a monthly report, which will be anonymous and no personal confidential data will be shared as a result of the information collection. When staff were asked about this it was evident that no formal processes had been put in place in response to these requirements.

Mandatory training

- We spoke with the Practice Development Midwife (PDM) who told us that there was a rolling training programme , with specific subjects covered on the four respective study days. A colour coded system was used to differentiate the differing content of each study day. For example on a pink day safeguarding and supervision was covered and on green days bereavement was included. We saw that 44 staff had attended the yellow, mandatory training day in March 2015. Content of this included for example; Mental Capacity Act, Deprivation of Liberty Safeguards, blood transfusion and information governance.
- There was a significant difference between what we heard and were shown on site and the records provided by the trust.
- Training data supplied to us indicated that midwifery staff undertook role specific training in respect to infusion devices, anaphylaxis, oxygen therapy and nebulisers but not training in essential areas such as management of shoulder dystocia, management of antepartum and post partum haemorrhage and management of a vaginal breech birth as recommended in the intercollegiate document Safer Birth (2007).
- The data provided by the trust showed a different picture of the rates of completion of mandatory training. The training matrix showed that at Conquest midwifery staff had completion rates lower than the trust target with 83% having completed BLS, 82% Blood transfusion training, 80% infection control training and just 42% having completed equality and diversity training.
- Junior medical staff at the Conquest had completion rates as follows; antibiotic prescribing 73%, BLS 64%, IPC 46% and information governance 46%.
- Midwifery staff at CBC performed slightly better with 85% having completed BLS, 90% IPC and 90% having completed transfusion training. Only 8% had completed equality and diversity training.
- Matrons told us there were monthly skills and drills on the labour ward and the anaesthetists ran simulation sessions. The PDM explained that Practical Obstetric Multi-Professional Training, (PROMPT) training was to be introduced from June 2015 but was not yet in place. A number of staff had already undertaken the training in this regard and would be cascade training. PROMPT is an evidence based multi-professional training package for obstetric emergencies. It is associated with direct improvements in perinatal outcome and has been proven to improve knowledge, clinical skills and team working.

Assessing and responding to patient risk

- There was evidence from RCA reports following serious incidents that trust and national guidance was not always being followed and that this had an impact on the wellbeing of women and their babies. There were examples of where the staff repeatedly failed to respond to situations in accordance with trust guidance around CTG interpretation and escalation of concerns and those relating to diminished fetal movements.
- The RCA reports provided by the trust showed that poor communication between staff was implicated in several serious incidents where the patients or their babies condition was deteriorating.
- There was an efficient telephone triage system in use on both the labour ward at Conquest and on the

assessment unit at Eastbourne. We heard midwifery staff deal sensitively with the women who had called and saw that information was recorded on a pro-forma document.

- Midwifery staff were not always undertaking general risk assessments as part of their routine practice, such as risk assessments concerning the individual's skin condition and risk of tissue damage over bony prominences and risk of falls. We saw assessments of the risk of developing a venous thromboembolism (blood clot). Where interventions were required we saw these were acted upon. For example, prophylactic blood thinning medicines had been prescribed.
- Midwifery staff used a Modified Early Warning System (MEWS) in each area to assess the well-being and condition of the individual. Safety parameters enabled clinical staff to identify concerns and to request support from medical personnel as necessary.
- Risk assessments carried out at booking included social and medical assessment and if necessary referral for relevant support.
- We attended the operating theatre for the initial part of the process leading to a planned caesarean section. Safety checks were carried out by staff, including relevant checks with the patient. These checks were in accordance with the World Health Organisation (WHO) recommended best practice guidance. WHO safety checklist records were seen in care notes reviewed where relevant.
- We reviewed Cardiotocogram records (CTG's) for dates, times and signatures and found these had been completed as expected.
- Community midwives reported anecdotally less deliveries before arrival at the planned location. Midwives said women knew they needed to add time to their journey.
- In the report we published following our inspection in September 2014, we expressed doubts about the robustness of the data relating to babies born before arrival at the Conquest unit. Information about babies born before arrival (BBA) was said in the Maternity and Paediatric Quality and Safety report to refer to those babies born before the arrival of a midwife and therefore even if a paramedic was in attendance it would still be classified as a BBA. The report indicated that action had been taken to ensure BBA's were reported accurately, with sub categories indicating where the baby was born and whether it could have been avoided or not. This action was to be implemented by 1 April 2015.
- Figures presented in the report for 2014 indicated four BBA's related to women who were booked to deliver at the Crowborough Birth Centre and 15 for women booked to deliver at either Eastbourne District General or the Eastbourne Maternity Unit. There were 26 BBA's for women booked to have their deliveries at the Conquest site. There were no reported adverse outcomes in any of these instances although at least one was avoidable as the mother had been sent home from the delivery suite an hour before giving birth, unexpectedly, at home.

Midwifery staffing

- Staffing levels were a identified as a major concern during our inspection in September 2014. The situation has not improved significantly and women are still subject to care lapses due to low staffing levels at the Conquest hospital.
- The unit risk register recognised that low staffing was an on-going risk. The entry related to midwifery staffing said, "Staffing is an on-going concern. One of the consultants reported that the HOM has put forward a paper exploring the options to resolve the staffing issues. This has gone to CME this week, we await their decision. No change to scoring." The entry was opened in January 2015.
- The trust had an escalation policy that was not fit for purpose. It suggested that when staffing shortages occurred during daylight hours the manager should explore possibility of moving midwives from better staffed shifts. There were no better staffed shifts and moving staff resulted in closure of midwifery led units.
- The policy for night time shortages was similar but the second option was to call in the on-call community midwife whilst acknowledging they had worked all the previous day and had work commitments the following day.
- We asked for a report of monitoring of the escalation plan and were directed to the maternity Dashboard which gave some very basic information about the number of women affected by unit closure but this did

not monitor the effect on staff of moving workplace, additional hours incurred, how often community midwives were called out or other information to provide assurance the escalation plan was effective.

- Staffing levels were displayed on the post-natal ward at the Conquest and indicated the expected midwifery and support staff levels along with the actual for the day and night shift. On the day of our visit we were told there were nine staff on duty, one of whom was an agency midwife when the planned establishment was for ten midwives.
- We reviewed the duty rotas on the Conquest site for the period 5 January to the 25 March 2015. We were advised that there should be 10 midwives on duty during each 12 hour period of duty we found between this period that this had been achieved on only 15 occasions on nights and on four occasions on days. There were numerous incident reports relating to low staffing levels and the impact this had on patient care.
- Staffing levels had been reported on a number of occasions via the incident reporting system and we saw a copy of the report for the period 1 September 2014 to 25 March 2015. The number of reports on this matter ranged from two in March to 10 in December 2014. This correlated with the information provided by some staff, who said there had been some difficulties in December in getting the right number of staff.
- There was no supernumerary labour ward co-ordinator. The intercollegiate document, Safer Childbirth: minimum standards for the organisation and delivery of care in labour recognises that there should be a an experienced senior midwife on each shift and who is supernumerary to planned establishment to optimise patient safety.
- We were told that a Band 6 midwife was sometimes the most senior staff member on duty. Within the staffing numbers staff nurses (not trained as midwives) were also counted as part of the midwifery staffing complement. The latter arrangement was said to have been put in place to free up midwifery time, as registered nurses could look after mothers after the birth.
- Staffing acuity was said to be entered onto an electronic system at various four-hourly intervals daily. However the matrons said they did not see the audit of this and whether it reflected activity or acuity on the wards. Staffing levels were based on the e-rota dictating numbers, rather than what was actually required.
- A midwife described staff as feeling the integration of Eastbourne and Conquest had been imposed on them and the current staffing model meant staff based at the Crowborough Birth Centre (CBC) carried full caseloads providing antenatal and postnatal care and also had to care for women in labour. They said, “It’s so hard sometimes because you can start work here, or think you are going to start your shift here but then if Conquest is short staffed our staff are called to work there – which is at least one hour’s drive, sometimes two from here and we might have to close this unit.” The intercollegiate document, Safer Childbirth: minimum standards for the organisation and delivery of care in labour states, "Staffing of the labour ward must not be at the expense of other areas of the maternity service.
- Staffing support was said not to be reciprocated to the CBC, for example, the night before our visit staff had to transfer a baby who was unwell and this meant that a member of staff at the CBC had to be pulled out of a mandatory training on the day of our visit to cover the work of the midwife who went with the woman and baby to Conquest the previous night. The midwife herself went to bed for the morning and then got up to do her clinic during the afternoon. We were told, “It’s really hard for staff to get time back off they work longer hours – to make it up.”
- An incident recorded as occurring during late September 2014 showed that a midwife had worked a 9-5 day and then provided on call cover. She had been called out at 22.00 and worked through the night, finally being relieved so she could go home at 7.00am. After approximately three hours sleep she had returned to work from 12.30 - 21.00hrs that day.
- Staff working in other designated non-clinical roles reported that they frequently were called upon to help with clinical care. This included the Patient Safety lead and Screening Midwife. Staff were also moved from other maternity areas, such as the CBC.
- A student midwife reported that it was hectic at times and sometimes it was calm. When it was busy or they were short staffed people (staff) became a little tense. She added it was either “feast or famine.”
- A student midwife in their first year told us they had been on their own and delivered a baby as there were not enough midwives to support the student. This was contrary to the Midwives Rules and Standards (2012) issued by the Nursing and Midwifery Council.

- Comments made in respect to the staffing problem included the lack of willingness for managers and specialist midwives being prepared to "roll their sleeves up" and work clinically. Some of the specialist midwives were viewed as being detached from what was happening and were not necessarily part of the ward teams.
- Community midwives reported an inconsistent approach to staffing arrangements. For example, one matron was said to be supernumerary but others were not and had case-loads. They reported confusion around compensatory rest time. For example on-call shifts were done before or after working a long day. If they took time to rest rather than starting a rostered shift after working in the on-call shift they were expected to pay the time they had taken back to the trust.
- On-call arrangements by community midwives were limited to a number of midwives only, as several could not do on-call. This was impacting on some, who were then having to do on-call back to back and as many as five on-calls per month.
- Shortages of midwifery staff were acknowledged by medical staff. We asked staff if they thought women were safe. Responses included, "Yes, but I do think something needs to be done about staffing levels." And, "We need to look at how we use what we have."
- A review of the maternity risks within the Supervisors of Midwives, (SoM's) meeting, which we attended on the 25 March 2015 indicated that there had been a 24% deficit in staffing (12% vacancy rate).
- We asked if staff were aware of the possible changes in staffing or knew about plans to improve staffing. The SoM's were not aware of any communication plan but agreed that they could put information about this in a newsletter and could disseminate information on a 1:1 basis and at staff team meetings.
- Requirements around staffing levels for professionals involved in the provision of safe care to women and their babies should demonstrate that the maternity service is working towards the recommendations within Safer Childbirth (RCOG 2007). The trust reported a better than England average for the midwife to birth ratio of 1:25 in December 2014 but we noted the ratio varied between this and 1:29, which was the level for March and July 2014.
- We received differing reports as to the midwife to patient ratio for women in labour. For example, minutes from the previous SoM meeting were confusing because they demonstrated differing ways of measuring rates of 1:1 care between September – December 2014. One way recorded 41%-53% of high risk women had 1:1 care in labour and the other (using an acuity tool) that 80%-91% had 1:1 care. We asked attendees at the SoM meeting if they could explain this difference but none could.
- The Maternity Dashboard 2014-2015 showed that the percentage of women receiving 1:1 care in labour was not recorded.
- The Maternity Dashboard 2014-2015 showed that the ratio of births to WTE midwives was variable. The monthly scores were mainly amber rated with some months showing as green and a range of between 24:1 - 33:1 against a target of 30:1. The intercollegiate document, Safer Childbirth: minimum standards for the organisation and delivery of care in labour states that a minimum midwife to women ration of 1:28 is necessary for a safe level of service to ensure capacity to achieve 1-2-1 care in labour. For services with more complex case mixes (such as the Conquest Hospital) it may mean a lower midwife to women ration of 1:25 to achieve this.
- We were told the midwifery management used the Birthrate plus (BR+) workforce planning tool to assess midwifery staffing needs. The foundation of BR+ is one to one care throughout labour which Conquest Hospital was not achieving.
- We saw there was an identifiable member of staff in charge of the duty shift. Discussion took place at the SoM meeting of the need to have Band 7 midwives' as supernumerary but there was no clear plan to achieve this or improve the current position.
- The staff turnover rate for midwifery for year to 28 Feb 2015 was said by the trust to be 13.2%, which equated to 16.6 full time equivalent leavers.

Medical staffing

- We were informed by the Clinical Director that there were ten consultants in place with 72 hours of consultant presence. This was provided Monday to Friday between the hours of 08:30 and 20:30 hours, with an additional telephone contact up to 22:00 hours. Weekend cover was provided 08:30 – 14:00 on Saturday and Sunday, 08:30 – 12:00, with on-call outside of these hours.

Maternity and gynaecology

- Staff confirmed there was consultant presence and that a Registrar and Consultant were available via the on-call system out of hours.
- The Clinical Director, who was a Consultant for Obstetrics and Gynaecology, discussed with us medical staffing and provided an update as to the arrangements in place. There remained two vacancies of middle grade doctors, although they had appointed to these and they were expected to start work in May. Individuals participating in the on-call arrangements were deemed to be fully competent. Where locums were needed, they only used "known" individuals and assigned these to low-risk areas, such as Eastbourne. A regular and familiar locum was used to fill gaps on nights.
- We were told a benefit of the merger had been the increase in medical staff numbers at middle grade on the Conquest site and there had not been any pressure to reduce these or cut down.
- We were present on the day assessment unit at Eastbourne when a locum doctor arrived to cover the shift. This person had not been to the location before and had no identification but was allowed to continue to work. Staff had undertaken a local induction after contacting the Conquest to ascertain the arrangements.
- Consultants undertook antenatal clinics at Eastbourne every Monday, alternate Tuesdays and Wednesdays and every Thursday, in addition to alternate Fridays.
- We were told there was supposed to be a registrar present every day at the day assessment unit but three times in the last six months there had not been a doctor available.
- There was an anaesthetist available immediately throughout the day and via on-call out of hours. A consultant anaesthetist was available on the labour ward during daytime hours and via on-call out of hours.
- We attended the consultant handover, which took place at 08:30 hours. Present at this meeting was the oncoming consultants, the night senior house officer (SHO) and night registrar and day staff. The night consultant was not present but had discussed activity with the oncoming consultant, who was covering sickness. Individual women were discussed and provisional plans were made, such as referring a woman to gastroenterology. Handover took place in an empty room and a handover sheet was completed by the SHO or Registrar and signed by the doctors coming on duty. This copy was provided to the Clinical Director for filing.
- There was no evening handover as recommended in the intercollegiate document, Safer Childbirth: minimum standards for the organisation and delivery of care in labour and identified following our inspection in September 2014.

Obstetric theatre staffing

- Elective caesarean sections took place weekdays, with the exception of Thursdays and weekends. There were two teams of theatre staff providing cover for elective surgical days and for emergency obstetric cases 24/7. A midwife was assigned to surgical lists to manage the care of the baby following delivery.

Administrative staff

- There was no administrative support ward clerk on the labour ward, which meant that staff had to deal with phone calls and queries. Between the hours of 09:00 and 16:00 a ward clerk was available on the post-natal ward.

Major incident awareness and training

- A member of midwifery staff said they would not be involved in responding to a major incident.
- We saw the Major Incident Response Plan for Receiving Casualties during a Major Incident related to Conquest and Eastbourne hospitals. We did not see any reference to maternity services and what staff would be expected to do in terms of response, such as cancelling elective C. sections.

Are maternity and gynaecology services effective?

Requires improvement

Care and treatment did not always reflect current evidence-based guidance, standards and best practice. Implementation of evidence-based guidance was variable. Staff had access to and were using evidence-based guidelines to support the delivery of effective treatment and care; however a number of these were not up to date. There was a high rate of induction of labour and lower than the trust target levels of normal deliveries. There was also evidence that very few women were having a manual sweep of their membranes prior to induction, as recommended in NICE guidance.

Maternity and gynaecology

The trust was not meeting the standards set down in the intercollegiate document Safer Childbirth; minimum standards for the organisation and delivery of care in labour (2007). Apart from staffing, the trust failed to meet the standards relating to specific roles on the labour ward, inter-professional training and handovers. It is acknowledged that there had been improvements to how handovers were conducted since our last inspection but there was still no physical evening handover despite a 72 hour consultant presence.

Outcomes for people who use services were sometimes below expectations compared with similar services. The outcomes of people's care and treatment was not always monitored regularly or robustly. Patient outcomes were variable with low levels of women having normal deliveries and higher than expected induction of labour rates and poor breastfeeding initiation rates. There was no monitoring of the numbers of women having one to one care in labour at Conquest, for example.

There were low numbers of stillbirths but the incidence of HIE was above the trust target.

There were mixed reports from women as to the effective management of their pain. Although there were choices for managing pain, they were not always acted upon. An anaesthetist was on duty to administer epidurals but overcrowding and staff shortages sometimes meant women could not have the pain relief of choice. The birthing pool room was often in use for women who were not using the pool and the staff reported that the pool was rarely used. There were no audits of pain management.

There were mixed views as to the quality and choice of food provided.

Support was offered to women feeding babies, although there were several recorded incidents where appropriate postnatal support was not offered. Breastfeeding rates on initiation were consistently below the trust goal of 85% with a monthly range of between 73.7% and 75.4%. The England average according to UNICEF statistics published in 2012 is 83%. The trust had not yet achieved UNICEF Baby friendly status but was working towards this.

Not all staff had the right qualifications, skills, knowledge and experience to do their job. Staff were not always supported to participate in training and development or the opportunities that are offered did not fully meet their needs. There were no specialist teenage or substance misuse midwives who had the specialist knowledge and skills needed to support these groups. Staff were competent in their roles but there were some subject matters in which staff had not yet received training and there were some limitations in accessing specialist skills.

There were gaps in management and support arrangements for staff, such as appraisal, supervision and professional development.The appraisal rates were low and this was recognised on the maternity risk register.

Women were provided with information which helped them to understand their treatment and care before consenting to this.

There was access to service out of hours. Staff worked well as part of the multidisciplinary team to serve the interests of women in the hospital and community settings.

Audit in respect to maternity service outcomes was taking place and there was monitoring of various standards via the maternity dashboard.

Evidence-based care and treatment

- The Clinical Director explained that there was a Guidelines Development Group, which met every two months. New guidelines were said to be sent to all staff by email and they were required to send a reply by way of acknowledgement that they had read the information.
- During the Supervisor of Midwives meeting, which we attended, attendees were advised that the National Institute for Health and Care Excellence (NICE) Intrapartum Care Guideline was being reviewed; guidance on auscultation of fetal heart had been changed and so the policy was being reviewed by consultants and a new policy would be introduced in the next few months. Prolonged rupture of membranes policy was also said to be under review.
- The maternity services were not meeting the national guidance on optimum staffing levels and roles, staff training and evening handovers and the care of women using the maternity services in line with the national guidance Safer Childbirth: minimum standards for the organisation and delivery of care in labour.
- Staff had access to guidance, policies and procedures via the trust intranet. We reviewed a number of these and found that most but not all were up to date. Out of date information related to the guidance for storage and

histological examination of the placenta, which was due to be reviewed in November 2014. Two policies related to the early and late medical termination of pregnancy were due to have been reviewed in 2010.

- We found from our discussions and from observations that care was being provided in line with the NICE Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care. We saw from our observation of activity and from reviewing care records that the care of women who planned for or needed a caesarean section was managed in accordance with NICE Quality Standard 32.
- We found sufficient evidence to demonstrate that women were, generally, being cared for in accordance with NICE Quality Standard 190 Intrapartum care. This included for example; having a choice as to where to have their baby, care throughout their labour, monitoring during labour and care of the newborn baby. However, choice was affected by staffing so their decisions may not be honoured. We saw evidence provided by midwives of women having to change their plans due to closure or potential closure of the birthing units and a woman being discharged at night with their newborn baby. There were also recorded incidents of women having to labour and deliver on a ward area without their preferred analgesia and another who had premature rupture of their membranes who was told to sit in a corridor and wait as there was no space on the delivery suite.
- There was evidence to indicate that NICE Quality Standard 37 guidance was being adhered to in respect to postnatal care. This included the care and support that every woman, their baby and as appropriate, their partner and family should expect to receive during the postnatal period. On the post-natal ward staff were supporting women with breast feeding and caring for their baby prior to discharge.
- Breastfeeding rates on initiation were consistently below the trust goal of 85% with a monthly range of between 73.7% and 75.4%. The England average according to UNICEF statistics published in 2012 is 83%. The trust had not yet achieved UNICEF Baby friendly status but was working towards this; 49% of trusts nationally have full accreditation.
- There were arrangements in place that recognised women and babies with additional care needs and for referring them to specialist services. For example, there was an on-site Special Care Baby Unit (SCBU).
- On the Eastbourne site we saw that mothers were able to bring their babies back to have tongue tie corrected. There was guidance within a policy for the management of Streptococcal A infection, which included reference to managing sepsis. Sepsis is a potentially life-threatening complication of an infection.
- The Royal College of Obstetricians and Gynaecologists (RCOG) evidence based guidelines related to feticide: Section 6.7 was being adhered to. This sets out the premise that feticide should be performed before medical abortion after 21 weeks and 6 days of gestation to ensure that there is no risk of a live birth.
- There was evidence from information reviewed and from discussion with staff that the service adhered with The Abortion Act 1967 and Abortion Regulations 1991. This includes the completion of necessary forms; HSA1 and HSA4. HSA 1 form was signed prior to admission and HSA 4 was initiated by the fetal medicine consultant when they agreed to do the termination and was only signed on completion. This was then sent off to the Department of Health. We were told the debriefing midwife who saw the notes and women during follow up checks that the forms had been sent off.
- We asked staff what recent auditing had been or was taking place in respect to service delivery. We were told there had been an audit of the triage service, of which a copy of the action plans arising was provided. We saw that there were timed deadlines for two of the actions, including for example, the completion of the triage record. Two actions had no confirmed target dates for resolution. This included the possibility of training in telephone risk assessment for staff.
- We saw a trustwide audit plan which showed that maternity services were participating in national and trust audits. In some, such as the NICE caesarean section wound infection retrospective study, the lack of availability of notes was an issue that impacted on completion of the audit.
- We saw the audit report for the management of second and third trimester miscarriage and intrauterine death by low dose Misoprostol induction of labour. This had been carried out in September 2014. Recommendations arising from the audit were made and a target date for re-audit was set for October 2015.

- Information on the audit of the introduction of Actim PROM to ESHT was also shared with us. This had been carried out in January 2015. The audit explained that Actim PROM was a swab test to help in the diagnosis of pre-labour rupture of the membranes during pregnancy in cases where the diagnosis was uncertain and a speculum examination was inconclusive. We saw that recommendations were made from the audit, such as the need to log all tests and to record results in the notes. The tests was only to be done when speculum examination was inconclusive and the electronic data system, 'Euroking' (a local data system) was to be used to aid in identifying actual numbers.
- A re-audit of Clexane adherence at home had also been carried out in January 2015. This identified improvement in compliance and patient understanding, which was linked to training of staff and there subsequent education of patients.
- The audit reports we saw were medically led. There was little auditing of midwifery practice.

Pain relief

- We saw that women had access to choices in relation to the pain management during labour.
- As part of the care of a woman undergoing elective caesarean section we were able to observe the preparation and commencement of an epidural. Staff were very informative and supportive throughout the whole procedure, ensuring the woman understood what was happening and was reassured.
- Women told us about their experiences of pain management, the majority of which was favourable, such as pain relief having been, "excellent." One women said staff had given her gas and air (Entonox) as needed and checked on their pain levels throughout the labour. Another said their pain relief had been good and well monitored. Other comments made included, pain relief having been good both before and after caesarean section, although one person said their husband had to remind staff about her pain relief.
- A woman who had been transferred from Eastbourne told us their experience was not as they had hoped. For example they wanted to use a TENS machine but the only one available was broken. They commented on the doctor not having read their medical notes, from which they would have identified medical history which would have affected the drugs they could have in an epidural.
- One new mother said they had asked for pain relief and was refused, other than having a few puffs of gas and air. They said they were "begging for an epidural" but it had been left too late. Another woman said they had been in a lot of pain throughout and the doctors did not seem to accept that.
- An incident report relating to low staffing levels that necessitated women in labour being cared for on the antenatal ward showed that the woman was denied an epidural that they requested.
- Discussion with a woman on the antenatal ward identified their concerns about pain management and in bringing this to the attention of staff. They described how they tried to get through to staff but could not get to speak to anyone and had been passed between Eastbourne and Conquest sites. Eventually when they got through they were able to discuss their pain with a midwife and were admitted to the ward. This person said they were to be discharged home when a doctor noticed they were in pain and recommended they stayed in. After this their experience was affected by a lack of continuity in doctors, having to repeat information and requested investigations being cancelled and then re-instated.
- Community midwives advised us that GP's prescribed Pethidine for pain management.

Nutrition and hydration

- The dietary requirements of women were acted upon. For example a woman who needed a gluten and dairy restricted diet commented on this being met.
- We spoke with women about the provisions of food and fluids. Comments made included: "The food is better than before but you don't get very much." This person said there were no snacks. Another new mother said, "The food is awful and samey." They added that the jacket potato was like a stone and food was, "Just bland." We were told by another woman that food was basic, whilst another said food was poor, very salty, gravy like jelly and porridge like "slop." Positive comments were made by another individual who told us, "There's food you can help yourself to and drinks for both of us and the menu looks good."
- A number of women told us staff had helped them with breast and bottle feeding; however, one new mother

said, "no one has sat with me to help with breast feeding." They told us, "They (staff) keep saying they will but then someone else turns up and it doesn't get followed through."
- Staff said the lead midwife for breastfeeding had left and they were recruiting a replacement. They told us they had peer support for breastfeeding. We saw too that there were a number of volunteers at Conquest who supported women with breast feeding.
- We were told the process of the UNICEF baby friendly initiative for breastfeeding had not been completed. The implication of this is that the service was not meeting the NICE postnatal care quality statement 5 on breastfeeding. (Facilities usually implement the standards in stages over a number of years. At each stage they are externally assessed by UNICEF UK. When all the stages are passed they are accredited as Baby Friendly. Baby Friendly accreditation is considered best practice).
- The Maternity Dashboard showed that the trust had low levels of women who were breastfeeding at initiation with between 71% - 75% against a target of 85%.

Patient outcomes

- Clinical outcomes were reported to be good by the Clinical Director and they had been maintained since the merger. An example of good outcomes related to the number of stillbirths, which was said to be three per 1000. This compared favourably to the national rate of 4.7 stillbirths per 100 births. The Maternity Dashboard confirmed that the trust had few stillbirths.
- The level of Hypoxic Ischemic Encephalopathy HIE) was based on figures supplied in the maternity dashboard as 3 cases of level 2/3 HIE in 2288 deliveries. This calculates to 1 case per 726 births which was within the normal range (quoted by the University of Oxford as 1.3 -1.7 per 1000 births).
- The Maternity Dashboard 2014-2015 showed a less positive picture with the percentage of women having normal deliveries being rated red with scores ranging between 36% and 43% against a target of 60%. The percentages of women having spontaneous vaginal deliveries was rated amber with scores of between 62 – 66% against a target of 70%. In September 2014 the rate was red rated with a score of 60%. The RCM document Normal Birth 2014 gives a national average for normal birth at 45% in 2014.
- The induction of labour rates were also high with red rated scores of between 25.3 – 34.9% against a target of below 20%.
- It was noted that very few women had a membrane 'sweep' prior to admission for IOL as recommended by NICE. (During an internal examination, a midwife or doctor sweeps their finger around the cervix. This action should separate the membranes of the amniotic sac surrounding the baby from the cervix. This separation releases hormones (prostaglandins), which may kick-start labour).
- A Supervisor of Midwives (SoM) based at CBC told us they were leading the 'Normalising Birth' group. We were told signage had been introduced on the labour ward white boards to indicate when a woman was midwifery-led care (rather than obstetric care). The aim was to help change the culture from one in which obstetricians felt that they had to go to see every woman on the labour ward and would do so "Whenever they felt like it." It was reported to us that induction of labour (IOL) was too high, at 30%. Monitoring and audit of this had shown that the "vast majority" were for good reasons.
- Although the IOL rate was high the caesarean section rate was approximately 23%, which was lower than the England average.
- A Vaginal Birth After Caesarean section (VBAC) clinic was said to have been started one year ago with a view to increasing the rate of VBAC in women who had previously had at least one baby born by caesarean section. The patient outcomes for this metric were variable on a monthly basis between red rated 36.4% to green rated 83.3% against a target of 75%. There was no clear identification of why the rates were so variable.
- The service was not identified as a risk for maternity outliers, such as maternal readmissions, puerperal sepsis and other puerperal infections. (A puerperal infection, or puerperal sepsis, is a condition that occurs when a woman experiences an infection related to giving birth).
- The Conquest and Eastbourne hospitals failed to meet the National Neonatal Audit Programme (NNAP) 85% standard for mothers receiving antenatal steroids when they delivered a baby between 24 plus 0 and 34 plus 6 weeks gestation. However they did meet the NNAP standard for babies having their temperature taken within an hour of birth, achieving 100% in the eligible sample.

- The trust website states that the trust delivers around 3,800 babies each year. There were 3,235 deliveries between the period of July 2013 and September 2014. Single deliveries accounted for 98.9%, with multiple deliveries in 1.1%. The majority of births (94%) took place at term, with 5.8% delivered pre-term under 24 weeks gestation.
- Patterns of maternity care were monitored in accordance with the RCOG 11 quality indicators and were broadly in line with England average rates. For example information provided indicated the number of elective caesarean sections was reported to have been 10.1% and emergency caesarean section 13.4%. Low forceps cephalic delivery accounted for 4.5% and other forceps 2.2%. Ventouse delivery rates were 6.3%. The RCM suggests that the best performing maternity units achieve caesarean section rates below 20% and the World Health Organisation gives a target of 15% as the optimum rate for caesarean sections.
- Maternity Mortality and Morbidity meetings were held monthly and individual cases reviewed. We saw cases discussed where little action was taken in response to identified risks and shortcomings. For example, one case where a baby had become hypothermic and floppy post delivery had a comment recorded that said, "SCBU staff said they often get cold babies from theatre". There was no evidence that this situation was further investigated or addressed.
- Another case from October 2014, discussed at a separate Mortality and Morbidity meeting, showed that there had been delays in seeking a review by a middle grade doctor when a pathological CTG was seen. There had then been delays in both the doctor's response time and the time from review until delivery. We had reported on previous recorded poor response to pathological CTGs following our September inspection but the action point from the M & M meeting was, "None".
- Where actions were recorded at M &M meetings they were vague and there was no clear accountability for implementation nor suggested monitoring to ensure the action took place. The minutes from October 2014 showed that the group felt a Stillbirth Group should be set up to review data for common themes. There was no record of any particular person being accountable for doing this nor any timescale. The minutes from the next meeting record the action update as, "Ensure Stillbirth Group is set up". Similarly in response to reports of cold babies arriving at SCBU the action is recorded as, "To discuss pre-warming". This is followed up at the next meeting with an action update that said, "Warm towels to be available at all times". There was no accountability and no timescale for action.
- The service did not currently capture information in respect to the percentage of women in labour seen by a midwife within 30 minutes and the percentage of women seen by a consultant within 60 minutes.
- Midwives were keen to promote a midwifery led service but found that there were obstacles to this, particularly on the labour ward, with women's care being very medicalised. There was no separate facility for midwifery led care on the labour ward and the accommodation was very clinical . There were no consultant midwives employed by the trust in line with recommendations of intercollegiate document Safer Birth (2007).

Competent staff

- Midwife-specific mandatory training and updating covered subject matters including; maternal and neonatal resuscitation, electronic fetal monitoring, and maintaining care when in labour, pre-eclampsia and post-partum haemorrhage. Breech delivery and shoulder dystocia were also covered. Sepsis was said to have been recently added.
- Matrons told us there were monthly skills and drills on the labour ward and the anaesthetists ran simulation sessions. The PDM explained that Practical Obstetric Multi-Professional Training, (PROMPT) training was to be introduced from June this year. A number of staff had already undertaken the training in this regard and would be cascade training. PROMPT is an evidence based multi-professional training package for obstetric emergencies. It is associated with direct improvements in perinatal outcome and has been proven to improve knowledge, clinical skills and team working.
- Newly qualified midwifery staff or those new to the trust were said by the PDM to be provided with a trust handbook, which they kept. We reviewed a copy of this and saw that it contained information and various areas of practice they were expected to demonstrate competence in, such as suturing.
- We asked if agency staff had any formal induction and were told that this was not known but that "most have been here a long time."

- The PDM was asked if there had been any training in respect to Female Genital Mutilation. They advised that this was to be part of the safeguarding training.
- We were told there was no specific training related to the treatment and care of women and young adolescents undergoing termination of pregnancy.
- Obstetric theatres were run by suitably skilled and competent staff. Midwifery staff did not scrub for surgical procedures; however, this was undertaken as part of their midwifery training. We saw evidence of this within a student midwife competence record.
- Appraisal rates for midwifery staff were provided for us and these demonstrated that 87.32% (124 out of 142) had been appraised during the past year.
- The unit risk register had an entry related to poor appraisal rates that identified the problem as, "Failure to comply with the required standard of 95% of midwives and maternity support workers having an annual appraisal. Reduced development of the staff and succession planning." The update and progress section of the register said, "Although exact figures are not available, there have been a large number of appraisals done so compliance is improving."
- The Assistant Medical Director had a responsibility for appraisals and job planning. They advised that they would also be the responsible officer for revalidation of medical staff once their training had been completed. The current appraisal rate for medical staff working in maternity was reported as 94.44% (17 compliant out of 18).
- The Nursing and Midwifery Council (NMC) sets the rules and standards for the function of the Local Supervising Authorities (LSAs) and the supervision of midwives. The Local Supervising Authority Midwifery Officer (LSAMO) is professionally accountable to the Nursing and Midwifery Council. The function of the LSA Midwifery Officer is to ensure that statutory supervision of midwives is in place to ensure that safe and high quality midwifery care is provided to women.
- The matron for the CBC and community services advised us they had been made Contact Supervisor. They told us there were now more clinical midwives than managers in SoM roles, which should make it easier to differentiate the roles.
- Supervisee ratios were said to be in the main 1:15 or 16; one SoM had 1:18. One SoM was leaving and one trainee was expected to be qualified by summer.
- Separate to their required annual appraisal with their SoM midwives reported having access to and support from a midwifery supervisor.
- There was a lack of specialist midwives to ensure the needs of specific groups were met. There was no specialist midwife for very young and teenage mothers despite the Office for National Statistics showing that Hastings having the fourth highest pregnancy rate amongst under 18s in the UK.
- There was no specialist midwife to meet ensure the needs of women who misused alcohol or drugs were met.
- There was no specialist bereavement midwife.

Multidisciplinary working

- We were informed that there was a monthly labour forum meeting, which was multi-disciplinary. Consultants, midwives and registrars were said to attend this.
- Midwives from Crowborough Birthing Centre (CBC) said they had good access to physiotherapists if needed, as well as other allied health professionals, including tissue viability nurses. The latter were said to be spread thinly and there was sometimes a delay in getting a response.
- Midwives reported that health visitors and the community midwifery team worked together in respect to identifying and reporting potential risks. Some community midwives were GP attached, which helped in being able to in the main achieve the bookings by 12 weeks.
- Community midwives were based on the post-natal ward at Conquest, which made it relatively easy for ward staff to engage with them. Ward staff filled in transfer documentation in order to hand the care of women over to the community. Summaries of the women's discharge and mode of delivery of their baby was also provided to the respective GP.
- There were good systems in place to request support from other speciality expertise, such as physicians, consultant microbiologists or pharmacy. Antenatal clinics provided access to additional expertise, such as diabetes care.
- Names were provided in care records as to the responsible midwife and contact details.
- The relationship and team working seen as key to ensuring optimal birth outcomes was not well developed. There was not a clear philosophy of care and we saw several records where poor communication was

highlighted from incident reports detailing medical staff 'belittling' midwives in front of patients to M&M meeting minutes that suggest that communication should be improved but which did not go as far as suggesting how.
- M&M meetings were very medically dominated: In December the meeting was attended by 12 doctors including a paediatrician and two staff from the SCBU but there was no midwifery representation. The more recent meetings had improved midwifery attendance.

Seven-day services

- Out of hours medical cover was available via on call. At weekends a consultant was available in the unit from 8:00 am to 2:00pm and was on call after this time.
- Community midwifery staff provided on-call cover for homebirths and to support the units out of hours. Their working arrangements resulted in excessive hours if they were called overnight as they would have worked a full shift the day before and have their normal work commitments the following day. This was identified in the report published following our inspection in September 2014 and was recorded as an issue in the maternity unit escalation plan.
- The entry on the unit risk register related to community midwifery working times said, "Staffing levels do not facilitate sufficient rest time following call outs. Midwives subsequently often work excessive consecutive hours to cover elective clinical activity. Risks include tired midwives, lack of continuity of care, disrupted risk assessment and timely referral. Where more than one home birth at same time, women may have to come into unit". The risk register showed this was an on-going problem since 2011 and had not been effectively resolved.
- The early pregnancy diagnosis service was available on both sites. Scans were accessible in the main in the main hospital ultrasound department at Conquest and Eastbourne. No midwives were trained to use ultrasound machines.
- There was access to out of hour's pharmacy and other support services when women were admitted and required additional interventions.

Access to information

- We saw information was available to women with regard to choosing where to have their baby delivered. A range of information was accessible via the trust web site, although we could not identify on the website if this could be obtained in an alternative language.
- Advice was available via the telephone triage line where women had a worry.
- Women reported that they had been given sufficient information to help in making decisions and in understanding the arrangements around their delivery.
- Staff had access to a range of guidance to support the provision of care via the trust intranet.
- Discharge information was provided to women and communications were taking place between community services, including midwives, GP and Health Visitors. However, there were recorded incidents where health visiting staff had not received the necessary information to provide appropriate care and support to women with particular needs, such as those facing pregnancy loss.
- There was GP direct access to the early pregnancy assessment unit.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had access to a policy titled 'Informed choice in maternity care'. This contained elements related to consent to guide staff. However we noted the policy had been written in November 2010 and should have been reviewed on October 2014.
- We saw when we reviewed care records that verbal consent had been obtained and recorded by midwives prior to vaginal examination.
- Consent records were present in relevant records where individuals were having caesarean section or instrument delivery. We heard staff checking a consent form with an individual prior to the commencement of their preparation for caesarean section.
- Before administration of vitamin K to the new born baby we saw verbal consent for this had been ticked in one care record but the formal consent form for this had not been completed. It is a recommendation of the Royal College of Midwives that midwives seek fully informed consent and record that they have done this prior to the administration of Vitamin K.
- We saw there was a record of consent for disposal of fetal remains, which applied to both termination of pregnancy or spontaneous miscarriage.

Maternity and gynaecology

- We asked staff about looking after women with mental capacity issues. We were told that nothing would be done, except in an emergency, unless the individual had someone with them to act as their support/advocate. This was said to be a rare need but the booking process would identify if any particular needs were required.
- The training figures supplied to us in respect to Mental Capacity Act training showed a significant number of staff had not had updated training since 2012 and two staff members had not been updated since 2007 and four since 2008. Similarly there were significant staff identified as not having an update in respect to Deprivation of Liberty Safeguards.
- We heard staff offering an individual the opportunity to have a chaperone.
- We did not see any assessment of mental capacity included in the records and when asked, a midwife told us there was nowhere to record this information.

Are maternity and gynaecology services caring?

Good

- Feedback from people who used the service, those who are close to them was generally positive about the way staff treated them People felt they were treated with dignity, respect and kindness during interactions with midwifery staff and relationships with staff were positive. People felt supported

People we spoke to whilst on site were, generally, quite positive about the care they received. They described the staff as kind and helpful. Reports and comments on the NHS Choices website were, generally, tending towards positive.

We did received some negative feedback through our national call centre after the inspection visit.

We observed positive and warm interaction between the midwifery staff and patients in all areas that we visited. Midwives were seen to provide gentle reassurance to mothers with new-born babies and those anxious about going into labour.

Feedback from users of the two midwifery led centres was entirely positive, with people enthusing about the care they received from, "Their" midwife. They appreciated the calmer and more domestic environment and the individual care they received.

Compassionate care

- The CQC Maternity Survey showed that the trust was better than other trusts in CQC Maternity survey in responding to the call bell.
- Results from the CQC maternity survey (other than in response to call bells) were similar to other trusts.
- The Friends and Family Test (FFT) where patients are asked whether they would recommend the service fluctuated below and above England averages. The Delivery Suite showed a very low score of 24 on the FTT in February 2015, for example. Crowborough Birthing Centre showed a score of 100 for the same period.
- There was no explanation available for the variations (which were significant); the range for the antenatal care varied between 80% and 100% in the twelve months to November 2014. The antenatal average score for this period was 91.7%.
- The FFT recommendation score for Antenatal services was regularly worse than England average and much worse in Nov 2014.
- Feedback from service users was variable with many feeling well supported and cared for.
- Feedback on the NHS Choices website was generally very positive about midwifery staff. One person wrote, "We always found all members of staff we encountered to be not only professional and efficient but also courteous and pleasant with a real sense of respect and care for you as an individual." and gave a 5* rating.
- Another gave only 2* but said, "Let me just begin by saying the midwifery care I received was second to none and could not praise them anymore." They were less positive about the medical staff, which accounted for the low rating.
- Another person giving a 5* rating said, "This is my first baby and I couldn't of been happier with all the midwives. Amazing people and me and my husband can't thank you enough for everything. Brilliant after care on the Frank Shaw ward."

Understanding and Involvement

- The women we spoke with felt they were well informed and actively encouraged to make plans for their delivery. Most felt the midwifery staff tried to support their plans, when feasible.
- We did see one report on the NHS Choices website where a woman reported different consultants telling her different things and making different plans for her. This woman said she was kept in hospital for a week waiting for an induction date to become available as the unit was, "Just too busy".

Are maternity and gynaecology services responsive?

Requires improvement

The needs of the local population were not fully identified or understood or taken into account when planning services; there were shortfalls in doing this.The maternity services were recently re-configured and this was still causing some concern with members of the public and amongst staff who considered that women may not always be enabled to access the service at each stage of their pregnancy with suitable ease. There were clear examples of where staff shortages had impacted on the trust's ability to deliver the planned services to meet the needs of women using the midwifery led units, for example. Women delivering at Hastings did not have a viable option of a midwifery led unit.

The maternity dashboard showed that there were 9 women affected by, "diversions to other unit within same organisation". During the period April 2014 to December 2014 there was only one month when there were no diversions. This meant women were not assured that the unit where they had chosen to have their baby would be open when they needed it. The maternity dashboard showed that overall the unit was never closed during this period but this related to the entire clinical unit on all sites rather than specific midwifery led centres. The dashboard was showing that there were no occasions when the trust could not accept any women to the maternity services across all sites not to closure of individual units within the trust provision.

There were shortfalls in how the needs of different people are taken into account, for example on the grounds of age, disability, race. There were no designated midwives for young mothers and children giving birth, nor for mothers who needed additional support as they misused drugs or alcohol. There was no specific service for traveller families.

Services were not always planned in conjunction with other local services. Services were not delivered in a way that focuses on people's holistic needs. Services were delivered in a way that is inconvenient and disruptive to people's lives. The pathways for women from the High Weald and other areas where there was potential to use the services of neighbouring trusts was unclear. The closure of units due to staffing shortages was disruptive. Whilst allowing partners to remain on the unit overnight, the facilities were inadequate and the needs of other women who did not want to share sleeping facilities with an unknown man were not fully considered.

On woman was discharged at inappropriate times in order to move staff to other locations. We were not provided with details of other 'out of hours' discharges by the trust, although we did request this information.

There was a lack of accessible antenatal and parent craft classes offered to women in some areas and the needs of partners had not always been fully considered and addressed.

The individual care needs of women at each stage of their pregnancy was acknowledged and acted on as far as possible.

There were arrangements in place to support people with particular needs although there was evidence these were not always effected in practice. Translation services could be arranged as required.

there was conflicting information from the trust and staff on the provision of a designated bereavement midwife. Many staff were unaware on one in the trust.

The complaints process was understood by staff and complaints were investigated and responded to when raised.

Service planning and delivery to meet the needs of local people

- We reviewed the progress report on 'Better Beginnings reconfiguration of maternity and paediatric services', dated 16 March 2015, which was due to be submitted to the Trust Board later on 25 March 2015**.** The aims of the

reconfiguration of maternity services had been with a view to improving services. A number of recommendations had been made in respect to maternity services. This included the development of midwifery care pathways. The progress report described actions taken by the Midwifery Care Pathways Working Group, which was established by the Better Beginnings Improvement Board. However, we were concerned that there was limited awareness of these actions as staff did not actively discuss these changes.

- We were informed that there were no antenatal or parent classes in the Crowborough region.
- Staff told us too that Friends of the hospital had bought an ultrasound scanner for the CBC but staffing for an ultrasonographer had been cut so the scanner was not being used.
- Post-natal arrangements for women with specific needs were identified as part of the discharge planning and communicated to the community midwives and health visitors, as part of the discharge arrangements.
- The trust website said, "We welcome a partner/ companion to stay overnight on the antenatal/postnatal ward, so you can take part in caring for your partner in early Labour or in caring for mother and baby." The consent of women sharing the bay was not sought and some women may have been uncomfortable sleeping with a man they did not know in the room. There was no facility to allow women who did not want to share sleeping accommodation with an unknown man to move to a single room as the ward was so busy.
- The facilities for partners to stay were lacking and this was commented on by women particularly at Conquest. There were no reclining chairs and one woman said she was concerned about the partner of another woman near her on the ward, in that he was not offered any pillow or blanket. They gave the man one of their own blankets to improve his comfort. The website did make it clear there were no showering facilities and that blankets were not provided but this was not likely to have been considered by a man taking his partner to hospital when they went into labour.
- There were arrangements in place for working with the Health Overview and Scrutiny Committee and we saw agenda information and minutes of information recorded in respect to maternity services.
- A range of information leaflets were seen to be available in the midwifery-led units. Information was also accessible via the trust website under the maternity services.
- Post-natal follow up care was arranged as part of the discharge process with community midwives and where necessary doctors. For example, midwives saw women who had suturing following a tear or episiotomy. Women with breast feeding problems were also invited back for support to the midwife led units.
- Bereavement facilities for the service were limited to one room set aside on the labour ward at Conquest; these facilities had not been improved since our previous inspection. There was a cold cot and memory boxes available.
- We heard from one couple who suffered a late pregnancy loss who were very dissatisfied with the facilities and care afforded to them. The father told us that the room was drab with wallpaper peeling off the walls, there were spots of blood on the bed rail and the room was not clean. The couple felt medical staff were rude and midwives uncaring in their attitude.

Access and flow

- We were told about and saw written documentation which confirmed women were supported to make a choice as to the place to give birth. This decision was made at 34 weeks and information was provided to assist in making their choice. We saw that there were specific risk factors, which needed to be considered and would lead midwives to advise a hospital birth, rather than home or a midwifery-led unit.
- Discussion with one woman who had recently given birth at the CBC indicated that she was aware of confusion around what was perceived to be a disjointed service in the Wealden area and the cross boundary working. She said women were worried their birthing plan would have been changed at the last minute due to closure or staff shortages. We were told the pathway was “Very confusing for first time mums”, with the initial booking with the GP or directly with the CBC. They also had to book at a nearby obstetric unit to get their scans, then transfer to Crowborough later in pregnancy.
- There was a medical model of care in place at Conquest hospital with no real emphasis on normalising birth and no viable option for midwifery led care. No consultant

midwives were employed to lead on normalising birth as recommended in Safer Births (2007). There was no facility to separate low risk women giving birth from high risk mothers who needed medical oversight.

- Midwives followed a clinical referral pathway for women who had concerns, such as reduced fetal movement or bleeding between weeks 14 and 20. The decision about whether a woman should be seen at a day assessment unit or by a consultant-led service was appropriately made in the light of risk assessment.
- The trust reported that the Conquest maternity unit had no closures since our last inspection. Safety and quality information, which was to be provided to the trust board meeting on 25 March 2015 indicated that between May the 7th 2013 up to the end of February 2015 the Conquest had not closed or gone onto divert.
- The maternity dashboard showed that the unit was never closed during this period but this related to the entire clinical unit on all sites rather than specific midwifery led centres. There were 9 women affected by, "diversions to other within same organisation". During the period April 2014 to December 2014 there was only one month when there were no diversions.
- It was acknowledged in the safety and quality information that the midwifery led units did have to close on occasion. Midwives at the CBC said that although there hadn't been so many closures recently. There was an awareness that a neighbouring trust were opening a birth centre soon and it was expected that women would choose to go there if they knew that it was going to be open rather than risk finding that Crowborough was closed they had to drive up to two hours from home to get to the Conquest.
- Pregnant woman who lived in and around Crowborough had a community midwife employed by ESHT and were given a choice to give birth at the CBC. In the event of an emergency at the CBC they were taken by ambulance to Tunbridge Wells Hospital.
- Women booked at Eastbourne who required emergency care were transferred to Conquest via ambulance.
- Women could be transferred to the Conquest for other non-emergency situations (such as when they wanted and epidural for pain relief), where there was a consultant-led unit.
- Midwives at CBC said the biggest challenge and threat was seen to be the geographical location of the unit, how to have flexible safe staffing and how to provide the care women wanted close to home.
- Cross boundary working was said by CBC midwives to cause considerable duplication of time and resources. Only 6% of women who birthed at CBC booked with ESHT. The principle reason for this was because women booked with the trust geographically closest to their home to have to access scanning at 12 and 20 weeks. Once their 20 week scan was done and they were confirmed as low risk some then changed to EHST and re-booked to give birth and have antenatal care at CBC.,
- The chair of the Maternity Services Liaison Committee spoke with us during our inspection. They advised that 85% of High Weald women booked at the neighbouring trust to avoid having to go to Conquest in Hastings and women had told them this was because they were uncertain of the CBC being open so they booked elsewhere to avoid being diverted to Hastings if the birth centre was shut.
- We noted that women, in general, did not appear to be discharged home as soon as possible and that this resulted in a shortage of beds and increased midwife workloads.
- In relation to transfers from midwifery led units the trust reported in the safety and quality report that the average transfer time met the agreed standard (from making the decision to handover, to the receiving unit within the area) of 80 minutes. The report confirmed that all local transfers for first births continued to be achieved within the national average of 36%.
- The majority of discharges home had taken place at appropriate times. However, we were told of a recent situation where a woman was discharged from CBC at 01:30am with her baby in a taxi, as staff had been requested to go over to Conquest to help there. The woman had no means of getting home other than by taxi as their partner was looking after another child. They had no outdoor clothing in which to dress.
- We asked the trust for details of all discharges outside of usual daytime hours but they told us they were unable to provide this information.
- We reviewed the Clinical Guideline for Pregnancy Loss, which included ensuring at every stage, the woman and her family needing to be given accurate information and communication regarding: what has happened and may

happen, practical matters, procedures and arrangements and the choices that are available to them. The guidelines contained descriptive information as to the procedural arrangements and these reflected expected practice. However, we did not see any specific reference to young adolescents and how their needs may be addressed.

- Women and adolescents requiring a termination of pregnancy for fetal abnormalities were managed at the Conquest site. For pregnancy of 13 weeks plus six days or below women were admitted to the Gynaecology ward. Terminations for fetal abnormalities above 14 weeks gestation were carried out on the delivery suite. Staff said there were not many of these, approximately six per year.

Meeting people's individual needs

- Women with complex requests or needs were said to be discussed with the supervisor of midwifery and a plan was then developed. We saw evidence of detailed recordings where a woman had made specific requests around the birth of their baby, which were outside of normal expectations that midwives would have. We were unable to determine whether these plans were effected in practice because there were no women with additional needs being cared for at the time of our inspection visit.
- We did see one RCA following a serious incident where one of the contributory factors was given as the woman having an hearing impairment. The recommendations made following the incident included staff should communicate with women properly. There was no real assessment of the impact of her hearing loss on the incident and how improved understanding of specific needs could have reduced the risk.
- A telephone triage system was available at Conquest and Eastbourne, the latter of which was provided on the day assessment unit between the hours of 09:00 and 17:00 hours. There was a clear criterion for seeing women at Eastbourne rather than sending them to Conquest.
- The Conquest day assessment unit was very busy and had activity between 60 and 80 patients. We noted there had been one week where they saw 100 patients. The service was run by two trained staff and one support worker and a Sonographer. Matron was available to cover Monday to Friday.
- The trust had guidance for staff, which included indications for referral to fetal medicine clinics where there was a suspected or identified fetal abnormality.
- Women had a choice regarding the management of a miscarriage of pregnancy. For example when there was a miscarriage women could choose medical or surgical treatment or await the natural expulsion dependent on the stage of pregnancy and any complications. For ectopic pregnancies the choice was either medical or surgical. Information leaflet was available to help women in making their choice in addition to discussion with staff.
- A room was set aside as a designated area for families suffering from bereavement. This was suitably equipped from a clinical perspective but would benefit from additional focus to improve the environment. Staff felt this was an area which could be improved but despite this being mentioned in our report published following our inspection in September 2014, nothing had changed. The rooms was not reserved for the exclusive use of women facing pregnancy loss but was also used for women in labour.
- We were told there was no lead midwife for women with learning disabilities.
- We saw that there was a translation service both face to face or via telephone. We had the opportunity to speak with a woman whose first language was not English and we required a translator to facilitate the discussion. Staff were made aware of this and despite allowing time to arrange we found this was not acted upon. We had been told by several women who had English as an additional language that they were not provided with interpreters and for some this had resulted in them feeling afraid and isolated.
- We asked if there were any specific arrangements to ensure the safe management for travellers and were told they were looked after the same as other women. There was no designated midwife working with the traveller community. The East Sussex Traveller Strategy 2010- 2013 states that Gypsy and Traveller mothers are 20% more likely than the rest of the population to experience the death of a child. It also that 22% of travellers had no authorised stopping place which exacerbate the challenges of building relationships and trust with this community.
- Community midwives said that women did not always get what they wanted. For example the only room with a birthing pool at Conquest was "bed blocked." One

midwife said in three years they had not seen a water birth. When we discussed the situation with midwives we were informed there was no forward planning to allow women that wanted to use the pool to do so; Women turned up and were put in the available rooms.

- One new mother commented on the attitude and "strictness" of one midwife, who would not allow the curtains to be closed around the beds at night. The midwife was said to have told her, "That's the way I like it." Another commented on the insensitivity of a midwife, who turned on all the lights when it was late. One woman said the lights were turned off too late by staff. A woman on the antenatal ward said they had wanted the curtain's closed round them when they were feeling nauseous for privacy but a midwife just came along and opened them, without asking.
- We had conflicting information about bereavement midwives. We were told there were two midwives with an interest in bereavement but no formally trained bereavement midwives. Another member of staff said there was a Band 7 bereavement midwife and they trained other midwives and made sure they could complete the necessary paperwork and support families accordingly.
- There was a lack of specialist midwifery staff for very young mothers and those with mental health problems.

Learning from complaints and concerns

- Midwifery staff said they would try to deal with issues in the first instance before they became a formal complaint. For example, if the woman had a concern about the management of their labour, they would review the notes with the individual and explain the course of action. They said they could also arrange a de-brief with the consultant. If necessary complaints would be escalated upwards or to the Patient Advice and Liaison Service.
- Midwives said they were not aware of any active complaints.
- The Deputy Director of Nursing (DDoN) and the General Manager were asked separately how many complaints were open and if there were any particular themes. The DDoN said there were none open but the general manager said a number had recently been received. Themes related to worries about where the person would have their baby, post-natal care, lack of open visiting and allowing partners to stay. In response to this we were told a letter was under construction, which would outline what to expect at each stage in terms of staff support.

Are maternity and gynaecology services well-led?

Inadequate

The delivery of high quality care was not assured by the leadership, governance or culture in place. A lack of cohesiveness meant there were missed opportunities for engagement and involvement of staff in developing the service to the benefit of staff and the service users.

There was no credible statement of vision and guiding values. Staff were not aware of and did not understand the vision and values. There were strategic changes taking place within the service for example in relation to models of care; however, the majority of midwifery staff were not aware of the development plans. Communication downwards from managerial leaders was poor and staff were not aware of the future strategy or vision for the service.

The strategy was not underpinned by detailed, realistic objectives and plans. Staff did not understand how their role contributes to achieving the strategy. There was a lack of formalisation of future development and no time frames were attached to short and long-term objectives. Engagement with specific stakeholders was ineffective and challenges to the trust were seen as unacceptable. Culturally, there was a defensive attitude within management and a subsequent failure to identify fully opportunities to develop staff ideas.

There was no effective system for identifying, capturing and managing issues and risks at team, directorate and organisation level. There was a lack of openness and transparency, which resulted in the identification of risk, issues and concerns being discouraged or repressed. Significant issues that threaten the delivery of safe and effective care did not have adequate action taken to manage them. The Risk Register was minimal and failed to adequately identify how the risks would be addressed. There were longstanding risks which were labelled as

'on-going' with little evidence that there was action being taken to reduce risks. Improvements noted were anecdotal and not based on numerical evidence(such as around appraisal rates) .

Midwifery staff reported positively on their direct line management but there was a lack of autonomy and some felt disempowered to make decisions or use their skills and expertise proactively. The midwifery structure was employing staff at lower grades than was usual for particular posts and expecting staff to perform above the usual expectations for a given grade of staff.

Some leaders were out of touch with what was happening on the front line. Quality and safety were not the top priority for leadership. Meeting financial targets was seen as a priority at the expensive of quality, as was evident from the WRASH minutes that did not address safety and cultural shortcomings but spent time considering whether they could impose lease cars on community midwives.

There was a failure by the midwifery management to recognise the findings from our report published following our inspection in September 2014. CQC has received numerous letters and emails from members of staff of all grades and disciplines, as well as from people using the service, that suggest the report was a very accurate reflection of the services provided by the trust.

There are high levels of stress and work overload. Staff do not feel respected, valued, supported and appreciated. Although the reports from midwifery managers suggested that the staff are happy and that the staffing shortages are much improved this is not what frontline staff told us.

The culture was very much top-down and directive. It was not one of fairness, openness, transparency, honesty, challenge and candour. When staff raised concerns they were not treated with respect as demonstrated by an incident report about low staffing where the response is to criticise the staff member and not consider the real issue of understaffing. There was a tendency to 'brush things under the carpet' with comments such as, "Managed appropriately given the circumstances".

The culture is defensive.

At ward and unit level there was a strong commitment to meeting the needs of and experiences of people using the service.

Vision and strategy for this service

- There was no clear vision about how the service was going to move forward from the reconfiguration. The findings from our September 2014 inspection had not been shared with maternity staff at the time of our inspection visit. The content was not shared until after it was published, which was after the follow up inspection.
- There was no plan on how the concerns raised in that report would be addressed effectively. Some of the findings were acknowledged and had been identified on the risk register but there was not a sufficiently robust action plan of how these shortcomings would be addressed.
- Staff that we spoke with were not engaged in moving the service forward and were not involved in action planning to bring about improvements.
- In the absence of the Head of Midwifery, we asked the Deputy Director of Nursing and the General Manager if there was an overarching strategy for the maternity services and if this had been shared with staff. We were told in response that the consolidation of services had been the strategy and they were now working with the Clinical Commissioning Group (CCG) on the vision to embed the changes. They added that they were reporting to Health Overview and Scrutiny Committee (HOSC) with respect to midwifery led care, as there was a lot more that could be done for low risk patients. We were told they were looking at other models of care and there had been a series of meetings. They were now at the stage of going out to consultation for discussion and sharing of ideas with staff.
- We asked if there was a formal programme related to this work with time scales and actions and were told there was not.
- We spoke with the chair of the Maternity Services Liaison Committee (MSLC) during our inspection. It was reported to us that the MSLC had been involved in organisational change and the chair had attended HOSC meetings regarding the ‘Better Beginnings” project. None of the midwives we spoke to talked about this project.
- There was no clear vision or set of priorities that midwifery staff were aware of, with the exception of Crowborough midwives, who had an awareness of the Head of Midwifery leading a group working on new staffing models. They told us the draft plan for that was ready for consultation with staff.
- A letter from the Head of Midwifery, dated 5 April 2015, sent to all staff following publication of our report from

the September 2014 inspection states, "Overall, I do not recognise this report as out unit". It went on to say the report could not be shared because the report had not been published. The trust had the draft report in January 2015, when it was provided with detailed information about our concerns but these were not shared with staff so that they could be involved in the improvement process.

Governance, risk management and quality measurement

- The Trusts Quality and Governance Strategy viewed by us indicated that monthly Quality Governance Meeting were to be held by each clinical area, during which they were to discuss and oversee governance issues. The review process was to include a number of aspects for example: clinical audit activity, themes and trends from complaints, incidents and near misses, clinical and non-clinical risks, morbidity and mortality, safeguarding, infection control, Procedural documents and outcomes from Nursing and Midwifery quality review meetings were also to be discussed.
- RCA reports provide by the trust showed several on-going trends in respect of contributory factors. One report recognised that there was no audit of how well staff were following trust guidance around diminished fetal movements and recommended this be done at a point in the future but this was only after a number of similar incidents over a timescale that covered information provided at both this and our previous inspection in September 2014.gh
- A summary of the issues discussed at these meetings was to be submitted to the Trust Patient Safety and Clinical Improvement Group via an exception report template.
- We reviewed the Maternity and Paediatric Quality and Safety report data for December 2014, which was for discussion at the Trust Board on 25 March 2015. This provided a detailed reflection on the services position in respect to quality and safety.
- In respect to governance, the Head of Midwifery (HoM) was said to work “Incredibly hard.” The HoM had support from a Band 6 who held the role of Patient Safety Midwife. The latter staff member was confirmed as an attendee of the daily risk meeting and it was said they followed up all incidents.
- We asked to see the Risk Register but were not supplied with a copy of this until after the inspection visit. We also asked what was on the Risk Register and were told staffing; the environment and lone working were actively being reviewed on a monthly basis at the risk meeting.
- We saw from the risk register that the issue of inadequate staffing was only opened on 13 January 2015. The recorded action to address the situation was recorded as, "Identify resources/money/staff. There was no real commitment from the trust to improve the midwifery staffing arrangements.
- The risk register also mentioned low appraisal rates as a risk. The progress report said, "Although exact figures are not available, there have been large numbers having appraisals so compliance is improving. We could not see any hard evidence that this anecdotal claim provided assurance of improvement.
- A letter sent from the HoM to all midwifery staff, dated 5 April 2015 showed a lack of acceptance of the serious nature of the concerns raised in our inspection of September 2014.

Leadership of service

- An action plan had been created following publication of our report from the September 2014 inspection but some of the issues raised were not addressed and the action plan was insufficiently robust to bring about sustained change. There was a lack of acceptance of the serious nature of the concerns we identified by the leadership of the maternity services. A letter dated 5 April 2015 sent to all midwifery staff by the Head of Midwifery says explicitly that she, "Did not recognise this report as our unit". Midwifery staff considered their direct line leadership to be good, with supportive leaders who understood and shared their aims to deliver quality care.
- We were told by a member of midwifery staff that there used to be three service managers prior to the merger and “even though they struggled then, we now only have one.” They added, “They are drowning” and it was “unsustainable; there must be a long-term impact.” Community midwives reported the service as being “crisis managed day by day.”
- As a high risk area in respect to litigation, it was said there could be a lack of back up within the leader team, as there was no cover. In particular when sickness or annual leave was happening.

Maternity and gynaecology

- There was concern about lack of experience in midwifery management structure and leadership expressed to us. For example, the grading of the Head of Midwifery was lower than usual; all Band 7 midwives were 'Matrons' and there was an increasing number of specialist midwives. There was to be an 'influx' of nine Band 5 midwives in October who would require preceptorship and therefore challenges to staffing were going to continue. One midwife said to us, "We don't have leadership; we have management….work harder, faster."
- We were unable to meet with the Head of Midwifery during our inspection visit. We were aware that they had attended a business meeting with the local authority during the period we were on site but were told they were on leave.
- Comments in respect to positive changes since the last inspection were made by staff at the CBC. They said having a lead midwife to support practice placements was making a difference. Last year none of the midwifery students had wanted to stay once qualified, "this year they all wanted to work here and have been offered jobs to start in October."
- Recruitment of specialist midwife for preceptorship was said to be in process and there was a proposal for a specialist midwife for teenage pregnancy.
- Midwives spoke positively about matrons at departmental level and their support in general. Community midwives said they had good managerial support. One matron said they had an "excellent manager" and added that the demands exceeded capabilities. Another midwife said their matron was, "Extraordinary", adding that they were very supportive but couldn't do things they would want to do as a result of instability.
- Matrons felt their responsibilities were limited in some respects. For example the level of autonomy they had in relation to managing staff. They explained how they could make decisions about booking agency staff but could not make requests for staff from other areas, such as Eastbourne. These decisions had to be made by the SoM. Decisions about closing units were made by the SoM, as there was no manager on call. Community midwives who transferred women in labour to hospital and then stayed with them were not permitted to book a taxi back and were required to call the site manager to do this.
- Matrons reported having no supernumerary time, with their roles split 50/50 between clinical and managerial. However, the managerial work often fell by the wayside as they had to cover shortages of staff. There was a feeling of lack of devolvement and although matrons were willing and able they felt little was delegated. Other midwives reported that their skills were not being used, for example, one said, "I have not been invited to things where my skills could contribute." They said they had put forward ideas but there was no investment in these.
- Community midwives told us there had been re-structuring two years previously and this had resulted in some Band 7's being downgraded to Band 6.
- Matrons told us the Head of Midwifery came to the ward, as did the Director of Nursing and there were site manager visits daily. The CEO provided a weekly message via email.
- We were told the Head of Midwifery had access to the trust board.
- Feedback from the chair of the MSLC was that the turnaround manager over rode the clinical advice of the midwifery managers when making changes back in 2013 and felt this was the root cause of the problems now. Several references to the management of staff being told it would be a disciplinary matter if they didn't go where they are told.
- It was said that the merger was more about medical staffing than midwifery and this impact was now being felt with many long term senior midwives leaving – they were "unsupported and overstretched."
- Community midwives reported that there was no consistency regarding the model of care across the community. One matron was supernumerary and others were not and had a caseload. A central team leader had support to undertake management duties, such as PDR, off duty planning, without having a caseload of women to manage as well. Other managers were expected to undertake managerial duties at the same time as having a caseload, which impacted on the ability to deliver the role requirements.

Culture within the service

- Matrons told us they felt valued by the staff they supported. One said they felt valued, listened to and

that managers were receptive. However other comments indicated otherwise particularly amongst lower grade staff. Community midwives described not feeling cared for and being just, “a cog in a wheel.”

- The culture within the maternity service was described by one person as “open”, with open discussion of incidents. Other staff were less positive and spoke about a blame culture. Staff were described by the Practice Development Midwife as a “Very good, amazing bunch of girls.”
- One matron said the culture was of greater understanding of the issues and management were trying to improve things, although they were not visible enough.
- We asked a matron if they were aware of the evidence in the Kirkup report (The Morecambe Bay Investigation Report) about poor relationships and behaviours between midwives and medical staff, which meant that midwives refused to allow obstetricians to access women in labour. They responded by saying that was not how things were in ESHT and cited the use of signage indicating – midwifery-led care was to help midwives to have responsibility and consult with obstetric colleagues appropriately.
- From our observations and discussion with staff there was a commitment to meeting the needs of and experiences of people using the service. In particular, midwives were keen to normalise the birth experience and to ensure that appropriate support was available following the delivery. This was very apparent in the midwifery-led units, where in some cases women were supported beyond the usual postnatal period.
- We heard in our discussion information which indicated that staff worked in a manner which encouraged candour, openness and honesty but saw from incident reports and meeting minutes that there was a management tendency to make recommendations about the practice and learning of individual staff rather than accepting organisational failings.
- Staff endeavoured to work collaboratively; however they reported having low morale and being stressed because of shortages of staff. Other comments made included; “It has been unhappy.” The needs of staff were not being met and they felt on their own, rarely seeing managers.
- We saw from the minutes of the Matrons Meeting at the Conquest Hospital dated 29 January that the service leaders were using disciplinary action rather than education and 'buy in' to bring about change. The minutes said, " ...will performance manage matrons and staff member in charge of the shift when equipment checking is not done."
- A member of the consultant medical staff talked about the different cultures on the Eastbourne and Conquest site, which they said was taking time to change. They told us, “We don’t have fighting but we know there are differences”, adding that the tensions were improving. The relationship between doctors and midwives was by this individual said to be “constructive.”

Public and staff engagement

- We asked matrons if they felt they were listened to and could make suggestions and share ideas for improvement. We were told there were agenda’s for meetings and they could put ideas forward; however, they were not always able to attend the meetings to discuss them.
- Staff at Eastbourne said they used to have day unit meetings but they had not had one for over a year, despite asking. We were told they never saw the manager. One manager was described as, “Not neglectful, just has too much to do.”
- Matron meetings were said to have been planned on a monthly basis but this was a set day. Staff had fed back to the manager that the day needed to be varied to allow greater flexibility of attendance.
- Staff did not feel that they had been actively encouraged to engage and share their views on planning the service. There was a general lack of awareness of any plans for the future and no feedback had been given from the previous report, with the exception that it was not good reading.
- The DDoN and the General Manager said there remained challenges in terms of unity. Supervision and appraisal provided an opportunity for individuals to see the opportunities and any weaknesses.
- Most midwifery staff did not provide any evidence that the trust or otherwise had sought public feedback and how improvements were to be made. However we were made aware that there had been meetings in 2014, with the three Clinical Commissioning Groups (CCG’s) for East Sussex, during which the ‘Better Beginnings’ public consultation on the sustainable future of maternity along with other services had been reviewed. The public consultation had resulted in the CCGs’ Governing Bodies agreeing service configuration as follows: The birthing

services were to be retained at all three current sites (Crowborough, Eastbourne and Hastings). Consultant-led maternity services were to be provided at the Conquest Hospital and midwife-led birthing units would be available at Crowborough and Eastbourne.

- We were also made aware that a midwife from the Crowborough site was on a working group to consider what to do with the results of a survey conducted with women after the last CQC inspection. There was concern that the trust did not really support the service at Crowborough.
- A new mother at the CBC reported that there used to be a focus group for women in the local community but ESHT had asked that this be disbanded. The Practice Development Midwife explained how they were trying to re-establish the focus group on the Conquest site as they recognised this as a valuable way of seeking feedback and ideas.
- A letter from the trust to the chair of the Maternity Services Liaison Committee suggested that the chair should, "Consider their position" after they raised concerns about midwifery staffing levels.

Innovation, improvement and sustainability

- Medical staff reported that there were improvements since the previous inspection and “It was a lot safer” and “a lot more robust”, with good consultant cover. There was no documentary evidence to support this assertion. Medical manpower was described as resilient but that midwifery staff remained short.
- In terms of developing the service and longer-term sustainability the DDoN and General Manager described some of the plans around opening the Eastbourne Maternity Unit only when women were in labour. These early thoughts had not been discussed with staff and were recognised as requiring local population understanding.
- We heard concerns expressed in relation to the on-going support of the triage service at Eastbourne, as there had not been any succession planning arranged. We heard that there were other speciality midwives lacking but there was no evidence to indicate that the service was ‘growing its own’ from staff who already had significant skills and possible interests. Staff also said there was no rotation to enable learning and subsequent “takeover” of roles.
- We asked the DDoN and the General Manager to what extent was the midwifery team working as a single team. Their response was that it was, “Very joined up. The midwives understand and recognise the need to have to move around at times.” They added that it was “a lot better than six months ago.” Worries were said to have been alleviated as they had got used to the environment. This is not what we were told by some midwives who contacted CQC directly. The minutes of the Matrons Meeting dated 29 January 2015 described staff from BCB and EMU who moved to work at the Conquest were ,"Not made welcome". One potential midwife was told by the staff working in the unit not to work a trust.
- We heard from the Practice Development Midwife how there was a focus on enhancing the midwifery-led care. We were shown signage which had been developed to indicate where women chose to have their care overseen by midwives in the first instance. We were also shown notes that pertained to an improvement activity meeting, where various activities had been discussed in relation to making changes happen.
- The Patient Safety Midwife had a responsibility to monitor the maternity service against Mothers and Babies; Reducing Risk through Audits and Confidential Enquiries-UK, (MBRRACE-UK) reports, Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) guidance, National Patient Safety Awareness, (NPSA) Never Events, Patient experience/complaints. Information from such monitoring was provided within safety and quality reports to the Trust Board.

Outpatients and diagnostic imaging

Safe	Inadequate
Effective	
Caring	Good
Responsive	Inadequate
Well-led	Inadequate
Overall	Inadequate

Information about the service

East Sussex Healthcare NHS Trust provides OPD services at its two Acute Hospital Sites Eastbourne District General Hospital and The Conquest Hospital. It also provides OPD clinics at Bexhill Hospital, Uckfield Community Hospital, Victoria Hospital and Winchelsea and District Memorial Hospital.

In the year 2014/2015 ESHT treated 134,872 patients in Outpatients (OPD) with 298,720 clinic attendances. 54,918 of these patients were treated at The Conquest Hospital with 126,346 clinic attendances during this period.

The conquest ran clinics in the following specialities Breast Surgery, Cardiology, Chemical Pathology,

Clinical Oncology, Dermatology, Diabetic Medicine, Endocrinology, Ear Nose and Throat (ENT), Gastroenterology, General Surgery, Geriatric Medicine, Gynaecology, Haematology, Maxillofacial Surgery, Neurology, Ophthalmology, Orthodontics, Paediatric Diabetes, Paediatrics, Pain Management, Plastic Surgery, Respiratory Physiology, Rheumatology, Thoracic Medicine, Trauma &Orthopaedics, Urology and Vascular Surgery.

East Sussex Healthcare Trust provides integrated Radiology imaging services across the hospitals in the acute and the community settings . The hospital offer Computerised Tomography (CT), Magnetic

Resonance Imaging (MRI), X-Ray, SPEC CT, Digital Mammography, Ultrasound, Interventional Radiography, dental radiography and Nuclear Medicine scanning.

We reviewed documents relating to the Radiology Department and observed the workings of the department provided by the multi professional healthcare professionals including care provided by medical and nursing staff, radiographic and administrative staff. We spoke to patients receiving radiology investigations and from people who contacted us separately to tell us about their experiences. We reviewed performance information held about the trust.

Outpatients and diagnostic imaging

Summary of findings

During our last inspection we found that the condition and availability of patient's health records was inadequate. At this inspection we found that no progress had been made and staff were still managing high levels of health records not being available for clinics, poor tracking of health records and health records which were oversized and in poor condition.

When we met with trust executive representatives they told us about plans for improvements in the management of records across the organisation. The Private Trust Board Minutes dated November 2014 showed that the board had approved the business case for an Electronic Document Management/Clinical portal and medical record scanning system that required TDA approval due to the scale of the financial commitment involved. The trust was aware that there were current problems in the safe and effective management of records and felt that the proposed system would improve the situation significantly.

At our last inspection we had concerns that staff were not consistently reporting incidents. Although at this inspection we found a raised awareness among nursing staff regarding incident reporting. We still found incidents that had been unreported these included an inadequate reporting mechanism for health records that could not be obtained for clinics.

At our last inspection the trust was not able to evidence that they were meeting with RTT NHS standard operating procedures across all specialities for either 2 week or 18 week targets. At this inspection the trust was still not able to evidence that they were meeting with these targets consistently across all specialities.

The call centre was not fit for purpose with a shortage of skilled staff and operating systems that were not working to advantage patients. As a result of these issues patients and staff were often unable to contact the call centre when they needed to.

We found that the OPD was not being cleaned or audited in line with the National Specifications of Cleanliness and Trust policy.

We found that medicines management had improved since our last inspection. However, we found some medicines that were being stored in the department had past their expiry date, and the keys to the medication cupboards was not stored securely. This meant that there was scope for improvement with the management and storage of medications.

During our last inspection we found that the condition and availability of patient's health records was inadequate. At this inspection we found that no progress had been made. Health records were not available for clinics, there was poor tracking of health records and health records which were oversized and in poor condition.

We also found that in some instances patient's confidential information was not stored securely.

There were four vacancies across the Consultant Radiologist workforce. Locum consultant Radiologists have been in post for over two years to support the service. Radiology registrars are part of the medical workforce. However there is a shortage of trainees, with the Trust having only two registrars instead of five. The outcome of below establishment Consultant Radiologist posts and training registrar posts was that the trust's out of hours reporting service was outsourced and the capacity of the department was diminished resulting in extended reporting times which was identified on the Trusts risk register.

We saw very caring and compassionate care delivered by all grades and disciplines of staff working in OPD.

At this inspection we found that patient's experiences upon entering the department had improved. Systems had been put in place to ensure that patients were directed to the correct areas, and IT systems now informed staff when patients had arrived in the hospital. This meant that if a patient did go to the wrong department staff would be aware of this. The queue at reception had reduced and the area was calm and ordered throughout our inspection.

At our last inspection GP letters were not being sent consistently within the five days allocated for this task. This was because of a lack of staff, and issues with the

quality of the letters being translated abroad. This had not improved since our last inspection and medical secretaries were still experiencing the same difficulties in performing their roles.

The team responsible for informing patients when clinics were cancelled had a backlog of work and were struggling to meet with the demands of the role. Many patients were being informed at short notice when appointments were cancelled even when clinics were cancelled with the required six weeks' notice. Many patients had not been notified when their clinic appointments had been cancelled and were arriving at the department to be sent away. There was no clinical triage where clinics were cancelled.

Nursing staff had made great improvements in service delivery since our last inspection. However, administration staff were still unsettled and unhappy about the changes that had been made to their department. They had experienced changes in management since our last inspection but felt that the service had not improved as a result.

Are outpatient and diagnostic imaging services safe?

Inadequate

Staff did not always report concerns, incidents or near misses. Staff were afraid of, or discouraged from, raising concerns and there was a culture of blame. When concerns were raised or things went wrong, the approach to reviewing and investigating causes was insufficient or too slow. There was little evidence of learning from events or action taken to improve safety. At our last inspection we had concerns that staff were not consistently reporting incidents.

Although at this inspection we found a raised awareness amounts nursing staff regarding incident reporting, we still found incidents that had been unreported and an inadequate reporting mechanism for health records that could not be obtained for clinics. Staff were amalgamating several incidents about missing records into one report on the electronic system so there was no real awareness of the scale of the problem. Whilst the staff kept a note of how many temporary notes were made up there was not monitoring of how many notes were unavailable.

Staff did not always assess, monitor or manage risks to people who used the services. Opportunities to prevent or minimise harm were missed. We found that the OPD was not being cleaned or audited in line with the National Specification for Cleanliness and Trust policy which meant the unit managers did not know whether the OPD was sufficiently clean. Staff had limited understanding of the specification and risk levels of their department. Audits were less frequent than was required and where audits had been carried out they showed cleanliness did not meet the required standard.

The management of healthcare records was a persistent recognised risk. The trust had some plans in place to address this in the future but at the time of writing the report there was no mitigation of the risks associated with missing and temporary notes. During our last inspection we found that the condition and availability of patient's health records was inadequate. At this inspection we found that no progress had been made and staff were still managing high levels of health records not being available

for clinics, poor tracking of health records and health records which were oversized and in poor condition. There was no system in place for reuniting the temporary notes with the original ones.

Clinic cancellation was a frequent occurrence and affected many clinics across most specialities. There was no clinical review of the patients affected when a clinic was cancelled and there was potential for people who needed urgent appointments because of their condition to have delays that affected the timeliness of their condition being diagnosed of treated.

We found that medicines management had improved since our last inspection. However, we found some medicines that were being stored in the department had past their expiry date, and the keys to the medication cupboards was not stored securely. This meant that there was scope for improvement with the management and storage of medications..

We also found that in some instances patient's confidential information was not stored securely.

There were inadequate plans in place to assess and manage risks associated with anticipated future events such as consultants in hard to recruit to specialities retiring. The trust was struggling to recruit to consultant posts in Ophthalmology, Rheumatology and in pathology. Ophthalmology had considered new ways of working to manage this situation. Rheumatology had used locum cover to clear waiting lists and pathology was also covering workloads using locums. The Trust was unable to evidence that this cover would be sustainable in the long term.

Radiology staff told us that across the trust there were several vacancies in magnetic resonance imaging (MRI) computerised tomography (CT) and Ultrasound (US). We were told that CT and MRI vacancies were due to introducing a seven day service, staff described the pressure they felt due to poor staffing levels.

There were four vacancies across the Consultant Radiologist workforce. Locum consultant Radiologists have been in post for over two years to support the service. Radiology registrars are part of the medical workforce. However there is a shortage of trainees, with the trust having only two registrars instead of five.

The outcome of below establishment Consultant Radiologist posts and training registrar posts was that the Trust's out of hours reporting service was outsourced and the capacity of the department was diminished resulting in extended reporting times which was identified on the Trusts risk register.

In the Pathology department the trust had a total of 3.80 full time equivalent consultant posts not filled. This was a vacancy rate of 27.6%. In the February Board meeting minutes it was reported that vacancies in histopathologists had been resolved through the use of locums but a longer term solution was required to achieve a sustainable position.

Incidents

- Trust policy stated that incidents should be reported through a commercial software system that enabled incident reports to be submitted from wards and departments. We saw a breakdown of incidents by category and date that allowed trends to be identified and action taken to address any concerns.
- Staff completed an incident form which once submitted went to their line manager who reviewed the incident and reported on the actions that they had taken to mitigate a reoccurrence of the incident.
- Nursing staff discussed incidents that had occurred in their departments and the investigations that followed them. They were able to demonstrate learning from these incidents by showing us the changes of care and processes that the department had instigated as a result.
- We were shown the trust data on incidents which detailed the incident and the action taken following the incident. Incidents were discussed with all nursing staff at monthly meetings.
- All the radiology staff that we spoke with told us they were encouraged to report incidents using the electronic reporting system, this including both radiation and non-radiation related incidents. A service level agreement (SLA) with Royal Sussex County Medical Physics and Engineering department oversee any radiation related exposure incidents providing expert Radiation Protection support and advice.
- Radiation Protection Supervisors (RPSs) employed by the trust ensure compliance with the Ionising Radiation Regulations 1999 (IRR '99) and Ionising Radiation (Medical Exposure) Regulations 2000.The RPS's are the

first point of reference in the investigation of all radiation related incidents. Every 2 months the Radiology risk meeting discuss all the significant incidents. Two risk radiographers (one from each site) attended the meeting. A template of the incident will be published and will be placed in the x-ray room control area, staff room and on line. Staff contacted the risk radiographers or Radiology Service Manager (RSM) if they had any queries. We saw evidence of the templates in the X-ray rooms during the inspection.

- The trust provided data about incidents reported in the eight months before our inspection. Incidents were recorded by speciality and location. In 2014, eight radiation related incidents for exposures 'much greater than intended' were reported to the Care Quality Commission which was greater than the previous two years but this must be measured against activity levels which have increased over this time.
- We reviewed the Radiation related incidents, the appropriate investigations were undertaken and from the outcomes new working practices had been put into clinical place to prevent similar incidents happening in the future. In the Computerised Tomography (CT) department an authorisation code was allocated to CT 'out of hours' requests to highlight to staff performing the examination, that the scan had been authorised by a Consultant Radiologist.
- Staff we spoke to had not received trust training on the statutory Duty of Candour (a legal duty to be open and honest with patients or their families when things go wrong that can cause harm) and were unable to describe the processes the trust had in place.
- Feedback from incident reporting in radiology was managed through monthly radiology clinical governance meetings that covered both sites. All staff were invited to these meetings. Where staff were covering the clinical areas and unable to attend, the meeting minutes were on the shared drive for staff to access. During the meeting, incident reporting was discussed. In the first 3 months of 2015, we were told that two staff meetings have taken place. We were unable to see the minutes of the meetings during the inspection.

Cleanliness, infection control and hygiene

- The trust was not cleaning and monitoring the OPD in accordance with requirements of the National Specification for Cleanliness in the NHS.
- OPD was generally clean but attention to high dusting and detail was lacking. There was in grained dirt on the floors of clinic areas A, B and C. Within the Ophthalmic Clinic there was 30 cm x 30 cm black cobweb with insects trapped in it above the fire escape door.
- The trust hotel services cleaning policy stated that, 'All trust cleaning is carried out to the NHS National Standards of Cleanliness, taking into account those changes introduced under the Health Act 2008'.
- National Specification for Cleanliness in the NHS categorise the risk factors for cleaning and auditing purposes into 4 categories. In the NSC OPDs are generally classified as significant risk areas unless invasive procedures are carried out when they become very high risk.
- We looked at the cleaning audit report from The Conquest OPD. The report highlighted seven areas, two very high risk, two high risk and three significant risk. None of the audits complied with the time frames within the National Specifications for Cleanliness in the NHS.
- Very high risk category areas must achieve 98% cleanliness and be audited weekly to demonstrate compliance. The high risk areas were audited in December 2014, February 2015 and March 2015, with the exception of the day unit which was not audited in March 2015. Therefore the trust was not auditing the areas to the required frequency.
- Of the five other areas which were classified as high risk or significant risk none were audited in December 2014, January 2015 or February 2015. Therefore the Trust was not auditing the areas to the required frequency.
- We were shown the last audit for ENT OPD and this classified this functional area as high risk. This area was last audited on 16th October 2014. The NSC auditing frequency for high risk areas is monthly; in effect this area was missing a minimum of 4 audits.
- We asked the Facilities Team Leaders if there were any cleaning checklists, we were told that these were only used on the wards and not in departments. A cleaning checklist is used to ensure that various items / areas are cleaned in accordance with the NSC. This is particularly useful when there are various members of the team and various working hours as this informs staff of what has been cleaned already on the day and what is outstanding.

- There were hand hygiene, 'Bare below the Elbow' audits undertaken which demonstrated staff were compliant with best practice guidance. These were done for each OPD area, and documented in the annual clinical governance report.
- The staff we observed in the OPD were complying with the trust policies and guidance on the use of personal protective equipment (PPE) and were bare below the elbows. We observed staff in the main OPD washing their hands in accordance with the guidance published in the Five Moments for Hand Hygiene published by the World Health Organisation (WHO 2014).
- Each area displayed their hand hygiene results for the previous month on patient information boards. The results for each OPD area was 100% compliant with hand washing techniques.
- We asked to see the last 2 corrective action sheets and they were as expected with the fault identified, date rectified, signature of member of staff carrying out the rectification and a signature of a supervisor having checked the rectification.
- We were told the auditing department came under Infection control and the person that completed audits had been on leave. We were also told that three new auditors had been recruited and were undertaking their induction.
- Staff working in radiology had a good understanding of their responsibilities in relation to cleaning and infection prevention and control. Departmental staff wore clean uniforms and observed the trust's' bare below the elbow' policy. Personal protective equipment (PPE) was available for use by staff in all clinical areas. We reviewed the training records and saw that radiographic and nursing staff had attended Infection Control Training.
- The Nuclear Medicine department had recently undergone an environmental agency inspection of their waste management procedures for radioactive waste. A Radiographer told us, the environmental agency had made several recommendations, which had been implemented by the Trust.

Environment and equipment

- We looked at equipment risk assessments which included the preparation of equipment, and disposal of sharps such as scalpels.
- The OPD held a register of medical devices used in the department, which described their usage and any related issues.
- We noted that the resuscitation equipment trolley in the OPD was checked regularly and equipment stored on the trolley was appropriate and within its expiry date.
- From observation in the OPD we saw that there was adequate equipment. Staff told us that there was not a problem with the quantity or quality of equipment and that replacements were provided, when necessary.
- We saw that resuscitation trolleys were available within the radiology department and were checked and maintained ready for use in an emergency. In the examination rooms we visited we observed the correct storage of PPE including lead coats, thyroid and gonad shields and radiation glasses. We observed that each item was labelled with the thickness of lead and we were told by the radiographer that visual examinations take place regularly and screening of the PPE will take place annually to ascertain if any cracks or folds have appeared. This complies with Regulation 9 (3) of the Ionising Radiation Regulations 1999.(IRR 99)
- Records of all equipment faults were recorded and the actions taken to mend any faults that develops during the working day. We saw that the necessary quality assurance checks for specialist equipment had been completed following equipment repairs before use. We saw that the relevant documentation had been completed in line with legislation and was available in the examination rooms control areas and in the Radiology Service Manager's

Medicines

- The keys for the medication cupboards in OPD could be accessed by unauthorised people. They were stored in a locked cabinet in a room in OPD but the key for the locked cupboard was stored in an unlocked drawer in a treatment room which had no lock. This meant that the key was not kept securely and patients, visitors and staff could access the medications cupboards.
- We found medicines stored in the Ophthalmology department which had passed their expiry date. Out of date medications included Lignocaine Hydrochloride, Iopidine 0.5%, Betagon eye drops and Polihexendine. This meant that the department did not have adequate systems to check that drugs being stored in the department were needed, and were within their expiry date and fit for use.

- Prescription pads were stored securely and the department had a system in place to ensure that a record was kept of prescriptions that were supplied to patients.
- Fridge temperatures had been recorded consistently and maximum/minimum ranges were recorded on the documentation.
- Due to the issues raised at our last inspection with consultants handing unlabelled medication to patients in Ophthalmology with no safe storage history, pharmacy had now labelled eye drops which were stored in the locked medicine cabinets.
- We spoke to staff working in the Nuclear Medicine Department, who were able to describe in detail the safe transfer of radio pharmaceutical substances. This included the safe transfer of the substances to the hospital from their supplier to the transfer, handling, storage and administration of the substances in the clinical setting. This was compliant with 'the Medicines (Administration of radioactive Substances) Regulations 1978.(MARS)
- Contrast agents for CT scanning and Interventional Radiology were stored appropriately in the imaging rooms.
- In the Interventional Suite we saw that locks were installed on the store room, cupboards and fridges containing medicines and intravenous fluids. Keys were held by nursing staff. We noted that Controlled Drugs (CD) were handled appropriately and stored securely demonstrating compliance with relevant legislation. We saw that CDs and fridge temperatures were regularly checked by staff. We audited one CD in the CD cupboard against the CD register and found the numbers were correct.

Records

- Health records were stored in paper format with diagnostic and with clinic letters being stored electronically alongside paper records. Relevant staff were given passwords to access electronic records and had been trained in the safe use of the system.
- The swipe card system to allow staff access to the medical records department was set to permanently unlock between 7am - 6pm. This allowed anyone to access the department during these hours and the door into the department was off a main corridor accessed by members of the public and patients. Staff were not manning all the areas with health records at all times and the main corridor in the department was piled with trolleys of notes and was unmanned. This meant that in this instance the department had failed to protect patient's personal information.
- In the ophthalmology clinic area A we found a room where patient health records were stored. The room was unlocked and was next to the patients' waiting area. There was no signage on the door. When asked, the sister said it was constantly monitored. However, on two occasions in one morning we entered the room unchallenged as there were no staff present in the area. This meant that in this instance the department had failed to protect patient's personal information.
- On walking around the radiology department we were able to enter the mammography room where we found patient identifiable material which had not been securely put away when staff had left the area. This meant that patient's confidential information was not being managed in line with trust policy.
- At our last inspection we raised concerns about the condition and availability of patient health records. At this inspection we found that the trust had not improved on these areas.
- The trust told us that they did not have any specific audits of unavailable patient notes but since February 2015 they had been collating the number of temporary notes that had been produced. This was now reported weekly as part of the clinical administration dashboard. We looked at the seven weeks' worth of this data, across both sites, which had been collected and saw that in this period 955 sets of temporary notes had been set up across the trust. This was an average of 136 temporary records being set up each week in the trust. The data was not broken down by site.
- There was no effective system in place to reunite the temporary notes with the original notes. Notes were returned and we were told they "should" end up together on filing but there was no monitoring to ensure this happened. The impact of temporary notes was that the staff did not have all the necessary information on which to base decisions. Vital medical history information was not available and this could lead to repetition of tests, a potential for missed diagnosis and additional costs for the trust.

- The Nursing Quality Performance Review Group Meeting recorded an impact on patient safety and said, "Some consultants have not been able to fully consult with patient as data missing that would have been found in the case notes."
- The board meeting minutes of February 2015 stated that the health records department had suffered from a lack of capital investment over the years making it difficult for the department to run an effective service. It was reported that a business case had been submitted to the TDA for funding extra storage space for paper records and investment in an electronic system going forward. We were told during our inspection that funding for these projects had now been secured.

Safeguarding

- Staff working in the OPD had completed mandatory safeguarding training to level 2, and Child Protection training to level 2. Staff were able to talk to us about the insight and knowledge they had gained from this training. They were also able to show us the Trust safeguarding policies on the intranet.
- Two members of staff had completed level 3 safeguarding children training. The intercollegiate document Safeguarding Children and Young People: roles and competencies for healthcare staff 2014 recommends that level 3 training should be completed by all clinical staff working with children, young people and their parents/carers.
- OPD staff were encouraged to contact the safeguarding lead if they had any concerns about patients. Staff assured us they knew who the Trust safeguarding lead was and how to contact them.
- Protocols were in place to manage situations where children did not attend clinic appointments. Staff liaised through safeguarding and health visiting teams where children were persistent non-attenders at clinics. We were given examples of when and how this protocol had been used.

Mandatory training

- Mandatory training was recorded electronically with a traffic light system which alerted managers when staff were close to or breaching mandatory training requirements.
- We were told that most nursing staff in the department were up to date with mandatory training requirements and that the only two exceptions to this were two members of staff, one who had started working for the trust in December 2014, with the other only being in post for a couple of weeks.
- All of the staff we spoke with confirmed that they had received their mandatory training in line with the Trusts policy.
- The mandatory training record provided by the trust showed that whilst 99% of eligible staff had completed BLS training, only 74% had completed fire safety training or information governance training and 82% equality and diversity training.
- The records did not show that medical staff had completed mandatory training.
- Staff are given time to undertake mandatory training which was offered in a format of one days' worth of face-to-face training, augmented with e-learning.
- We were able to review the training records of the multi professional radiology department and saw that the majority of the staff had completed their mandatory training in 2014/15.
- We were told that new staff would go through a trust and departmental Induction Programme and they must prove to be competent in the specialist imaging modalities before they can become a lone worker.
- In the CT department we were shown the competency framework that new radiographic staff had to complete before they could become lone workers .This was a comprehensive competency framework and the modality lead signed off the staff member before they were able to work out of hours on their own. We were told by one staff member that Local Rules were incorporated into the departmental induction and training which is updated yearly.

Assessing and responding to patient risk

- Staff had received mandatory training in patient resuscitation and demonstrated a good knowledge in dealing with medical emergencies.
- The OPD had written protocols for staff when dealing with a patient taken unwell or collapsing in the department. The OPD did not use National Early Warning Score (NEWS). Staff that we spoke with were able to describe how they would deal with a medical emergency in the department.
- We observed procedures being followed when a child in the department required hospital admission. The child's

wellbeing took priority and they were quickly transferred to the children's ward. OPD staff followed the protocol and one nurse was removed from clinic duties to oversee the process.

- We observed the systems were in place to prevent contrast induced nephropathy. The computerised tomography (CT) and Magnetic resonance imaging (MRI) scanning units had access to the 'e-searching system' which enables radiographic staff to check blood results of patients before contrast injection to ensure that patients at risk of Acute Kidney Injury did not inappropriately receive contrast agent. Staff told us that trauma patients who may not have blood results will require a medical consultant authorisation if a contrast agent is required. This system significantly reduced patient risk.
- All rooms that performed radiographic examinations had all the necessary warning notices on the doors and illuminated boxes outside the rooms that light up when a radiographic exposure is made. However we did observe that not all room doors stated what piece of equipment was in the room, for example the second CT scanner. We observed that the mammography room doors were not kept closed when the room was not in use or a member of staff was not present which could result in a person's entering the room and cause damage to themselves or the equipment.
- We saw that systems were in place to ensure the right person, got the right radiological scan at the right time. This included the justification of the request forms on receipt of the request by the modality radiologist or radiographer who could re direct to another imaging modality if it was felt the requested examination was not appropriate.
- On arriving in the Computerised Tomography (CT) department, we observed patients completing a safety questionnaire followed by checks performed by the radiographer prior to the scan being performed. This ensured that the right person was receiving the right radiological scan. Across the department, several incidents had occurred around the identification of patients, we saw the department had responded to the incidents in a timely, appropriate manner and further processes had been introduced to prevent further similar incidents happening in the future.
- The World Health Organisation (WHO) Surgical Safety Checklist was required for use in any operating theatre environment. We were told by nursing staff that the Checklist was part of the process which included a 'team brief' before the list started and a 'team de-brief' at the end of the list. The Nursing staff we spoke to were able to describe the process and show how the WHO surgical safety checklist was being used within the interventional Radiology Suite
- There were no WHO Checklist audits within interventional radiology.

Nursing staffing, Allied Healthcare Professionals and other Staffing

- All of the staff that we spoke with felt that staffing was not an issue in the OPD and felt that there were enough staff of a suitable skill mix to manage the workload.
- The OPD was managed by the Head of Nursing who, in turn, reported to a general manager and clinical services manager. OPD areas were managed by matrons who were Band 7 nurses, the department then employed band 6 and band 5 staff nurses. HCAs were both band 2 and 3 nurses. The matron on the Conquest site also oversaw the Rye and Bexhill locations.
- The OPD was running on a 40% trained nurse to 60% health care assistant roles. The OPD managers had recently attended a study programme on productivity and efficiency and following this had plans to alter the staff ratio to 30% trained nurse to 70% health care assistant. The matrons across both main OPD sites were working together to manage a shift in staffing ratios.
- The OPD had three vacant Band 2 posts with interviews for the posts arranged. The matron felt confident that the posts would be filled with suitable candidates.
- Clinic templates were set up six weeks in advance and nursing rotas were constructed around clinic demands.
- The matron attempted to ensure that nurses worked within the speciality that they were experienced in. Where clinics required it for example, in clinics with invasive procedures Staff nurses were supplied.
- The OPD did not employ agency nurses and only used regular bank nurses that they knew had obtained the relevant competencies to work in the department.
- Managers were able to describe how they were managing long term sickness. The department had a low turnover of staff.
- Radiology staff told us that across the trust there were several vacancies in magnetic resonance Imaging (MRI) computerised tomography (CT) and ultrasound (US).
- In US we were told that the lead radiographer had left and had not been replaced which placed pressures on

the operational staff. Attracting ultra-sonographer was a national problem, so the Trust has introduced incentives to attract ultra sonographers to the trust. However we were told the equipment was old and there were poor career development for the staff which made recruitment difficult.

- The RSM told us that there was enough staff to support the radiology service, however when we spoke to staff we were told that staffing of clerical and radiographic staff was an issue. One member of staff told us that it was hard to recruit and retain staff in CT and MRI due to working extended days and having to support the on call service. This meant that staff were stretched and rotas were very tight which for many meant a poor work home balance. There was no effective mitigation of this and no clear plan to ensure the sustainability service.
- The department is a training centre for student radiographers; applicants for vacancies are received from the training student following graduation. The RSM told us that the feedback from students is good which helps in the Trusts recruitment of staff.
- The radiology nursing workforce employed across the Trust consists of a matron, 2 clinical Nurse Specialists,2 Nursing sisters,2 Staff Nurses and 1 HCA. Five of the Nurses are available to cover on call in the interventional radiology service across both hospital sites.2 further nurses were in training and will be available on completion of their training to participate in the on call rota. A radiologist we spoke to told us that the Interventional on call is demanding and nursing staff had to cover both sites.
- The call centre for both sites was situated at the Conquest hospital. During our last inspection staff were raising concerns about the central location for the call centre as many staff did not want to relocate to the other hospital site. Since that inspection the call centre had relocated and the majority of staff had been redeployed on the Eastbourne site. This had meant that a low number of appropriately skilled staff had been moved to the new site. The staff that had had skills in place were upgraded and most had been redeployed to the clinic maintenance team which managed clinic cancellations.

Medical staffing

- Shortages of medical staff in some specialities resulted in many cancelled clinics and long waits for appointments. The problem was exacerbated by locum doctors being used to clear the backlog of first appointments and improve trust compliance with the referral to treatment time targets. These patients were then not always offered follow up appointments within a clinically acceptable timescale as the permanent consultants did not have capacity to see them
- The trust had struggled to fill the post of a Rheumatology consultant who had retired and another who had moved away/ Despite several attempts to advertise the post the trust had been unable to recruit. As a result the referral to treatment times (RTT) in this area had been particularly poor. The trust had recently cleared lists using outside consultant cover over four weekends. However, this was not a sustainable approach to dealing with the issue in the long term and only resulted in reduced waiting times for the initial appointment. Patients awaiting follow up for treatment had very long waits. We were told that the permanent consultant rheumatologists refused to follow up patients seen by locums for their initial appointment.
- The most recent trust board report stated that trust had been unable to recruit as this was a national shortage area and it was also having difficulty in obtaining locums to cover. Rheumatology clinics were currently being covered using a locum rheumatologist, along with a clinical nurse specialist.
- Trust policy stated that medical staff must give six weeks' notice of any leave in order that clinics could be adjusted in a timely manner. The unit audited compliance with this policy.
- The Ophthalmology OPD had plans in place to recruit to future consultant vacancies. They planned to redesign the service in order to replace consultants with optometrists and at the same time increase nurse led injections and competencies.
- In the Pathology department the trust had a total of 3.8 full time equivalent consultant posts not filled. This was a vacancy rate of 27.5%. In the February Board meeting minutes it was reported that vacancies in histopathology had been resolved through the use of locums but a longer term solution was required to achieve a sustainable position. The trust had advertised its vacancies internationally but there had been no interest.
- Minutes of the Pathology Services Meeting in March 2015 reported that the fifth advert for consultant histopathologists had again been unsuccessful, including international recruitment. The department

was presently three consultants short, with another doctor due to retire. The minutes stated that they were managing cross-cover wherever possible but service was severely compromised, and even at risk when a consultant was off.

- There were four vacancies across the consultant radiologist workforce. Locum consultant radiologists have been in post for over two years to support the service.
- Radiology registrars are part of the medical workforce. However there is was shortage of trainees, with the trust having only two registrars instead of five.
- The outcome of below establishment consultant radiologist posts and training registrar posts is that the trust's out of hours reporting service was outsourced and the capacity of the department was diminished resulting in extended reporting times which was identified on the trust's risk register. The outsourcing only covered the reporting on emergency and urgent scans and x-rays leaving a backlog of routine work for fewer permanent staff.
- There were no audits of the quality of the service where the reporting was outsourced.
- There was no clear strategy to improve recruitment in hard to fill posts and in specialities where there were national shortages.
- The trust provided us with a copy of their induction policy which included the induction of locum staff. The policy included a generic local induction tool to guide staff as to what needed to be covered when a new member of agency staff started work for the first time.

Major incident awareness and training

- OPD was designated as an ambulatory care decant area for the emergency department during a major incident.
- Staff were aware of their role in a major incident and had prompt cards to remind them how to manage a major incident.
- One senior staff member told us they had completed major incident training and were able to describe the department's role in the event of a major incident. Regular exercises were carried out across the trust.
- The trust had major incident cascade systems in place.
- We spoke to staff in the Nuclear Medicine department who were able to describe the effective systems in place if there was a major spillage of a radioactive isotope which included the closing off of the room, contacting the RPA and the cancellation of any lists. We saw the department had a 'spill box' which contained items including a radiation notice, goggles, absorption pads ,radiation tape and spray mist. We reviewed the incident book and found that two incidents had been documented in 2014. Actions taken followed trust policy.

Are outpatient and diagnostic imaging services effective?

Staff were able to demonstrate the use of NICE guidelines and best evidence practice in the planning and delivery of patient care.

There was very little evidence of monitoring patient outcomes from the non-admitted pathway.

There was very little evidence of clinical audit in the OPD (either medically or nursing led).

Staff were able to evidence competence in their roles and in the delivery of care.

The department did not routinely work over seven days but had on occasions ran clinics over weekends.

Evidence-based care and treatment

- The Ionising Radiation (Medical Exposure) Regulation 2000(IRMER), stipulate the basic measures that need to be in place to provide radiation protection of persons undergoing a medical exposure. Across the imaging modalities we visited, we observed that the regulations were being actively implemented. We saw evidence of standard operating procedures, clinical protocols; local referral guidelines based on the Royal College of Radiologists guidelines, justification policy to ensure all medical exposures were justified prior to the exposure being made. We saw evidence that systems were in place for the Trust to report 'much greater than intended' incidents to the Care Quality Commission (CQC). This is a statutory requirement and the trust actively engaged with the CQC.
- The Ionising Radiation Regulations1999 (IRR '99) aims to protect the public and the health of the staff who work with ionising radiation, by specifying the duties of the trust to ensure compliance to the regulations. We were able to observe compliance to the regulations within the department through the carrying out of risk assessments, Quality Assurance programmes, and the

provision of PPE, the development of Local rules for each modality and the employment of a RPA. Radiation protection policies, including Local Rules, were available in the shared drive and also within clinical areas.

- In the CT department we were told by staff that the NICE pathways were in place around the care of Stroke and Head injured patients. This required for certain situations for Brain CT scans to be performed within a one hour window. We were unable to review data during the inspection of the compliance level of meeting this requirement.
- We saw evidence that the WHO surgical safety checklist for radiological intervention was being used for Interventional procedures.
- The Rheumatology OPD demonstrated how they were using NICE guidance 130 Adalimumab, etanercept and infliximab for the treatment of rheumatoid arthritis by using the DAS28 score which is a measure of disease activity in rheumatoid arthritis (RA).
- The Rheumatology OPD also demonstrated compliance with NICE guidelines CG79 Rheumatoid arthritis: The management of rheumatoid arthritis in adults with regard to the criteria for drug administration within this guidance.
- Doctors in the Colorectal OPD demonstrated the ways in which they followed the Royal College of Surgeons of England guidelines for the management of colorectal cancer (2007).
- A Urology clinical nurse specialist was able to demonstrate how the department followed NICE guidelines (CSGUC) Improving outcomes in urological cancers. The department used a referral pathway for patients with erectile dysfunction along with a patient group direction for the administration and supply of Alprostadil.
- National Institute for Health and Care Excellence (NICE) guidance for Smoking cessation had been met within the department. The OPD assessed each patient who accessed the service to establish whether they would benefit from a referral to the Smoking Cessation service. Staff would refer patients to the service where a need was established

Nutrition and Hydration

- On reviewing a patient information letter sent to patients attending for a CT scan, we saw that guidance was given to patients who may be diabetic to ensure the patient's health was not compromised prior to the examination.
- Retail outlets and cafes were available on site for people to purchase refreshments when they attended the OPD.

Pain Relief

- Patients were provided with analgesia, if requested.

Patient outcomes

- The OPD ran a continuous patient experience survey which patients were encouraged to complete following their visit to the department. Patients completed this on paper.
- The trust was designing a pilot study to trial the use of Cancer Clinical Nurse Specialists running 'breaking bad news' clinics, to support the 62 day target and expedite the patient pathway. The target timescale for this was March 2015.
- There was a trust protocol for patients who have breached 2 week targets.
- The trust informed us that there were no audits of waiting times in clinics within the preceding 12 months.
- Overall the trust has an average Follow-up to New ratio when compared to other trusts.
- There were no audits of patient outcomes for outpatient care and treatment.
- The trust told us in an email that, "Any relevant audit issues to the department are discussed at Governance meetings". The governance meeting minutes did not detail very much about clinical effectiveness and audit.

Competent staff

- Health care assistants (HCA) in the department were working towards the protected care certificate. The Trust employed a HCA development educator who was supporting staff with this.
- Generic protocols were in place to ensure that staff understood the department's expectations in relation to tasks such as running clinics, booking patients into clinics, and uniforms.
- The OPD held information on training records which indicated which staff had obtained further competencies above mandatory training which enabled them to perform their role.

- Nursing staff working within speciality clinics had obtained competencies to deliver care in the areas that they were working. For example, in the gynaecology clinics nurses were able to demonstrate that they had received both theoretical and practical training in basic cervical sample taking.
- On starting work at the Trust staff attended a corporate induction. Following this they worked in OPD supported by a named member of staff who supported them. Staff were expected to complete a competency training pack during their local induction programme. New staff in Opthalmology completed two weeks supernumerary in order that they could learn specific skills and techniques.
- A Service Level Agreement (SLA) was in place to support the trust with access to a Radiation Protection Advisor (RPA) as required by IRR ('99) and a Medical physics expert (MPE) as required under IRMER. Both roles being undertaken by a registered physicist The RPA's duties included producing Diagnostic Reference Level's, writing Local Rules in collaboration with Radiation Protection Supervisors (RPS's) and Radiology Services Manager, advising the RPS and attending the Radiation Protection Committee on matters of dose limit/ dose excesses/ incidents.
- RPS's with a 3 year validation schedule were employed by the Trust whose function is to secure compliance with the IRR (99) and whose main role is to oversee the Local Rules and ensure that they were implemented. One RPS we spoke to told us that an update in training was due and that the Trust would support the attendance at a three day course.
- All Radiographic staff were trained and held either a Diploma of the College of Radiographers (DCRR) or a BSc (Hons) in diagnostic imaging. We were unable to review the records that confirmed that all radiographic staff were registered on a two year basis with the Health and Care Professionals Council (HCPC).There are codes of Practise for both the SCoR and the HCPC which must be followed, any breaches would result in a radiographer being reported. The RSM told us no staff had been referred to the HCPC recently however one staff member had been referred in the past.
- We were told by a member of staff that all newly appointed Radiographers had a mentor allocated to them for at least the first 6 months post qualification. We were unable to substantiate this during the inspection. Student radiographers were classed as 'operators' by the trust. This allowed students to carry out a variety of functions which are clearly defined in the standard operating procedures of the modality they are being trained in. A modality lead told us that students were under direct supervision of a radiographer during their work experience in the department. This was in line with current legislation.
- The nurse specialists within the interventional suite had completed the necessary training and were able to administer conscious sedation, work solo and participate in the interventional on call rota. Two registered nurses were undertaking the nurse specialist training at the time of the inspection. We were shown the competency framework which included attending study days and hands on experience. The training we were told would be completed in 10-12 months.
- Across the trust we were told that 5 radiographers had completed the post graduate training in clinical reporting. Radiographers supported appendicular and extremities plain film report and one was trained in CT head reporting.
- The IT technical manager told us that all staff received Information Governance training as part of their mandatory training, which was supported with written procedures. We reviewed the training records and saw the majority of staff had received Information Governance training. However we were told that staff were not always aware of all the systems in place around the transfer of images. Training was therefore made available on a 1:1 basis.

Multidisciplinary working

- The Colposcopy clinic held multidisciplinary team (MDT) meetings every three weeks. We were shown the minutes from this meeting which were attended by Clinical Nurse Specialists (CNS) Staff nurses, pathology and the Consultant. Other specialities held similar MDT meetings at varying intervals dependant on necessity. For example, urogynacology held meetings once a month whereas Oncology held them weekly.
- One stop clinics were run where needed for gynaecology patients where colposcopy, biopsy, and bloods were collected during one clinic appointment.
- Staff were able to access dieticians and pharmacy support in clinics where needed.
- MDM video conferencing is available across both sites of the Trust.

Outpatients and diagnostic imaging

- Consultant Radiologists were core members at the Cancer MDT meetings; this allowed the MDT meetings to meet national standards. Non- cancer MDT's including cardiology; rheumatology and A/E also require radiological input. A consultant Radiologist told us a quarter of a radiologist time is spent preparing and attending the MDT. This placed pressures on the working of the department and the workload of the Radiologists.
- In the imaging departments IR(ME)R 2000 Medical Exposures' Manual & Standard Operating Procedures lists the non-medical staff able to make referrals for radiological examinations; these include for example Podiatrists, Chiropractors, Radiographers, Nurse Practitioners, and Physiotherapists. Non-medical referrers must have undertaken Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) training.
- We were told by the RSM that a one stop breast care clinic operated within the trust twice a month. This was a family history clinic, with radiology providing mammography and ultrasound support.

Seven-day services

- OPD were running clinics over five days. However, they had recently opened weekend clinics to clear a backlog in Rheumatology clinics.
- The CT and MRI scanners at The Conquest Hospital provided a seven day service.

Access to information

- The Picture Archiving and Communication System (PACS) links all the patients examinations and reports together which means the Radiologist can access all examinations and reports during the reporting process. The PAC's system links in with other systems across the south coast which means if the patient has an X ray examination at another hospital, this examination can be accessed and used in the reporting process.
- However we observed the inclusion of the PAC system on the trust's risk register. There was a risk that when the PACS tape library failed that the service was unable to retrieve historic images which meant that comparison reports could not be produced in a timely manner, causing a disruption to Radiology reporting service. The trust was monitoring this and has introduced systems to mitigate the risk.
- The Technical support manager told us that an Image exchange portal (IEP) which connected to other providers was in place to transfer images if patients require a specialist opinion or emergency transfer. The radiology PACs is connected to the IEP at another hospital allowing the immediate access to information to healthcare professional across different providers to support improved patient outcomes.
- The Clinical Record Interactive Search System (CRIS) is a workflow management system that is integrated with the PAC system. All images and patients history can be accessed for comparison and consistency.
- All access to the PACs is through the practitioner applying for access. The technical support manager told us that medical locums can be issued with an emergency account and log on book. Weekly checks were performed to chase up access forms to ensure the Trust Information Governance policy was adhered to. The technical support manager was able to demonstrate this process in action to us during the inspection.
- The RSM told us that a risk assessment had been carried out around the backlog of plain film reporting. The trust was in the process of reducing its backlog of OPD, IP A&E and plain film examinations however there was a risk that there may be clinically urgent or unexpected findings which could have been missed, or misdiagnosis even after clinical evaluation of images by referrers may have been undertaken.
- The RSM told us that all the high risk examinations including chest and abdominal films had all been reported. We spoke to a reporting radiographer who told us that an SLA was in place for extra plain films to be reported each month. The radiographer would come in the evening and weekend to report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The OPD had link nurses for safeguarding, and child protection. The OPD had a link nurse for Mental Capacity Act (MCA). Staff that we spoke with had a good understanding of MCA 2005 and their responsibilities under this act.
- We were given an example by one member of staff of an occasion when a patients capacity to consent to treatment was questioned. They were able to talk us through the procedures they followed and demonstrated that they had treated the patient in line with MCA 2005 regulations.

Outpatients and diagnostic imaging

- We spoke with an HCA who demonstrated a good understanding of safeguarding and MCA and was able to give us two examples of care which demonstrated their understanding.
- The training record provided by the trust showed very low levels of training completion in the Deprivation of Liberty Safeguards 2005. At conquest hospital 14.8% of staff had completed the training. The record showed the training was not applicable to the majority of staff, including nursing staff. There was no explanation for this.
- Radiography staff we spoke to were unable to demonstrate a consistent and sound understanding of the principles and their professional responsibilities in respect of Consent, Mental Capacity Act 2005, Deprivation of Liberty Safeguards and Safeguarding. The lack of understanding around good practice when performing of radiographic procedures for persons who lacked capacity did not follow current legislation.
- Staff were unable to describe when 'a best interest's decision' had to be made and where this would be documented.

Are outpatient and diagnostic imaging services caring?

Good

Staff responded compassionately when people needed help and supported them to meet their personal needs, as and when required. We saw very caring and compassionate care delivered by all grades and disciplines of staff working in OPD.

Staff communicated with people and provided information in a way that they could understand. People understood their care, treatment and condition

Staff offered assistance without waiting to be asked. Staff worked hard to ensure patients understood what their appointment and treatment involved.

Compassionate care

- One of the strengths of the service in the OPD was the quality of interaction between staff and patients.
- We watched staff assisting people around the different OPD areas. Staff approached people rather than waiting for requests for assistance, asking people if they needed assistance and pointing people in the right direction.
- We saw staff spending time with people, explaining care pathways and treatment plans. We noticed that staff squatted or sat so that they were at the same level as the person they were speaking to and maintained eye contact when conversing.
- We observed staff interactions with patients as being friendly and welcoming. We saw staff stopped in clinics to greet patients that they knew and ask after their well-being. We observed that patients that attended clinic regularly had built relationships with the staff that worked there.
- Staff were expected to keep patients informed of waiting times and the reasons for delays. We observed this happened in all areas of the OPD during our inspection.
- All of the patients we spoke with were complimentary about the way the staff had treated them. One patient said, "Excellent service and excellent care, I have no complaints".
- Patients also told us that they had been treated with dignity in the department.
- We saw that staff always knocked and waited for permission before entering clinic rooms.
- Patients in radiology told us that they had been treated with dignity in the department. One patient told us, "I have been coming to the hospital for the last 18 months and I can't fault the service here.
- Sitting in the Ultrasound waiting area we were able to hear the reception staff booking patients in by asking their name, address, GP and area being examined. The radiology reception area was an open area, in the main corridor leading into the x ray department, across from the Ultrasound waiting area. There was no privacy for patients when reception staff were booking patients in. This meant that people's personal information could be overheard by people in the US waiting room and anyone walking down the corridor. The reception was inadequate and did not protect people's personal information or their dignity.
- We spoke to staff and asked what systems were in place if a patient asked for a chaperone. In the Nuclear medicine department staff told us that another member of staff, which could be a nurse or Radiology Department Assistant, would support the examination.

Outpatients and diagnostic imaging

However if a staff member of the opposite sex was required this would have to be arranged in advance. A member of the Eastbourne team would come over to the Conquest hospital. This showed that staff were able to meet the needs of the patients.

- Friends and Family Test results were recorded in the monthly Nursing Quality Performance Review Group report. For conquest hospital the OPD scores for January and February 2015 were given as 94% and 89.1% respectively.

Understanding and involvement of patients and those close to them

- We spent time in the department observing interactions between staff and patients.
- All of the patients we spoke with told us that their care was discussed with them in detail, and in a manner that they were able to understand. Patients told us that they felt included in decisions that were made about their care and that their preferences were taken into account.
- We saw literature being explained to patients in clinic. We saw patients being handed detailed information which was explained to them by nurses who checked their understanding. Nurses also ensured that patients had a contact number to call if they had further questions or concerns when they returned to their homes.
- We also observed the doctors behaving in a friendly and respectful manner towards the patients in their care.
- Friends and Family testing was also being used in OPD but and had been adapted for use within the department.
- In February friends and family tests for Maxillofacial OPD were 75%, Ophthalmology 80.7% and Trauma and Orthopaedics 92%.
- Results of surveys and friends and family testing were shared with staff and patients on display boards within the departments.

Emotional support

- The OPD was a calm and well-ordered environment. We saw nurses constantly updating patients on clinic waiting times and checking that patients were comfortable and happy.
- We saw an example of staff supporting a frail elderly patient with compassion and dignity. One relative said, “We had a bad experience somewhere else. She likes to come here; staff are much more friendly and capable”
- The OPD had a comfortably decorated room set aside to offer to patients and their relatives to have quiet time to reflect and speak with staff after being given bad news.

Are outpatient and diagnostic imaging services responsive?

Inadequate

At our last inspection the Trust was not able to evidence that they were meeting with RTT NHS standard operating procedures across all specialities for either 2 week or 18 week targets. This trust performed worse than the England average for all three measures of cancer waiting times by Q2 14/15. At this inspection the Trust was still not able to evidence that they were meeting with these targets consistently across all specialities, although members of the executive team were able to show us how they were beginning to make some improvements to address the backlog.

The trust was not meeting the national cancer targets. In Q4 (January 2015- March 2015) the trust performed worse than the England average for all three cancer targets. The performance against the 2 week target for urgent referral by a GP to the first consultation showed 92.4% compliance against a national average of 94.7%. In Q4 the 31 day target for the time between deciding to treat and the first treatment for this period was achieved for 94.2% of patients against a national average of 97.5% .In the same period the 62 day target for the time from initial referral to the first treatment was achieved 77.7% of the time against a national average of 82.3%

People were frequently and consistently not able to access services in a timely way for an initial assessment, diagnosis or treatment. People experienced unacceptable waits for some services. At our last inspection we found that the patient journey through the department on arrival was poor with patients experiencing long queues, being sent to the wrong departments by the central reception, and nurses in clinic having inadequate IT systems to allow them to know when a patient had arrived in clinic.At this inspection we found that patient’s experiences upon entering the department had improved. Systems had been put in place to ensure that patients were directed to the correct areas, and IT systems now informed staff when

patients had arrived in the hospital. This meant that if a patient did go to the wrong department staff would be aware of this. The queue at reception had reduced and the area was calm and ordered throughout our inspection.

The trust was not meeting the planned trajectory for improvement in the waiting lists and backlog for the admitted 18 week target. The trust supplied up with details of their performance against the RTT performance trajectory agreed with TDA and local commissioners. It showed that the trust performance was red RAG rated for most specialities in respect of the 18 week admitted pathway. In some specialities the waiting list had increased over the two month period the trust had supplied us with data for.

The call centre was not fit for purpose with a shortage of skilled staff and operating systems that were not working to advantage patients. As a result of these issues patients and staff were often unable to contact the call centre when they needed to.

The call centre had been relocated to the Conquest Hospital site since our last inspection. The move had resulted in the organisation having to staff the call centre with new inexperienced staff and this had caused teething problems which were still on-going at the time of our inspection.

At our last inspection GP letters were not being sent consistently within the five days allocated for this task. This was because of a lack of staff, and issues with the quality of the letters being translated abroad. This had not improved since our last inspection and medical secretaries were still experiencing the same difficulties in performing their roles.

The team responsible for informing patients when clinics were cancelled had a backlog of work and were struggling to meet with the demands of the role. Many patients were being informed at short notice when appointments were cancelled even when clinics were cancelled with the required six weeks' notice. Many patients had not been notified when their clinic appointments had been cancelled and were arriving at the department to be sent away.

Clinic preparation staff were still under a great deal of pressure and felt that the problems that they reported to us at the last inspection had not improved. They were preparing clinic health records at short notice due to staffing levels. They were wasting time preparing clinic health records due to the poor tracking of patient records across OPD. Many records were still unavailable for clinics and the preparation of temporary health records was regular practice at every clinic, these were also set up by clinic preparation staff.

In the radiology department the main reception desk did not provide any privacy for patients booking into Radiology. The area was open which allowed patients conversations with staff to be overheard.

We observed that the waiting area outside MRI and US was inadequate. The waiting area was a corridor which was busy and provided the patients awaiting examinations no dignity. Members of the public and patients were sitting together. Patients both male and female were sitting in gowns. One patient we observed had their gown on incorrectly. Patient's dignity was not being met prior to patients receiving radiological examinations.

Service planning and delivery to meet the needs of local people

- On entering the department patients checked in a central reception desk located in the lobby. Staff at these desks told us that they were concerned about the height and security of their terminal screens. They said that patients often tried to peer over the top of their screens which made it difficult for them to protect patient confidential information.
- Staff had worked on systems to ensure that patients understood which clinic areas they should go to and what to do when they got there. This was a vast improvement on our last inspection when we found patients were joining long queues and getting lost often presenting in the wrong areas of OPD.
- Computer systems had also been improved since our last inspections and staff in clinics were able to tell when a patient had checked in at the front reception desk. Therefore on the rare occasions that patients now got lost staff were able to track them down and help them to the correct area of OPD. Staff all acknowledged that the checking in system had made huge improvements since our last inspection.
- Each area had patient information boards these contained a variety of information including staff photos, infection control and hand hygiene audit results and patient survey results.

Outpatients and diagnostic imaging

- The OPD had bariatric chairs available in most areas. There was scope for further work on seating particularly with different height chairs to meet with the requirements of patients who required this.
- The trust had a 'pay on foot' car park for visitor use. Parking was charged based on the amount of time people were parked for. We saw that where clinics over ran staff could assist patients with partial refunds on their parking costs.
- Patients attending for outpatients and other visitors had access to a coffee shop and restaurant area.
- In the radiology department the main reception desk did not provide any privacy for patients booking into Radiology. The area was open which allowed patients conversations with staff to be overheard.
- We observed that the waiting area outside MRI and US was inadequate. The waiting area was a corridor which was busy and provided the patients awaiting examinations no dignity. Members of the public and patients were sitting together. Patients both male and female were sitting in gowns .One patient we observed had their gown on incorrectly. Patient's dignity was not being met prior to patients receiving radiological examinations.
- The reception area was an open area, in the main corridor leading into the x ray department, across from the Ultrasound waiting area. Sitting in the Ultrasound waiting area we were able to hear the reception staff booking patients in by asking their name, address, GP and area being examined. There was no privacy for patients when reception staff were booking patients in. This meant that people's personal information could be overheard by people in the US waiting room and anyone walking down the corridor. The reception was inadequate and did not protect people's personal information or their dignity.
- There were no information displays explaining to people how they could complain. The waiting areas were poorly signposted. They lacked information such as patient relevant information.
- The OPD used these boards to display a 'you said we did' section – these told patients about things that they had said and what the department was doing to improve this for them.

Access and flow

- At our last inspection the trust was not able to evidence that they were meeting with RTT NHS standard operating procedures across all specialities. At this inspection the trust was still not able to evidence that they were meeting with these targets across all specialities, although trust executive officers were able to talk to us about plans for improvement.
- The non-admitted RTTs were very variable with a trust wide data showing an average of all specialities meeting the 18 week target in 92.8% of cases but with much worse performance in specific specialities. Notably gastroenterology showed a 61.7% achievement, 88% in general medicine and89.6% in General Surgery . There were specialities that showed a significantly better performance with Geriatric Medicine showing as achieving the target 100% of the time.
- The trust had performed worse than the England average for all three measures of cancer waiting times by Quarter 2 - 2014/2015.
- The trust did not see or treat the required number of patients against two week wait standard, breast symptom two week wait and 62 day standard. The two week wait standard average for the trust was 91.23% which sat below their target of 93%.The two Week Breast standard sat at 89.64% for the trust which was below the standard of 93%.
- In Q4 (January 2015- March 2015) the trust performed worse than the England average for all three cancer targets. The performance against the 2 week target for urgent referral by a GP to the first consultation showed 92.4% compliance against a national average of 94.7%.
- In Q4 the 31 day target for the time between deciding to treat and the first treatment for this period was achieved for 94.2% of patients against a national average of 97.5% .In the same period the 62 day target for the time from initial referral to the first treatment was achieved 77.7% of the time against a national average of 82.3%
- The most recent board meeting minutes stated that in relation to the cancer targets the trust had not achieved the 2 week wait standards due to patients being unable to attend urgent appointments within fourteen days and that the Trust had engaged with the CCGs and stakeholders to improve this. It was reported that an audit had been carried out between May and September 2014 of the referrals by GPs into the two week wait categories and those patients who had breached because they were unable to attend.
- The Trust had written to 12 GP practices asking them to ensure that patients were aware of the potential seriousness of their position and had provided them

with a script and leaflet to use. As a result two practices had responded asking for more information; and a further audit had conducted in one practice with the main rationale for non-attendance being that patients had been elderly and confused.

- RTT times for Non-admitted patients have been consistently below the England average and below the national standard since Nov 2013. The trust used the following protocol for managing compliance with the 18 week RTT times. Daily Monitoring of RTT Outpatient waits were recorded through an electronic booking tool which appointed patients to their relevant pathway and its targets. Daily or weekly meetings with individual specialties. Weekly meetings managing patients who had exceeded 18 week patient pathway performance targets. A weekly NHS Trust Development Authority (TDA) call; and monthly meetings with Clinical Commissioning Groups (CCG).
- The trust compliance with RTT for non-admitted pathways showed poor compliance against targets agreed with the TDA and local commissioners. The ratings for February 2015 showed five services (General surgery, Trauma and Orthopaedics, Ophthalmology, gastroenterology and rheumatology) were all rated red with waiting lists and backlogs significantly higher than agreed.
- The trust was not meeting the planned trajectory for improvement in the waiting lists and backlog for the admitted 18 week target. The trust supplied up with details of their performance against the RTT performance trajectory agreed with TDA and local commissioners. It showed that the trust performance was red RAG rated for most specialities in respect of the 18 week admitted pathway. In some specialities the waiting list had increased over the two month period the trust had supplied us with data for.
- For trauma and orthopaedics the waiting list target was 801. In January 2015 the actual waiting list was 1468 and in February 2015 it was 1427. In ENT the waiting list had risen from 284 in January to 332 in February 2015 against a target of 249. In gynaecology the waiting list had increased from 271 to 285 over the same period against a target of 218.
- The overall waiting list for February 2015 showed a waiting list of 20, 530 against a target of 19, 480. This was an increase from the previous month.
- The overall backlog target was set at 874 but the actual backlog reported was 1259 which was 31% over the target figure.
- In order to manage the long waiting lists in rheumatology, which the most recent NHS England statistics (January 2015) showed were at 30.2% (for non-admitted pathways) where the national standard is 95%, the trust had run weekend clinics for four weekends running which cleared the long waiting lists. In order to manage this the trust had bought in consultants from other areas of the country to work these clinics. The week that we inspected the trust had bought the RTT for Rheumatology up to 86.1% (the trust's own, non-validated figure) which although a significant improvement still left the division sitting below the expected operating standard for the NHS.
- Staff told us that although they saw the benefit of clearing the waiting list for new patients which helped the Trust to manage its 18 week pathways for new patients they were concerned that this had left the Trust with a backlog of around 150 patients who needed to be seen in clinic for follow up appointments. The Trust was able to manage 15-20 Rheumatology clinics at its two acute sites per week ordinarily which were staffed by two consultants and two nurses.
- Paper referrals from General Practitioners (GPs), consultants and A&E were managed by a team at the Eastbourne site. Once received referrals were opened, date stamped and sorted into specialities. Clerks then booked the patient onto the partial booking system before sending the referral to the relevant consultant for triage. The protocol stated that this should be completed within 48 hours and staff were managing the process at the time of our inspection within 24 hours.
- Once triaged the referral would be rated for urgency and then forwarded to the central booking team at the Conquest site to make the appointment. Due to the limitation of the IT system the urgency of an appointment did not translate to booking staff so the team at the Eastbourne site needed to send a separate email instructing the booking team about which referrals were urgent, soon, or routine.
- Urgent appointments were to be made within two weeks, soon within four weeks and routine within six weeks.
- Central booking staff then booked appointments using the urgency scale along with guidelines for each speciality.

Outpatients and diagnostic imaging

- Speciality guidelines informed staff of the timescales for booking appointments. If staff were unable to book appointments within this timescale they would use the escalation policy to escalate this to divisional leads. For example, at the time of our inspection general surgery was booking at no more than nine weeks whereas ophthalmology was 13 weeks, with gynaecology being 10 weeks at The Conquest Site and 17 weeks at the Eastbourne site.
- Where booking staff had escalated patients who they were unable to book within the timescales required divisional managers would steer staff on how to manage these bookings. We were told that this would be addressed by providing extra clinics, converting follow up appointment slots into new appointments, double booking clinic spots or by agreeing breaches in the RTT.
- One issue raised by both staff and patients was the cancellation of clinics. Clinic cancellations were managed by a team at the Conquest site. Trust protocol dictated that clinics should be cancelled with at last six weeks' notice. Staff told us that this was not always adhered to and they were regularly receiving cancelled clinics within six weeks for reasons such as study leave.
- On the Conquest site between September 2014 and March 2015 179 clinics had been cancelled at short notice (less than 6 weeks), with 3466 clinics cancelled during this period with more than six weeks' notice.
- The team managing clinic cancellations had a backlog of work, which meant that they were cancelling clinics within one to two weeks of the clinic. This meant that even where clinics were cancelled with more than six weeks' notice patients may not receive this information until a week before their appointment.
- Staff told us that patients did turn up in the department unaware that there clinic appointment had been cancelled. Staff responsible for telling patients about cancellations confirmed that this did sometimes happen. They told us that this was usually because they did not have the patient's most up to date information on their records, and were unable to track the patient down.
- On the Conquest site between 15th September 2014 to 30th March, the Patient Advice and Liaison service (PALS) had received 52 complaints from patients who had arrived for clinic appointments that were cancelled without being notified.
- We spoke with seven patients from both sites about clinic cancellations. Of the seven patients we spoke with five had had clinics cancelled. One had not been notified and arrived for their appointment to be turned away. They told us that they had been informed of their new appointment the day before by letter. They said, "I didn't complain because the staff were so nice and apologised". Another patient said, "I arrived for an appointment to be told that it had been cancelled the week before and a letter had been sent to me telling me. I hadn't received it and there were a lot of people that day being sent away. I got another appointment but it wasn't until March which meant my appointment was six months overdue".
- This meant that the central booking team were a new team with most of their staff employed over the Christmas period. The team had no experience and were trained with support for a short while from a member of the clinic maintenance team. The clinic maintenance team were located in a temporary building, a ten minute walk away from the booking staff base. Plans were in place to move this team back to the main booking office although there were no dates for this at the time of our inspection.
- Medical secretaries told us that the lack of experienced staff in clinic bookings meant that they were often distracted from their own work by staff from clinic booking requiring assistance. The booking department manager told us that inexperienced staff who needed support was their main challenge along with attempting to retain a disgruntled staff group
- At the time of our inspection staff and patients told us that contacting the call centre was extremely difficult. Medical secretaries told us that they were constantly fielding calls from patients who were unable to contact the call centre. Medical secretaries told us that they also could not get their calls answered by the call centre so they emailed requests to them rather than call.
- It was established during our inspection that there was a fault on the line between the Eastbourne site and the call centre. Staff did not know how long the fault had been in place.
- Some patients still had previous letter heads directing them to call the Eastbourne number. Their call should have been redirected through to the conquest booking centre but this had not been happening.
- When the booking centre had been moved it had taken the department three months to change the appointment letters being sent out to reflect the new telephone numbers for the booking centre. We were

told that the reason for the fault was that all telephone traffic from Eastbourne to The Conquest went via an Integrated Services Digital Network (ISDN line) which was only 2 mega bites in size and was not large enough to cope with all the traffic sent across it.

- Another issue was the 'Round Robin' telephone system in operation in the call centre. This meant that calls would ring on each phone in sequence until someone answered the call. The Round Robin system had been set up to use 12 telephone lines however the call centre used five to six operators. Therefore the system still rang through to twelve phone sockets which increased the time that people were left waiting for calls to be answered. When the calls got to the end of the line of twelve terminals the caller was thrown out of the system, with no option to leave a message.
- It had been discovered that when staff were busy on other tasks they were unplugging their telephones at the socket, the operating system was unable to detect that phones had been unplugged and this also increased the time that people were waiting on the line.
- We were told the solution would be a new call centre, the funding for this has been secured and the telecoms department were meeting with a company on the 26 March 2015 to discuss the options available to them.
- Since our last inspection staff told us that it had been recognised that follow up appointment bookings needed to be addressed and the Trust had placed a team at the Conquest site to manage follow ups.
- At our last inspection clinic preparation staff were under a great deal of pressure and were struggling to manage workloads. At this inspection they told us that although they had seen a change in management the situation had not improved.
- Clinic preparation staff printed off a list of patients attending clinics around a week before the clinics and their job was to locate and prepare patient health records for the clinics. The team were assisted by two runners who collected notes that were tracked to the library.
- As in our last inspection the biggest challenge for staff was locating notes that had not been correctly tracked and were waiting in other areas of the hospital. The job of tracking health records from clinics had still not been allocated. This meant that from the point in clinic until medical secretaries tracked notes which they had collected in clinic back to the library no one knew where health records were.
- Clinic preparation staff needed to travel around the hospital sites attempting to locate and collect the health records that they required. They told us that they still needed to set up a large number of temporary note folders which was both time consuming and unsafe in some clinics.
- They told us that four consultants refused to see patients without health records whereas other consultants would take a view on whether it was safe to see a patient without their full health records. A temporary set of health records contained patient identification labels, the most recent clinic letter and recent test results. We did not observe this during our inspection visit but have subsequently been contacted by people to whom this had happened and a senior nurse confirmed to us, by telephone, that this was the case.
- Clinic preparation staff were meant to prepare notes three days in advance of clinics. However they told us that they usually prepped clinics for the next day. Records we looked at confirmed this. This meant that where health records were not available consultants may be cancelling patients for clinic for the following day.
- The Trusts policy required GP letters to be sent following clinic appointments within five days. Medical secretaries we spoke with across both sites told us that this policy was not being adhered to consistently. They said that the reason for this was that dictated letters were sent abroad for typing. They said that the typing of these letters was not always correct and that secretaries had to listen to the dictation and check them against the letters that they received back. They also told us that they did not have enough staff in some areas (for example Ophthalmology) to meet with the demands of the service. We asked for the data collected on this but the trust did not provide us with it. There was no monitoring of the quality of the outsourcing.
- DNA rates for all Outpatient clinics have generally been higher (worse) than the England average over the last year. The England median DNA rate over the period 2013/2014 was 7% whilst the trust median for the same period was 8.5%. We asked but were not were not told of any plans that the Trust had to address this issue.

Outpatients and diagnostic imaging

- We were told that on the whole the radiology department was meeting the 6 week diagnostic target with a 1% tolerance. This means that in February 2015, 10 patients were outside this target. Trust data confirmed this.
- Demand for CT scans had increased by 7% in the last year. The complexity of scans now required more time spent on reporting the images to ensure all the necessary information was retrieved from the examinations. With increasing demand, the complexity of the procedures and workforce issues extreme pressure was being placed on the effective workings of the radiology department. However the department was managing to stay within the 6 week target.
- Staff we spoke to told us that this was happening to the detriment of patient wellbeing and care as many staff felt they could not give patients the time they required.
- Plans were in place to bid for a second MRI scanner.
- The GM told us that a cancer tracking meeting took place weekly .This closely monitored the time cancer patients wait for examinations. All patients that were close to breaching were discussed and processes put in place to prevent this happening. For example if a MRI scan had not been reported and the MDM was due, the GM will expedite this to ensure the report was available to discuss at the MDT.
- Inpatient examination aimed to be performed within 24 hours. We were told they were not achieving this in all cases. Requests could be escalated if there is a clinical concern. The RSM audits the time taken from when the examination is performed to the time the report is reported.
- We were told by the RSM that routine MRI scans were taking up to 30 days for a report to be released.
- Urgent CT scans are reported on the day however over two hundred routine CT scans were waiting for three weeks to be reported. The decision had been made to outsource any CT scan that was not reported within a month.
- On the day of the inspection, 312 routine CT scans were awaiting reporting and 176 MRI'S. We were told that the oldest scans were three weeks old which was outside the two week target.
- We were told that the number of scans requiring reporting fluctuates and a radiologist told us they are struggling to keep the numbers of scans under control. In Nuclear Medicine we were told that the SPECT CT images were not meeting the 5 day reporting target.
- The RSM told us that they will be outsourcing CT reports to the independent reporting company the hospital used. We observed that on the trust risk register 'examinations required' surpassed the reporting capacity of images and that images were not reported in a timely manner.
- Capacity paper already highlighted workforce deficiency in numbers with high number of non-urgent MRI and CT scans unreported at present.' To mitigate this situation, solutions had been sought including ad-hoc and extra hours of the radiologists, outsourcing reports to the independent company and prioritising cases.
- We spoke to a reporting radiographer who told us that a SLA was in place for extra plain films to be reported each month. The radiographer would come in the evening and weekend to report but this system was not sustainable.
- The RSM told us that a risk assessment had been carried out around the backlog of plain film reporting. The trust was in the process of reducing its backlog of OPD, IP A&E and plain film examinations however there was a risk that there may be clinically urgent or unexpected finding or misdiagnosis even after clinical evaluation of images by referrers may have been undertaken.
- The RSM told us that all the high risk examinations including chest and abdominal films had all been reported.

Meeting people's individual needs

- Interpreting services were available to patients through a three way telephone system. These could be arranged at quick notice when patients presented themselves in clinic.
- Patients with learning difficulties, mental health needs and dementia were prioritised in clinic. On occasions staff would be made aware that they were attending clinic beforehand. However, staff told us that whether they were aware previously or not patients would be bought to the front of the list on arrival in the department to make their visit as stress free as possible.
- The OPD had folders for staff which included information for assisting patients with a learning disability. The information included a variety of communication tools, along with information and spare copies of hospital passport. Hospital passports were completed at home and bought into hospital to give staff information on the best ways to care for the patient's individual needs.

- The OPD had a link nurse for dementia who ensured that they were informed of new initiatives and best practice and shared this with the rest of the team. Although he OPD did not use the butterfly scheme adopted in the rest of the Trust they did highlight patients with dementia during hourly intentional rounding. The OPD had a resource box for staff including information on dementia and tools such as memory photos to assist people with dementia within the department.
- Staff told us that where ladies required a female doctor to examine them due to cultural or religious preference, that this request would always be respected.
- Information leaflets were available in different languages upon request. The department was also able to access information leaflets in easy read formats.
- Staff in the nuclear medicine department told us that they did not produce information leaflets for patients with learning difficulties.
- There were patient leaflets in each waiting area which provided patients with information about the department, how they could complain, and information on diseases and medical conditions. We saw patients reading this information. When asked, they all said that the information was in a format that they understood.
- The Service provided chaperones where required for patients. We were told that staff were always available for this.
- In CT staff told us that extra appoint times slots would be allocated to patients with dementia or learning difficulties. These patients would be scanned over the lunch time when the department was at its quietest and more time could be given to the patient and their carer to ensure a positive outcome.
- An on call Interventional Radiology service is provided which undertakes a variety examinations to ensure patients' needs are met outside the normal working hours.
- There were no patient leaflets in waiting areas in the radiology department. Patients told us that they had been sent information letter explaining the examination they were having prior to their appointments.

Learning from complaints and concerns

- The trust provided us with information about complaints received regarding complaints in OPD, across the trust. This showed a total of 79 complaints had been received between September 2014 and March 2015, 27 had been regarding Patient Pathway, 17 around Communication,16 regarding the provision of services, 14 the standard of care, three about the attitude of staff, one about the environment, and one regarding infection control. There was no breakdown by site provided. The figure differs significantly from that provided by the PALs service where 129 complaints were recorded about cancelled and delayed appointments on the Eastbourne site alone. No PALs figure was provided for the Conquest site.
- The trust held a log of complaints and the learning points established from each complaints investigation.
- In the Board Report Feb 2015 Patient Advice and Liaison service (PALs) summary noted that there had been a spike in contacts during the latter part of July and August and this related to the changes in the outpatient booking-in system.
- Of the 279 OPD contacts made with PALS from 15th September 2014 to 30th March 2015 on the Conquest site 68%% (183 complaints) were regarding the appointment telephone line, 19% (52 complaints) were about cancelled appointments with no letter received, 2% (6 complaints) about the Queuing and booking system, and 4% (11 complaints) about Incorrect information being within appointment letters. The remaining 7% were about specific, individual concerns.
- Staff told us that they mainly dealt with verbal complaints which were mainly around appointment issues and long delays in clinics.
- In each OPD area matrons held regular meetings with staff where complaints were discussed as an agenda item. The Head of Nursing held monthly clinical unit meetings where complaints and risks were discussed. Each matron compiles a monthly quality report which was discussed at these meetings. This included positive and negative comments from their department which were discussed as a group.
- We reviewed the data submitted by the trust and saw that 19 Complaints had been made with regard to the Radiology services. Complaints made included the attitude of staff, communication and the standard of care.
- The RSM told us that complaints are tracked at the risk meeting. Within the department the RSM will investigate the complaints with the modality leads. Contact is made with the complainants and any issues are discussed and resolved if possible.

Outpatients and diagnostic imaging

- The RSM told us that staff had not received training in the Duty of Candour, and this was confirmed by the staff we spoke to however we were told that the PALS team had introduced the duty of candour process across the trust.

Are outpatient and diagnostic imaging services well-led?

Inadequate

Nursing staff had made improvements in service delivery since our last inspection.

we saw that there was much work in progress and saw the potential for this work to improve services; but this was still very much 'work in progress' at the time of our inspection and was too early to judge its full impact.

There was minimal ownership and local involvement in addressing key service delivery issues on the department risk register. However, nursing staff had improved governance structures and were meeting regularly to monitor and improve the service using learning from quality data, complaints and incidents.

Nursing staff were engaged with their managers and were all working towards building the best service they could for patients.

Administration staff were still unsettled and unhappy about the changes that had been made to their department. They had experienced changes in management since our last inspection but felt that the service had not improved as a result.

Just prior to this inspection a new interim manager had been employed to improve the administration service. They were aware of the issues that had occurred due to the poor implementation of the restructuring of administration services last year. They were able to discuss with us the learning from this.

Although it was early days the interim manager had started to implement positive changes to the governance surrounding administration and was able to demonstrate that they had a plan to improve some of the areas that had caused concern. It was too early during this inspection to make a judgement on the effectiveness or sustainability of these changes.

Vision and strategy for this service

- Nurse management was working towards building skill sets across nursing teams. This would work towards further nurse led services.
- Ophthalmology were involved in a new design for clinics. All staff had been involved in the consultation process.
- Nursing staff told us that the trust wide administration review had caused problems in clinics which had not been resolved. Clinic staffs main concerns around administration were relating to health records management, DNA's and clinic cancellations.
- Staff working in administrative roles told us that they did not feel that the department had improved since our last inspection. They told us that they had seen changes in management and felt that the management structure was unstable and uncertain.
- Some call centre staff were inexperienced and were not able to work at capacity due to staff shortages and a lack of support. They had experienced a recent change in management. Although we spoke with this manager they were very recently in post and unable to provide us with evidence of strategic improvements and reassurance that the department would improve.
- There was recognition from these managers that the OPD had gone through a difficult period due to the redesign of the administration of OPD.
- They discussed with us the learning that they had taken from the way in which these changes had been made. They said as a result any further improvements made to the service would be planned with gateway reviews preventing them from progressing until each action had been completed.
- They also recognised that the department had lost staff with historical knowledge about the department and its workings.
- The strategy going forward at the time of our inspection was to improve administration by recruiting bank and agency staff to fill roles whilst recruitment of five further booking staff and three further reception staff took place. To create standard operating procedures (SoP's) for clinic cancellations, escalating cancellations, and escalating and reporting RTT breaches; And to create a buddy system allowing staff to have specific competencies in the speciality they are working in along with a buddy sharing this knowledge when they are not at work.

- They felt that their biggest challenge was ophthalmology due to the high demand for the service and complex pathways.They had created a five step action plan. We requested this document but the trust did not provide us with it.
- Managers had also devised a clinical administration dashboard which would be reported on monthly. This dashboard covered activities such as partial booking, cashing up and RTTs. It had only been in operation for two weeks at the time of our inspection. We requested this document but the Trust did not provide us with it.
- We were told by the General Manager for radiology that the first 5 year strategy for the service had been developed. The strategy was due to be presented to the board in April 2015 for sign off. We were told that the strategy links in with the Trusts vision and covers areas including workforce, equipment and capacity and demand planning. We did not see the strategy during the inspection.
- Development of the strategy was through a radiology working group, whose membership included the trust chairman, Director of assurance, Lead Radiologist, General Manager and the Radiology service manager.

Governance, risk management and quality measurement

- Minutes from the Specialist Medicine Risk and Incident Meeting for clinical matrons showed minimal ownership and local involvement in addressing key service delivery issues on the department risk register. In response to the waiting list backlogs entered on the risk register, the comments following discussion showed simply that there was, "A recovery plan which will address this". The data provide by the trust did not provide assurance that the recovery plan will address the risk.
- We were provided with minutes from meetings that showed local consideration of specific issues of concern and local monitoring of issues but we did not see evidence of wider organisational learning.
- The Trusts Quality Improvement Targets for 2014/2015 were for 95% of non-admitted pathways to be completed within 18 weeks, and 99% of patients waiting less than 6 weeks for diagnostic tests.
- The OPD collected data monthly for the Trust Clinical Governance Report. There was a governance board in operation at the trust. The OPD matrons attended a regular trust wide quality meeting where governance data was discussed and analysed.
- The Head of Nursing chaired a monthly quality review meeting and clinical unit meeting for matrons. In addition to this each matron compiled a monthly quality report which was discussed at these meetings.
- Minutes from the Specialist Medicine Risk and Incident Meeting for clinical matrons said, in respect of the report from our September 2014 inspection, "The report is currently available to selected staff in the organisation for verification checking. There are areas of concern highlighted in the report, which will be shared within the Organisation once it is released." There was no evidence from our visit or from any on the evidence provided by the trust that the nature of concerns were shared prior to publication of the report. Whilst the full report could not be shared, the main concerns could have been disseminated and improvements begun rather than waiting for publication.
- In radiology the medical imaging department we saw evidence of systematic audit both clinical and safety which was used to inform practice this included auditing the out of hours reporting service to ensure standards were maintained. Presently out of hour scans were re reported the following morning however we were told that this practise was being reviewed.
- Radiology is not a regular board agenda item. However the GM told us that radiology representation is present at the Clinical Management Executive Meeting which is attended by the Chief Executive, all executive's, GM's and clinical leads. The GM told us that at the meeting topics such as the risk register are discussed every 2 months, where high scoring and new risks are discussed. This forum gives the management teams the opportunity to learn about risks in other directorates and the effect they may have in delivering an effective service.
- The trust have a Radiation Protection Committee (RPC) which meets every 6 months and is chaired by which is chaired by a senior member of the Radiology Directorate management team. The IR(ME)R Subgroup (individual RPSs) of the RPC will consider and act upon those issues relevant to this legislation. This and other specialist subgroups of the Committee may be empowered to undertake specific tasks on behalf of the Committee and the employer, though the responsibility for all actions remains with the employer under this legislation.

- The Head of Radiology is the IR(ME)R Practitioner responsible for defining Practitioner Guidelines, IR(ME)R 2000 and subsequent amendments policies, procedures and the implementation.
- The Radiology Service Manager attended divisional bi monthly clinical governance meetings where areas such as incidents, complaints and business cases are discussed across the directorate. This allowed other parts of the directorate to learn about challenges and service improvement plans that may affect them.
- Once a month a PACs meeting takes place to discuss IT issues. Attendance at the meeting includes the PAC system manager, Radiologist, RSM, modality leads and the outside contractor. This allows any issues that arise with the system to be discusses and systems put in place to mitigate any risk as well as a forum to inform staff of possible problems with the system and solutions.
- Attendance at the Quality Committee, which was chaired by the Head of Nursing, allowed the GM to learn about serious incident updates and complaints. Business cases were discussed which allowed other GMs to learn about developments and the effect it may have on their service. When a Radiology Business case was discussed the lead modality Radiologist would be present during the discussions. Feedback from the meeting is given to the Radiology Service Manager who kept staff up to date with developments across the Trust.
- Following the investigation in to a serious incident a 'communicator' was introduced into the Trust IT system which was linked to the Radiology Information system (RIS). All referring clinicians had to accept and confirm they had received the radiological report. This would provide assurance to the radiology department that referrers had received the report and actions will be able to be undertaken by the referrer if necessary to improve patient outcomes.
- The radiologists had quarterly 'discrepancy meetings' which were an educational meeting whereby Consultant radiologists discuss radiological reports. Reporting Radiographers we were told were invited to these meetings. Any discrepancies found would be anonymised and discussed at the radiology risk meeting. The member of staff who reported the examination received feedback via email. If it is thought that the patients management has been compromised an electronic reporting system alert was raised. Discrepancy Meetings are good clinical practice and provide on-going education for radiologists in a lessons learned continuous cycle of improvement which will benefit future patient outcomes and enhance reporting skills. It's a form of continuous professional development and service improvement.

Leadership of service

- We received very positive feedback about the impact of the Head of Nursing on the service. At our last inspection the Head of Nursing had only been in post for two weeks. Since that time it was evident that they had made an impact on the Nursing side of the service with patients having a far better experience once arriving in the department. Nursing processes were slicker with protocols in place to assist staff to perform their roles. There was a sense of calm and purpose in the department which was not evident at our previous inspection.
- At our last inspection staff had not had a clinical leadership meeting for more than 18 months. There were now regular leadership and governance meetings leaving staff better informed and feeling empowered to make positive improvements within their own areas.
- Feedback on the executive team was varied. A few staff told us that they had seen the executive team during walkabouts. However, the majority of staff told us that the executive team did not visit OPD.
- Administration staff were not positive about the leadership of the service. They told us that managers had been moved and replaced but that they had not seen positive changes to their systems of working as a result of this. One member of staff told us that they didn't know who their manager was.
- An interim manager was in post to make improvements to the administration side of OPD. They demonstrated a good understanding of the challenges in the department, which had been bought about by the poor implementation of the restructuring and relocation of central booking and reception areas, along with a long term lack of investment by the trust in the storage, tracking and condition of health records. We did not see any written evidence of the plans. We have been advised by the trust that there were two entries on the risk register at the time of the inspection that related to the poor condition of medical notes and the failure of staff to update the notes tracker.

Outpatients and diagnostic imaging

Culture within the service

- Nursing staff we spoke with demonstrated that they were engaged with the senior team and received regular briefings regarding their departments.
- Administration staff did not feel supported and some staff were unsure of who was managing them. They demonstrated a lack of interest in improvements to the service because they felt that there department had deteriorated through the redesign of the service and felt that nothing had been done to improve this. One member of staff told us that since our last inspection, "The good news is that the people who made this big mess up have been moved, but the bad news is – it is still the same".
- We were contacted by several staff from administration who felt changes were made without any input from people doing the job. Some were angry and felt dismissed by senior staff. In one focus group administrative staff told senior staff, including associate directors, that it felt like they worked in a different hospital to the one being described by the senior staff.
- Other staff contacted us during and after the inspection visit to say they felt bullied and that when they had raised concerns they had been made to suffer. We saw emails from executive directors that were dismissive of concerns.
- Radiology staff that we spoke with told us that they felt communications across the department were poor. One member of staff we spoke told us that they felt let down by management. Staff told us that they did not always feel supported.
- Staff told us that each morning the team leads in radiology had a 5-10 minute meeting with staff to update the staff on any information of importance. We were shown that a communications book was in place for the general x-ray rooms. However we were told large staff meetings were scheduled but did not always take place.

Public and staff engagement

- Quality data was displayed in each area for patients and staff to view. The data displayed showed cleanliness scores, hand hygiene scores, friends and family test scores, staffing levels number of patient attendances in that area.
- Whilst there was still much work to do, all of the nursing and medical staff we spoke with placed a high importance to patient experience. They were able to describe to us how they had made improvements to patient journeys through the department, and how they received feedback when patient's experiences did not meet with the vision and values of their department.

Innovation, improvement and sustainability

- An HCA in orthopaedic clinics had identified a council run weight loss programme and had enrolled patients onto the course. This had allowed patients to reduce their weight and become clinically fit for anaesthetic and surgery.
- The plans put in place to reduce the backlog of the waiting list and improve compliance with RTT times was reliant on staff working additional hours and overtime. Weekend clinics had been put in place and more clinics set up without additional funding. This was not sustainable.

Outstanding practice and areas for improvement

Outstanding practice

In maternity, the telephone triage system provided a high standard of information, guidance and support to women, without them necessarily needing to come into hospital.

Areas for improvement

Action the hospital MUST take to improve

Importantly, the trust must:

- Review the tracking of records. The outpatient department were not tracking patient health records because this job had not been considered during the redesigning of the service. The location of medical records were often unknown and resulted in delays or temporary notes being used. Trusts have a responsibility to track all patients' health records (Records Management: NHS Code of Practice Part 2, 2nd Edition, January 2009).
- Comply with the Data Protection Act 1998. The outpatient department was not protecting patients' confidential data. Patient records were left in public, accessible areas without staff present.
- The trust must make sure the privacy and dignity of patients is upheld by avoiding same sex breaches in the clinical decision unit (CDU).
- Review staffing arrangements for the community midwifery service to ensure they are compliant with the Working Time Regulations (1998), which implement the European Working Time Directive into British law.
- Ensure that all women in established labour receive one-to-one care from a registered midwife.
- Ensure that there are adequate staff, including managers, consultant midwives and labour ward coordinators employed to meet the recommended minimum standards detailed in Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Royal College of Anaesthetists (RCA), Royal College of Paediatrics and Child Health (RCPCH), 2007.
- Review staffing arrangements for the community midwifery service to ensure they are compliant with the Working Time Regulations (1998), which implement the European Working Time Directive into British law.
- Ensure that all women in established labour receive one-to-one care from a registered midwife.
- Ensure that it meets the requirements of the National Specifications for Cleanliness in the NHS. The trust must be able to provide documentary evidence to demonstrate compliance.
- Consider ways of improving the leadership and improving the culture within maternity services.
- Ensure women who need to be transferred after giving birth are not separated from their babies.

Action the hospital SHOULD take to improve

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Ensure fridges used for the storage of medicines are kept locked and are not accessible to people and that medicines are secured in lockable units. This is something that is required as part of Regulation 13 in relation to the management of medicines but it was considered that it would not be proportionate for that one finding to result in a judgement of a breach of the Regulation overall at the location.

Consider how it may improve the experiences of women with regard to their pain management.

Consider ways of updating policies and procedural guidance so staff have access to relevant information.

Consider how it enables staff to attend required training and supports staff to gain additional qualifications to support the service.

Outstanding practice and areas for improvement

Consider how it can improve the checking of all technical equipment across each department.

Consider how it can improve the completion of care records, so that all risks are assessed and recorded.

Consider ways of improving the bereavement facilities.

Consider ways of improving peoples experiences related to food, inappropriate discharge times, antenatal and parent craft provision and partner facilities.

Consider ways of improving the sharing of information and improving engagement with midwifery staff, so they are aware of and involved in future developments.

Consider ways to improve breastfeeding support to new mothers.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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